NHS GREATER GLASGOW AND CLYDE

LOCAL UNSCHEDULED CARE ACTION PLAN

June 2013

INTRODUCTION

NHS Greater Glasgow & Clyde (GGC) has been undertaking a whole system approach to winter planning for 5 years and this has carried on throughout the year both in order to plan for public holiday periods such as Easter and in recognition of the fact that unscheduled care activity is a constant pressure.

Over the winter of 2012/13 there were a number of challenges within GGC admitting or discharging patients quickly enough from Emergency Departments. A number of immediate actions were taken to address the situation and recently performance demonstrated a trend of improvement.

This plan reflects experiences over the recent winter, a review by clinicians and partners on each site and across the Board area, and includes positive learning gained from reviews of systems elsewhere and the guidance issued by NHS Scotland.

Proposed actions are targeted to both achieve immediate improvement and to deliver sustained change in order to improve patient experience and patient outcomes on all hospital sites. Planning will continue to develop medium and longer term plans in lien with the Clinical Services Review

A further detailed winter plan is also in preparation.

This plan will support the achievement of the Scottish Government target for the maximum 4 hour A&E wait of 95% by October 2013 and a programme to achieve and sustain 98% thereafter.

SECTION 2

LOCAL SYSTEM 'HEALTH CHECK'

2.00

GGC currently has a number of performance metrics in place to monitor the local unscheduled care system on a daily, weekly and monthly basis which assists in identifying areas of pressure. (appendix 1) These measures will continue to be used to monitor the unscheduled care system across Greater Glasgow and Clyde.

In addition, GGC has undertaken a system-wide review of Winter 2012/13. This review has considered, both for the NHS Board as a whole, and for

individual sites :

- Number of attendances at Emergency Departments(ED)/Medical Assessment Units (MAU) and Minor Injury Units (MIU)
- The number and rate of emergency admissions
- The number of attendances at GPOOH and Primary Care Emergency Centres
- The number of patients in acute hospital beds who are fit for discharge
- The average length of stay of inpatients
- The pattern of variation across sites , on individual days and at different times
- Intelligence on the clinical conditions requiring attendance and admission
- The number of potentially avoidable admissions of older people
- The reasons why patients are not admitted or discharged in four hours
- The incidence of Norovirus
- The pattern of referrals during the day

The following section provides a brief summary of the review of the local unscheduled care system, against the measures/indicators. The outcomes from this review will inform the proposed action plan to achieve and sustain the 98% HEAT target.

2.1 Performance

Over the winter of 2012/13 performance against the HEAT standard 2012/13 that 98% of patients should be admitted or discharged within four hours was challenging across all sites. The difficulties experienced by this Board were mirrored across Scotland.

Table 1 % Patients admitted or discharged from ED within four hours

Site	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	April 13	2012/13
Western Infirmary	90	83	79	83	87	89	90
Glasgow Royal Infirmary	98	93	88	89	87	89	94
RHSC	92	93	97	98	97	96	96
Southern General Hospital	95	91	89	89	91	92	93
Victoria Infirmary	94	86	85	87	92	92	92
Royal Alexandra Hospital	96	91	86	85	82	88	90
Inverclyde Royal Hospital	96	93	90	91	91	91	95
Board Average	**95**	**90**	**88**	**89**	**90**	**91**	**93**

2.2 Breach Analysis

The top three reasons why patients waited for longer than four hours are shown below .

Table 2 Reasons why patients waited more than four hours

	Wait for bed	Wait for first assessment	Wait for specialist
2011/12	25%	28%	15%
2012/13	36%	22%	13%

2.3 12 Hour waits

GGC has a robust process in place to monitor the length of time patients wait in EDs and should any patient wait more than 8 hours this is escalated to a senior manager. During 2011/12 very few patients waited over 12 hours however this was a feature during winter 2012/13 and the detail is shown below. No patients have waited over 12 hours in May or June 2013.

Table 3 Number of patients waiting over 12 hours

	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	April 13
NHS GGC	0	9	40	21	4	5

2.4 Rate of A&E Attendances

Table 4 shows that attendances at EDs and Minor Injury Units have not increased markedly over recent years. The introduction of assessment units at GRI and the Western diverted some attendances but even including these the overall total is relatively static.

Table 4 ED/ MAU / MIU attendances

	2010/11	2011/12	v'ce	2012/13	v'ce
RHSC attendances	43928	45268	3%	47051	4%
Other Hospitals attendances	422087	412204	-2.3%	408751	-1%
MAU attendances	4486	22764	400%	23550	3.4%
Sub Total	426573	434968	2%	432301	-0.6%

Adjustment made for eye casualty changes at RAH in May 12
Only WIG MAU was open in from May 2010

2.5 Emergency Admissions

Table 5 shows the growth in emergency admissions. Emergency admissions have risen over recent years, changes in hospital configuration at Stobhill and the Vale and new initiatives like the assessment units make direct comparisons difficult. However, these services were all in place during 2011/12. The number of emergency admissions during 2012/13 showed an overall increase of 2.5%. Medical specialties show a larger increase of 3.6% with the greatest increase noted over the winter months.

Table 5 Emergency Inpatient Admissions
Note excl Obstetric

	2010/11	2011/12	v'ce	2012/13	v'ce
RHSC EM admissions	10,220	11,513	13%	11,345	-3%
Other Hospitals EM admissions	208,195	212,161	2%	217,874	3%
ECMS EM admissions	114349	116971	2%	121139	4%

The growth in admissions varies across the sites within the Board area, with the South and Clyde experiencing higher rates of growth. It is noted that the admissions via EDs increased over the period despite GP referrals being directed via MAU on three major sites and despite ED attendances having reduced

The rate of emergency admission per 100,000 population rose by 3%, this was particularly marked at the Southern, RAH and IRH.

In addition on individual days admissions can vary greatly as shown below in Table 6.

Table 6 Variation in attendances and admissions

NHSGGC Atts	Mean	Min	Max
2011-12	1217	966	1567
2012-13	1204	989	1469
NHSGGC ADMITS via ED	Mean	Min	Max
2011-12	295	217	379
2012-13	299	234	385

Notes
1. Covers period Nov - Feb

2.6 Average length of stay (ALOS)

The length of time patients spend in hospital is a critical factor in the Board's service planning, in particular for the number of beds required. Length of stay in most specialities within the Acute Division currently exceeds the Scottish average.

Table 7 ALOS

	GGC Dec 12	Scottish Average Dec 12
Acute Medical Specialties	4.3	4.1
Medicine for the Elderly	16.9	15.9
General Surgery	3.8	3.9

The average length of stay for patients traditionally increases over the winter due to the complexity of presentations however this was particularly marked during 2012/13 within medical specialties.

2.8 Occupancy

Most sites within the Board operate at a high level of occupancy. These high levels of occupancy mean that there are few empty beds in the morning as availability for both elective and emergency admissions is dependent on each day's discharges. The variability in the pattern of daily admissions is also challenging. These delays in beds becoming available lead to delays in EDs and particularly on those sites with limited space, such as the Western and the Victoria, it also leads in delays for assessment and overcrowding in the department.

2.9 Capacity

In addition to the current funded bed capacity, across GGC a number of initiatives were implemented to create additional capacity to manage pressures at key sites over the winter period. Additional temporary beds were opened, beds were realigned from surgery to medicine, five day wards were kept open at the weekend, and the assessment units were used as inpatient wards as were the day surgery units and 23 hour beds on occasion.

2.10 Patients awaiting discharge

Overall the number of patients waiting more than four weeks to be discharged from acute hospitals has fallen from 27 in April 2012 to 13 in April 2013. However the 83,385 bed days were occupied in the acute division by patients who were fit to be discharged. This equates to 228 beds every day ad is a major focus on joint working with local authorities to free up this substantial resource.

2.11 Other Issues

Although the winter did not see a high level of Flu in the community, clinical feedback was that patients were presenting with a viral respiratory infection that, particularly for those patients with existing long term conditions, led to a longer than usual length of stay. This is demonstrated by the increase in admissions to with a respiratory diagnosis over the winter.

An audit was undertaken by medicine for the elderly physicians and a GP to consider if patients could have been treated by an alternative to hospital admission and this identified that a range of existing services could have been used as alternatives on a number of occasions

A research project was undertaken in EDs to understand the needs of patients who choose to present at EDs with complex medico-social problems, For many of these patients there is an inter relationship between adverse social circumstances , such as poverty and violence and their medical needs, including the affects of alcohol and addiction. An action plan has been agreed as result of that work

NOROVIRUS arrived earlier this winter than in the two previous winters. From 1st November 2012 to 31st January 2013, there were 80 wards closed to Norovirus (1,177 bed days lost). This compares to 23 wards closed (509 bed days lost) for the same period in 2011/12 and 19 wards closed in 2010/11. This is a 326% increase in activity since 2010/11.

2.12 GP Out of Hours

Overall, GPOOH services saw significant increases in home visits and attendances at Primary Care Emergency Centres during the winter period and in particular over the months of January and February 2013. PCEC attendances were high over the festive period, peaking in January 2013 to 14,526 attendances (average monthly attendances of 13,000). Walk-ins to this service continue to rise with an average 25% of this activity associated with self presenters. Home Visits were particularly high in January 2013 with 3489

visits recorded (average (monthly visits 3,000). 94% of Home Visits were responded to within the KPIs.

GPOOH continued to support NHS 24 in taking pre-prioritised calls over the festive period – 6,468 calls noted – this is a 20% increase compared to last year.

GPOOH are co-located with A&E departments on a number of sites and work closely with acute services to support redirection of patients who present at A&E with primary care related ailments.

Filling the OOH shifts over the summer has been exceptionally difficult this year due to doctors being less willing to work out of hours or so many out of hour shifts due to choices about work life balance, the increased workload in both in hours and out of hours and issues regarding remuneration and contractual status. Enhanced rates have had to be offered for five weekends over the summer at significant cost to the board and an urgent review will be undertaken to establish a longer term solution.

SECTION 3

INTERVENTIONS AND REDESIGN TO IMPROVE UNSCHEDULED CARE PERFORMANCE

3.1 Principal points of pressure

The review to date has shown that the challenges to delivering consistently high levels of unscheduled care performance are :

- The rate of attendance at EDs/MAU/MIU which, although static this year, compared to last year shows an ongoing cumulative growth
- The 3% increase in the number of emergency admissions in 2012/13 in addition to a 2% increase the previous year
- The average length of stay for medical services and medicine for the elderly is above the national average
- The number of acute bed days occupied by patients who were agreed to be fit for discharge but were waiting for discharge arrangements to be made for them to receive social care

The changes needed to overcome these challenges are to develop a system that

- minimises the time patients spend in hospital
- promotes alternatives to hospital attendance and admission that have the confidence of clinicians and service users
- has a consistent system of assessment and admission in EDs and Medical Assessment Units with senior decision makers in attendance
- has consistent patient flows across services, sites and days of the week
- matches capacity to demand across health and social care
- has much stronger incentives for Local Authorities to prioritise rapid discharge from hospital
- establishes more integrated services and patient pathways between primary and secondary care

GGC has a programme of service redesign underway using lean and other service improvement methodology. Currently focus is on

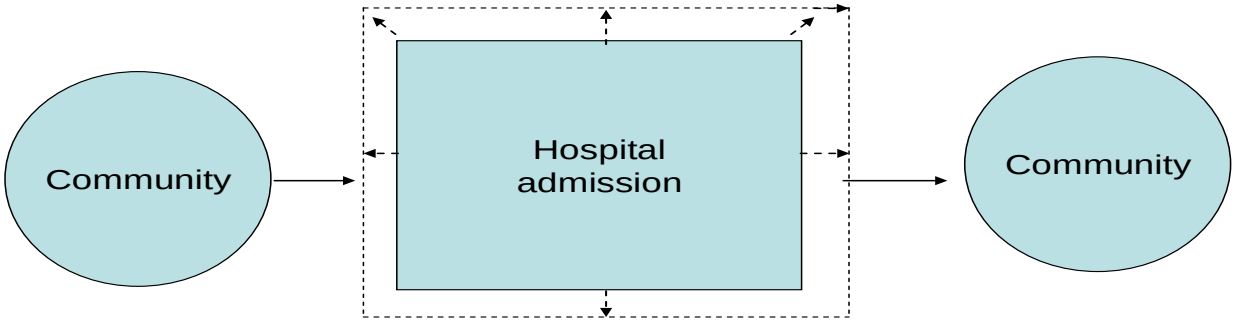
Time of day of discharge including daily board rounds in each ward
Reducing the wait for specialist assessment in EDs
Reducing the wait for diagnostics

3.2 Strategic Planning

NHS GGC has embarked on an ambitious programme looking at the shape of clinical services to ensure we can adapt to future challenges. The first stage focussed on the case for change. The key findings set out in the case for change were then used to inform the development of the clinical service models

The current position is one where we face challenging demand pressures across a system in which where 'hospital' and 'community' services are largely seen as separate, with often poor communication and joint planning across the system. While there are some good examples of joint working, these are not systematic and often on a small scale.

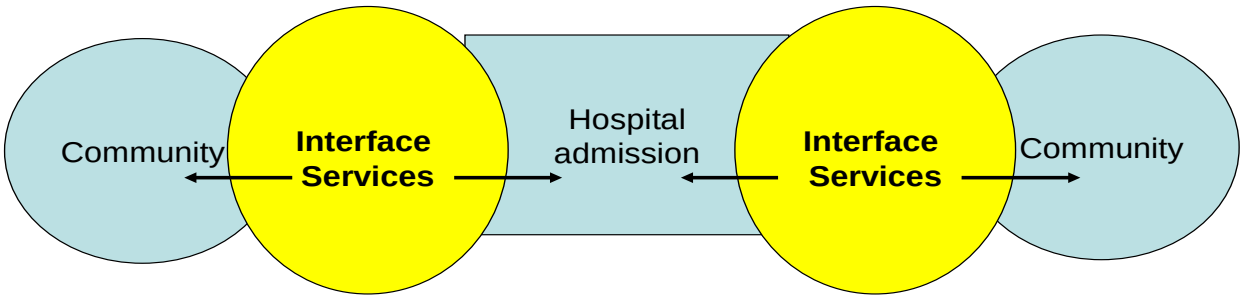
Figure 2



The system of care we want to move to sees a significant change focusing on providing care where it is most appropriate for the patient. This is based on strengthened 24/7 community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits.

Working differently at the interface (represented by the yellow circles below) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Figure 3



Therefore many of our plans in the short term will focus on developing services at the interface as well as developing appropriate services in the community. These may include:

- Anticipatory care planning with plans for rapid escalation of support from health, social care and third sector agencies and developing a single point of access;
- Comprehensive Geriatric assessment in the community and in hospital
- Providing a more flexible range of responses to patients requiring emergency assessment. These may include rapid access to urgent medical clinics, provision of rapid access specialist advice to GPS by email/phone
- Development of 'step up' beds where patients require additional support which cannot be provided at home but does not require an acute admission
- Deployment of specialist advice for patients at home with secondary and primary care teams working together.

The system will see strengthened community services, acute services focused on the assessment and management of acute episodes and a range of services developed at the interface including shared care of high risk patients and a range of alternatives to face to face hospital visits. It is proposed to test key components of the service model with robust assessment of what is required to enable services to deliver these and to identify the implications of the model on all parts of the system.

It is anticipated that there will be pilots developed, aimed at deploying both acute and community resources in a more effective way to rapidly address the needs of acutely ill patients and use resources to best effect.

The specific interventions proposed to deliver improvement in unscheduled care in the coming months are described below aligned to the five strategic themes of the national unscheduled care plan. The intention is to ensure that these actions are delivered systematically across all of our sites. More detail is provided in Appendix 3

3.1 Flow and the acute hospital

- Ensuring discharge planning starts on admission and that estimated dates of discharge are in place and monitored
- Ensuring that patients are discharged earlier in the day
- Reviewing ward round processes to assist earlier decision making and reduce length of stay
- Provide AHPs at weekends in acute assessment, receiving and vascular wards to reduce length of stay
- Establish a dedicated role to ensure that discharge prescriptions are written in advance and discharges progressed by 11 am
- Develop clinical support workers to support ward medical staff with non medical duties
- Development of urgent outpatient appointments in key services accessible by EDs
- Improving Outcomes and Efficiency by Optimising Flow – Proof of Concept Testing, pilot site for national work supported by QuEST
- Review of the acute bed model to consider further realignment of beds to ensure that patients are admitted to the specialty they require.
- Review of the bed model applied to each site
- Review of non acute beds with a focus on those off main hospital sites to ensure all beds can be used optimally to aid patient flow

3.2 Promoting senior decision making

- Additional senior decision makers in Emergency Departments until midnight
- Acute care physicians providing early decision making in assessment and receiving units to allow earlier discharge
- Additional ward rounds at peak times to reduce length of stay
- Development of other professions to progress decisions about discharge
- Development of elderly care assessment nurses to ensure holistic assessment of older people and link with community services

3.3 Assuring effective and safe care 24/7 at the hospital front door

- Direct admission from Emergency Departments to specialty wards
- Additional assessment unit capacity to allow GP referred patients to

bypass EDs
- Completion of upgrading of IRH ED to provide more space and better flows
- Creation of area for minor patients at Western
- Redesign of RAH ED including colocated GP OOH
- Considering an admission prediction score for use in EDs

3.4 Making the community the right place

- Further develop Acute Medicine Outpatient Clinics
- Extend Virtual Fracture Clinics across sites
- Extended use of Same Day Assessment Units for surgical specialties
- Development of medical day areas taking planned and urgent cases
- Rapid Access Day Hospital for older people
- Review of 23 hour and short stay surgery to maximise use of dedicated facilities
- Trial of providing Older Peoples Mental Health liaison in an ED

A systematic review will be undertaken to ensure that the following key elements will be provided in all partnerships, this will be joint work with local authorities where partnerships are not integrated

- Rapid response community services accessible via a single point of access
- Rapid response home care providing reablement
- Rapid access to care home placement where this is indicated
- Anticipatory Care Plans to be in place as required by the GMS contract
- Polyharmacy reviews fully in place

Each partnership is reviewing the audit of older people's admissions to ensure that existing services, described above, are used where appropriate t support older people at home.

An evaluation is underway of the initiatives currently in place across all partnerships supported by the Change fund. Those initiatives that have been found to be successful will then be rolled out across the Board area. This includes consideration of

- Step Up Care for patients to be directly admitted from home to a community bed
- Fast track palliative care discharge
- Community transport service taking people home from Emergency Departments

The outcome of the District Nursing review and the review of specialist support to Care Homes will be implemented to ensure a Board wide service response that helps to maintain people in their own homes both in times of acute illness and at the end of life.

Joint working with local authorities will ensure that patients, where clinically appropriate, complete complex social care assessments in the community not in hospital.

A pilot of a professional to professional line will be developed with the SAS and GP OOH service.

3.5 Developing the primary care response

The Board has a primary care planning group and framework and an ongoing work programme to

- Develops services that are sensitive to the needs of patients with complex medico-social needs.
- Provide information on ED attendance and acute admission by practice to partnerships to allow local discussions as to variation

In addition a new approach to working between acute and primary care is being developed in Inverclyde CHCP with the first workshop held on 27th June, an action plan will be developed from that day.

A GP interface group has been established to develop a work programme that develops more effective working between primary and secondary care. Initial plans are to consider a community phlebotomy service, a review of pathways of patients with long term conditions to review shared care arrangements and improving the sharing and transfer of information between primary and secondary care

A review of OOH GP services and their remuneration will be completed given the challenges in ensuring service delivery over the summer of 2013.

3.6 Winter Planning

GGC will continue to take a single system approach to Winter Planning and will work across Primary and Secondary Care and with other key partners to develop a detailed and robust Winter and Escalation Plan for 2013/14. This includes Primary Care, NHS24, Community Health Partnerships, Local Authorities Social Work, GGC Out of Hours, Scottish Ambulance Service, the Acute Division, Mental Health Partnership, Public Health, Oral Health, the Communications Team, Occupational Health and Addiction Services. This plan will be developed synergistically with the LUCAP plan and in addition to the

above redesign initiatives will make reference to the specific winter initiatives that require to be enacted to manage the anticipated demand

In addition the Winter plan will :

- Provide additional capacity for a predicted 3% increase in admissions and attendances
- Consider the level of planned care at predicted peak times
- Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent. The Communications team will support the preparation for Winter through the local and national winter campaigns and will continue to use the Know Who To Turn to approach to identify alternatives to attendance at A&E. The team will liaise with Local Authorities to ensure staff are aware of the festive season arrangements in their daily contacts with specific groups such as users of home care services.
- Effectively implement Norovirus Outbreak Control Measures
- Ensure continuity plans are in place – in recognising the need to prepare for all possible scenarios, a system-wide contingency plan including criteria which will necessitate its activation has been developed
- Support the National Flu campaign and introduce measures to further enhance uptake by staff of the Flu vaccination

SECTION 4

Performance Framework

GGC recognises the need to improve its performance on a sustained basis.

Appendix 2 provides a trajectory towards the 95% standard and outlines the initiatives expected to deliver that improvement. Given the complex linkages between aspects of unscheduled care these actions have been shown thematically

Performance towards the trajectory will be monitored via the governance processes described below and will be based on the agreed dashboard of daily, weekly and monthly data. Daily reports are issued across acute services with weekly reports considered by the Acute Directors and monthly reports taken to the acute management team, corporate management team and the NHS Board. Appendix 4 shows the performance tool that will be used to track the impact on each action of the performance on each site

Trakcare is now in place on all sites which will allow the integration of current information systems to provide real time and anticipatory reporting. This reports are currently in development but will include the key measures required for the LUCAP

The wardview system will be introduced at the Western Infirmary as an initial pilot. This system allows real time monitoring at ward level of actual and expected admissions / discharges as well as clinical indicators such as early warning scores.

Daily beds meetings are held each day twice a day with clear escalation plans in place.

SECTION 5

Workforce Plan

GGC has made significant investment into acute services over the last 12 months across consultant and nursing staff. The introduction of 14 additional ED consultants has allowed sites to extend access to senior decision maker until late in the evening. The further 3 advance appointments funded by the government will allow this to be put in place on all sites.

GGC is seeking to appoint an additional 3 WTE acute physicians to assist with the planning and delivery of unscheduled care and in particular to provide acute out-patient clinics

GGC has reviewed the nursing workforce including the implementation of the Keith Hurst workforce tool, the skill mix in wards and the role of the Senior Charge Nurse

Additional investment has been made to facilitate AHPs to work seven days in certain areas, additional funding from the national unscheduled care action plan is sought to provide this in a wider range of wards

It is proposed to create clinical support worker roles in the acute assessment units to provide phlebotomy, ECG and other tasks currently undertaken by medical and nursing staff to free up more time for assessment and decision making

Each site will have a dedicated role focussing on ensuring that patients are discharged as early in the day as possible. These posts will work with the discharge team who support discharge planning for patients whose discharge is more complex and may require input from social care.

SECTION 6

Governance

The delivery of the Unscheduled Care Plan will be undertaken by the following arrangements

Board Strategic Unscheduled Care Group - this will be chaired by Chief Operating Officer and will be attended by the Director of Glasgow City CHP/Mental Health Partnership; Board Medical Director, Director of Emergency Care & Medical Services; Director of Corporate Planning and senior clinicians . This group will bring together the Board's work on unscheduled care with the reshaping care for older people programme.

Operational Unscheduled Care Group – this will be chaired by the Director of Emergency Care & Medical Services and will meet monthly. The group will have a key role in working with partner agencies. This group will include senior management representation from across Primary and Secondary Care; NHS24; Mental Health Services; GPOOH Service; Public Health; Corporate Services Communications and the Scottish Ambulance Service

Acute Unscheduled Care Group – this will be chaired by Director of Emergency Care & Medical Services and will focus on issues internal to the acute division This group will meet monthly and will include senior clinical/management representation from across all Directorates within Acute services.

Hospital Unscheduled Care Groups – these will meet on each acute site and bring together local clinical and management staff to review that site's performance

Locality Unscheduled Care Groups – these will be jointly chaired by the General Managers of Medicine and partnership Heads of Service and will include management/clinical representation from primary, secondary and social care. Their role will be to consider initiatives that might reduce admissions and attendances and link with work on reshaping care for older people locally.

GGC UCAP Support Team - to further support the implementation of the Programme, it is intended to establish a LUCAP Support Team which will comprise management, nursing, clinicians and information services staff. This team will provide project management support to each of the sites. Senior clinicians will be released from clinical duties to lead service redesign and improvement on each major site. A Band 6 project officer will be appointed in the service sectors to provide support to the Lead Nurses and Service Managers to take forward service redesign and improvement.

SECTION 7

Financial Investment

The investment of supporting the management of unscheduled care services is £m. Of this GGC has committed £2.2m of this and is bidding against the national funding to obtain £2.7m. Detailed breakdown of the cost is identified in Appendix 3.

GGC has invested significantly in unscheduled care over the recent years including significant capital improvement in Emergency Departments and additional diagnostic capacity. 13 additional consultants in adult emergency medicine have been appointed with 2 additional in paediatrics. This has allowed the extension of senior decision making in the departments, nurse staffing has been increased in medical wards and an additional medical ward created at the Victoria Infirmary.

Non recurring resources were made available to partnerships and acute services during winter 2012/13 and the detailed winter plan will inform any additional investment required this winter.

WEEKLY PERFORMANCE REPORT APPENDIX 1

NHSGGC (All hospitals)	Week Ending:			
	09-Jun-13	16-Jun-13	23-Jun-13	30-Jun-13
New A&E Attendances				
4hr A&E Target Compliance				
Admissions via A&E / MAU				
A&E patients waiting over 8 hours				
Total breachers				
Breach - wait for specialist				
Breach - wait for bed				
Breach - wait for 1st assessment				
Inpatient elective admissions				
Elective cancellations				
Boarders				
Transfers after 8pm				
Beds becoming available after 4pm (Mon-Fri)				
Average Length of Stay				
Delayed patients at end of week				
Average no. patients per day awaiting transfer to DME				
For each hospital site				
New A&E Attendances				
4hr A&E Target Compliance				
Admissions via A&E / MAU				
A&E patients waiting over 8 hours				
Total breachers				
Breach - wait for specialist [n/ave wait(mins)]				
Breach - wait for bed [n/ave wait(mins)]				
Breach - wait for 1st assessment [n/ave wait(mins)]				
Inpatient elective admissions				
Elective cancellations				
Boarders				
Transfers after 8pm				
Beds becoming available after 4pm (Mon-Fri)				
Average Length of Stay				
Delayed patients at end of week				
Average no. patients per day awaiting transfer to DME				

WAIT FOR SPECIALTY REFERRAL

Number of patients

INITIALS	CHI NUMBER	HOSP	ADMIT SPEC	REG DATE & TIM	WAIT TIME

WAIT GREATER THAN 8 HOURS

Number of patients

INITIALS	CHI NO	HOSP	SPEC	Arrival Date Time	TIME IN DEPT	GENBREACH

APPENDIX 2

NHS Greater Glasgow and Clyde Performance Trajectory

	% performance
July 2013	94
August 2013	94
September 2013	94
October 2013	95
November 2013	95
December 2013	95
January 2014	95
February 2014	96
March 2014	96

APPENDIX 3

Actions to deliver improve outcomes and associated cost

Immediate actions

	Impact	Cost
Additional transport to GGH , new vehicle plus staffing	10 patients moved each day	£30,160 revenue £25,000 capital
Dedicated role for early discharge	30% increase in patients discharged by 11am	Nil – redesign
Nurse to take calls from GPs at GRI	Reduction in time to first assessment	Nil – redesign
Discharge lounge at SGH	20 beds freed up each day earlier in day	Nil – redesign

Further Actions

	Impact	Cost £
Reduction in number of patients awaiting discharge	31,929 fewer occupied bed days	Nil
Additional community services to provide more rapid response at weekends	Reduction in admissions at weekends	500,000
Provision of Step Up care beds	Reduction in admissions	Funded by Change Fund
Community Transport from EDs	Reduction in patients waiting on Transport	Funded by Change Fund
Emergency Community Dental service at RAH from October to December to reduce attendance at EDs	Reduction in patients attending ED with dental issues	90,000

Direct access from SAS to GP OOH	Reduction in ED attendances by SAS (999)	220,000
3 acute physicians for South / West Glasgow	Provision of acute out-patient clinic and increase in patients discharged from assessment unit	300,000
Opening of 8 beds in assessment unit at RAH over weekends	Reduction in patients waiting for medical assessment at weekends	161,000
Opening of 9 beds in assessment unit at Victoria at weekends	Reduction in patients waiting for medical assessment at weekends	161,000
Opening of 9 beds in assessment unit at SGH at weekends	Reduction in patients waiting for medical assessment at weekends	160,000
Creation of dedicated minors area in evenings and weekends at WIG	Reduction in patients waiting for first assessment in evening and weekends	73,000
Weekend AHP service in acute medical and surgical receiving units	100% of patients seen within one day of referral to AHPs	384,000
Pharmacy service til 20.00 and weekends from October to March	Reduction in time to issue discharge prescriptions	100,000
6 Band 3 Clinical Support Workers to free medical staff	Improved time to completion diagnostics	106,345
Additional Consultant sessions to provide additional ward rounds from October to March. 5 sessions per main site	Increased discharges; reduction in number of patients waiting for bed	300,000
2 band 6 nurses to focus on ensuring early discharge at GRI and Western	Reduction in patients waiting for beds	81,000

Corporate Actions

	Impact	Cost £
Unscheduled care team 1 WTE project manager, 1 WTE data manager, 6 clinical leads, 4 project officers	To ensure consistent practice across all sites and to develop sustainable service improvement	350,000

Winter 2013/14 Actions

	Impact	Cost £
Communication campaign on " know who to turn to "	Increased use of minor injury units	15,000
Additional Portering, Nursing and medical staff in ED and assessment units over winter months	Capacity to cope with increased demand	250,000
Additional area in WIG ED overnight	Reduction in waits for first assessment	72,000
Additional 90 beds from December to March in IRH, GRI and SGH	Capacity to cope with increased demand	1,000,000
Additional Diagnostic Capacity from December to march	Capacity to cope with increased demand	300,000
Additional GPs in OOH over peak holiday periods	Capacity to cope with increased demand	100,000
Additional ambulances over winter months	Capacity to cope with increased demand	100,000