UNSCHEDULED CARE WINTER PLAN

November 2015

NHS Greater Glasgow and Clyde

Final Draft

UNSCHEDULED CARE WINTER PLAN

WHOLE BOARD OVERVIEW

1. Introduction

This plan has been developed through detailed review processes within the Acute Division and our Partnerships and collective consideration by the Board Chief Executive, Chief Officers and Directors across our system with scrutiny by the Board and by IJB's. That planning process reflects the fact that acute, community, primary care and social care service are interdependent and need to operate as a coherent system to achieve our objective to deliver high quality patient care throughout the pressurised period of the winter and to meet the national target to deliver care to 95% of Accident and Emergency attendees within 4 hours. Our Partnership plans provide a strong focus on maintaining flows out of hospital, including reducing delayed discharges and this is a critical element of our ability to deliver the target.

2. Communication

Public information and communication is a critical part of our preparations and this section sets out the activity which will be led by our Corporate Communications team.

Late November

- Publish the next edition of Health News (our 16 page magazine) on 24 November. We will include information on what the six HSCPs are planning to do to continue to provide community and primary care services over the 2x4 day holiday period and signpost people to the winter booklet that will be published in December. We have also had confirmed that we will have detailed local information on pharmacy opening times for those opening throughout the four day holiday periods.

- NHS 24 Be Health-wise campaign launches on 26 November. Promote the NHS 24 national messages via social media, website, distribution of posters in community venues and local PR

Early December

- Staff campaign on winter, including Staff Newsletter, Staffnet, Core brief, hot topics and winter preparedness web portal for staff and public.

- Produce the winter booklet as usual and distribute to GP surgeries and social work colleagues to share with their clients. Publication date is first week in December.

- Online version of booklet posted on our website and shared with NHS24 and local authorities

- Social media and media release to promote the booklet

- Local authorities asked to promote the booklet in their public magazines

- Co-ordinated social media activity with other SNS including Sandyford twitter account and website to promote the services that are open on the 2 x 4 day period.

- GPs to be encouraged to remind patients of closures.

Additional activity

- Develop an eight page guide to your NHS in winter for every household in NHSGGC (with key information about how to use emergency services, flu vaccinations, Know Who To Turn To messages). We will also heavily promote the online postcode finder facility for A&E and MIUS and reinforce messages about GP Out of Hours services and using NHS24 to access them.

- We will also develop and launch an in-house video that we can publish on our Youtube channel and also show on our solus screens in health centres and hospitals encouraging people to make use of community NHS services in the holiday period.

  Social media will be used to promote the household guide.

3. Escalation

A system wide escalation process is being finalised.

4. Resources

The Acute Division and Partnership plans include additional investment over the winter period, this is particualry challenging given the financial pressure being experienced across NHS and social care spending.

5. Flu Vaccine

We have an extensive programme to maximise the numbers of staff and patients vaccinated for flu. The coverage of the programme is under detailed review and action is being taken to achieve the highest possible vaccination rates.

6. Performance Review

The delivery and effectiveness of this plan will be continually reviewed and modified, within the Acute Division, each Partnership and across our whole system. Each part of this plan includes key performance indicators which enable us to assess the effectiveness of each element of our planning.

ACUTE DIVISION OVERVIEW

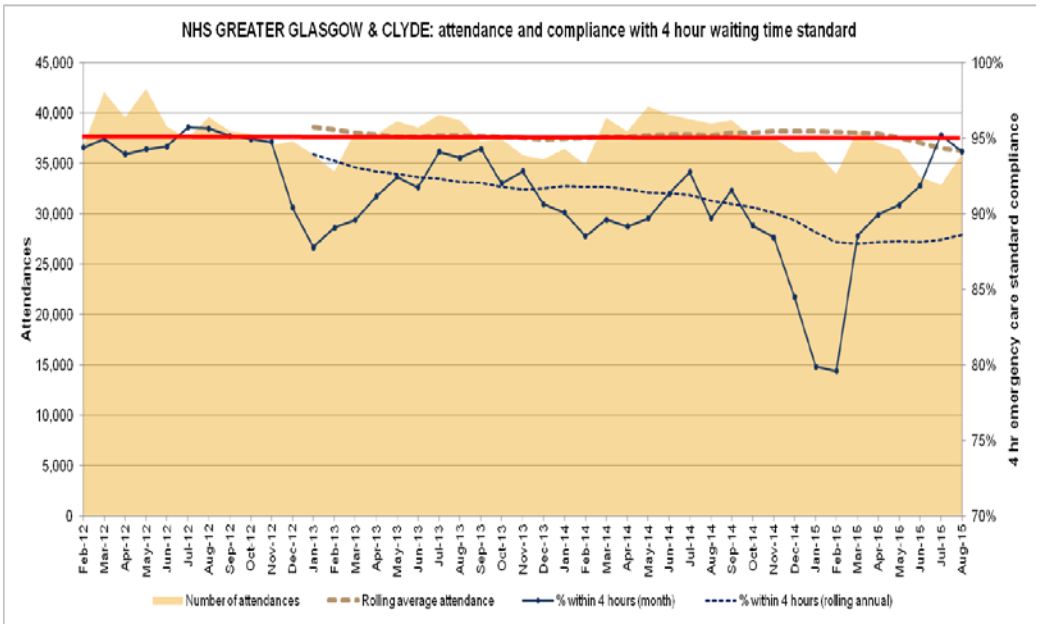
1. Introduction

This section provides an overview of issues across the Acute Division and is followed by the detailed plans for each of the three sectors and our Children services, which deliver unscheduled care.

2. Current Pressures

There is current pressure on performance in relation to the Accident and Emergency target as shown in the graph below:

A&E Performance



3. Analysis of Capacity and Demand

- This year's plans are being developed within a significantly different context following the reconfiguration of services associated with the opening of the Queen Elizabeth University Hospital and the closure of the former Southern General Hospital, the Victoria Infirmary and the Western Infirmary. With the opening of the new QEUH, new service models have been introduced for the management of GP urgent care referrals bypassing A&E into purpose designed assessment units. Patient flow has also been affected by boundary changes with South Lanarkshire Health Board, intended to divert demand mainly from the South sector towards Hairmyres Hospital.

- The changes make the ability to forecast demand using historic trends more challenging. We have approximately 20 weeks of experience upon which to build an understanding of the new patient flows, both across the city and within the QEUH.

- Our understanding of the year on year profile of A&E attendances is that overall numbers are stable with variance of annual totals of less than 1%. The variation in-year also follows a consistent profile with attendances rising during the spring but dropping in the winter months.

- In terms of the flow of activity across the Board area, the plan and actual are set out below:-

- **A&E attendances:**
  - Model worked on basis of a split of 42% GRI / 58% QEUH.
  - Experience for Jun/Jul/Aug indicates actual split of 52% GRI / 48% QEUH.

- **Non elective admissions - Total:**
  - Model worked on basis of 46% GRI / 54% QEUH.
  - Experience for Jun/Jul/Aug shows the balance has been accurate at 45.7% GRI/ 54.3% QEUH.

- **Non elective Admissions - Emergency Care & Medicine (including RAD):**
  - Model worked on basis of 47% GRI / 53% QEUH.
  - Experience for Jun/Jul/Aug shows the balance has been accurate at 46.5% GRI/ 53.5% QEUH.

- **Non elective admissions - Surgery & Anaesthetics:**
  - Model worked on basis of 39% GRI / 61% QEUH.
  - Experience for Jun/Jul/Aug shows a balance of 42% GRI /58% QEUH

- **Have Medical Admissions increased across the city?**
  - Trend across 5 years does not indicate any substantial increase in Medical Non - elective admissions

4. Resources for the Acute Division Plan

In the light of the reconfiguration of Acute Services we have less beds available this winter than previously and therefore Scottish Government have already agreed £5m additional funding to enable the new ways of working across the Acute Division to become embedded through the first six months of 2015. This additional funding underpins baseline activity and capacity relevant to achieving all extant Scottish Government waiting time targets.
In addition to that funding we have received the following additional funding from Scottish Government:

- £7.1m for delayed discharge, passed in full to Partnerships as directed;
- £1.67m for the six essential actions programme which is already committed;
- £1.8m further winter monies;

In previous years the Board has used non recurrent resources to fund additional services and capacity for winter. In financial planning for 2015/16 we have allocated £4.5m from non-recurrent sources for the winter, with the uncommitted SG funding this gives is £6.3 million for this winter. Bids from the Acute Division are shown below.

NHSGGC

Winter Plan - Summary of Costs

	South £000's	North £000's	Clyde £000's	W&C £000's	Total £000's
Assessment Capacity	842	536	829	209	2,416
Flow Management	99	510	26	12	647
Optimise Capacity	1,181	1,803	920	153	4,057
Discharge	89	97	180	29	395
	2,211	2,947	1,955	402	7,515
Facilities & Support Services Costs					200
Diagnostic Services					300
					8,015

Figures above are based on a 4 month period from 1st December 2015 to 31st March 2016

It is not anticipated that all schemes would have a 1st December 2015 start date.
Therefore total costs likely to reduce by c£500k, Hence likely full cost would be in the region of £7.5m.

These proposals will be reviewed in the first week in November and prioritised to remain within the available funding envelope which cannot be increased given the Board's overall financial position with a substantial overspend in Acute services.

5. Key performance indicators and reporting:

- We have a set of key performance indicators which enable us to assess in each sector and across the Division whether we are delivering the performance required to meet the target, covering:-

  - Length of stay
  - Delayed discharge (all reasons not just social care)
  - Weekend discharge
  - A and E and Assessment Unit discharge and admission rates and lengths of stay.
  - Estimated date of discharge
  - Boarders

6. Norovirus

We are finalising our approach to norovirus for this winter including the updating of the policy for managing outbreaks in single room accommodation and how we will approach the implementation of updated national guidance which suggests that it may be beneficial to exclude visitors to closed wards. We will continue to monitor trends daily and communicate the impact in real time to senior managers.

7. Staff Bank

NHSGGC Nursing & Midwifery Staff Bank supports clinical areas in complex situations with competing initiatives and priorities. During the winter months there is an increased reliance on the nurse bank service to provide additional workers to support extra capacity. In addition, this winter as a result of reorganisation one of the key challenges may be the unknown clinical demands on the bank service. In order to prepare for this NHS GGC Nursing and Midwifery Staff Bank have worked closely with key stakeholders to understand their pressures and priorities and therefore optimise the support available from the bank service.

- To ensure robust communication and engagement with services.
- To ensure the optimum provision of bank
- To ensure responsiveness to capacity surges
- Provide reporting and tracking to highlight increase in demand and areas of weakness.

NHS GGC Nurse Bank leadership team initiated early engagement with key service stake holders to ensure that a communication strategy was agreed with each sector in readiness for dealing with high demands. Engagement with the bank workforce is ongoing through existing structures and reinforced by site based presence, regular newsletters and key information on Nursing Portal. The newly qualified recruitment campaign is now coming to fruition with 150 qualified nurses being placed in ward areas across the sectors identified as having the greatest need this will provide a consistent approach to managing rota gaps as well as support or newly qualified nurse to consolidate knowledge and learning. Staff bank leadership team are working with service colleagues and recruitment to develop October – January recruitment strategy. The introduction of bank support teams have begun in the South and Clyde sectors with roll out to North sector planned for early November. Engagement with framework and non framework agencies will ensure that they have systems in place to meet demand over the period. In order to ensure services are kept

informed of local demands and risk the staff bank will provide daily and weekly reports on bank and agency usage with function to drill down to specific areas. The contact Centre will identify additional temporary call handlers to focus on out bound activity specifically focusing on the identified areas of concern highlighted from daily huddles. Business continuity plans are in place to allow the contact centre to provide and effective service in the event of a systems failure.

8. Escalation Process and Actions

We are finalising a Division wide escalation process.

9. Elective Activity

This plan assumes limited restriction on elective activity over the holiday period but we are continuing to review whether elective activity can be sustained at the current level through the winter period.

10. Six Essential Actions Programme

The Scottish Government launched the Six Essential Actions Programme earlier this year to spread good practice in management of Unscheduled Care. These actions have been incorporated into the Winter Plan and improvement work is will improve our ability to manage patient flow and utilise beds more effectively.

Essential Action 1: Clinically Focussed and Empowered Hospital Management

The Board has restructured its management arrangements to established clear site leadership with a Sector Director supported by a Chief of Medicine and Chief Nurse. This structure is replicated through the Clinical Directorates and Specialties. Daily 'Huddles' are now in place on all sites ensuring effective communication and action to respond to the pressures as they present day to day.

Essential Action 2: Hospital Capacity and Patient Flow (Emergency & Elective) Realignment

This plan is being built on thorough analysis of activity trends underpinning our understanding of the likely workflow pressures over the winter.

Essential Action 3: Patient rather than Bed Management – Operational Performance Management of Patient Flow

We have benefitted from Government support in detailed analysis of 'front door' pathways to inform our understanding of how patients present through the day and where the bottlenecks present. Our information services have a programme to introduce close to real-time reports on patient flow. We are embedding the Expected Date of Discharge practice throughout the Board enabling greater understanding of when discharge is taking place and where action is needed. Our focus is on improving our rate of discharge before noon and expediting weekend rates.

Essential Action 4: Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway

The design of the QEUH 'front door' is predicated on cohorting patients to improve patient flow with Acute Receiving Units aligned to clinical specialties to expedite specialist assessment and rapid decision-making. The GRI, RAH and RHSC have assessment units as part of the infrastructure for managing demand. Learning from last year and the Renfrewshire pilot is being applied across the Board to introduce pathways and rapid

access clinics as an alternative to unnecessary admission. Clinical practice on the wards is also changing, enhancing the practice of ward rounds to ensure a focus on expediting actions around patient care and creating the capacity for patients who need admission.

Essential Action 5: Seven Day Services Appropriately Targeted to Appropriately Reduce Variation in Weekend and Out of Hours Working

Building on the above actions, we have identified pathways and patient flow which can be problematic outside 'normal' working hours, evenings and weekends. Services and staffing plans are being introduced to ensure capacity is aligned to where this workload exists. This means extending hours of operation of Minor Injuries Units, Discharge Lounges and diagnostic facilities. More and more services are enhancing provision to provide a 7 day service.

Essential Action 6: Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting

We are working closely with the IJBs to join up planning of services to enable patients to be discharged safely and effectively following admission. Alternatives to admission are also intrinsic to this approach, providing GPs and Community teams with options to ensure access to urgent specialist care through 'hot clinics' and avoiding unnecessary admission.

CLYDE SECTOR UNSCHEDULED CARE/WINTER PLAN 2015/16

1. INTRODUCTION

This plan provides an overview of the Clyde Sector winter actions and contingency planning taking place to ensure preparedness for winter 2015/16. It details the approach to use previous data and information available to forecast and support increased demand over the winter period and describes the escalation plan that will support the delivery of unscheduled care and manage surges in demand across the sector. Additionally it includes the actions required to evaluate, and where appropriate mainstream the output from the Renfrewshire Development Programme to ensure the benefits of the schemes continue to be realised through the winter period.

2. PLANNING ASSUMPTIONS

Based on the general stability of activity levels and patterns over the last 3 years we have planned for winter on the basis that the demands on the system will be broadly similar to last winter. Therefore we have not assumed or planned for an overall increase in activity or attendances.

3. CLYDE SECTOR BED CAPACITY

Acute in patient and emergency services in Clyde are delivered in 3 hospitals these being Royal Alexandra Hospital (RAH), Inverclyde Royal Hospital (IRH) and the Vale of Leven (VoL). RAH and IRH both have an Emergency Department (ED) which operates 24/7. In VoL emergency services are provided via a minor injuries unit and a GP Medical Assessment. In patient bed numbers on each of the sites are as follows:

Table 1 - Clyde In Patient Bed Numbers (based on SMG submission)

	RAH	**IRH**	**VoL**	**Total**
Medicine for the Elderly	160	97	41	298
Medical Specialties	203	127	39	369
Surgical Specialties	202	93	10	305
Total	**565**	**317**	**90**	**972**

4. REVIEW OF HISTORIC ACTIVITY

4.1 ED PRESENTATIONS 2015/15

The graphs below details the AE presentations across Clyde from Oct 2014 to Sept 2015. The rate of ED presentations (as is the case Board wide) increases across the Summer months. Figure 2 more clearly shows the differences in daily attendances between summer and winter with a comparison in daily attendance figures drawn between Dec/Jan 2015 and August Sept 2015 where activity across the sites peaked.

Figure 1: ED Presentations

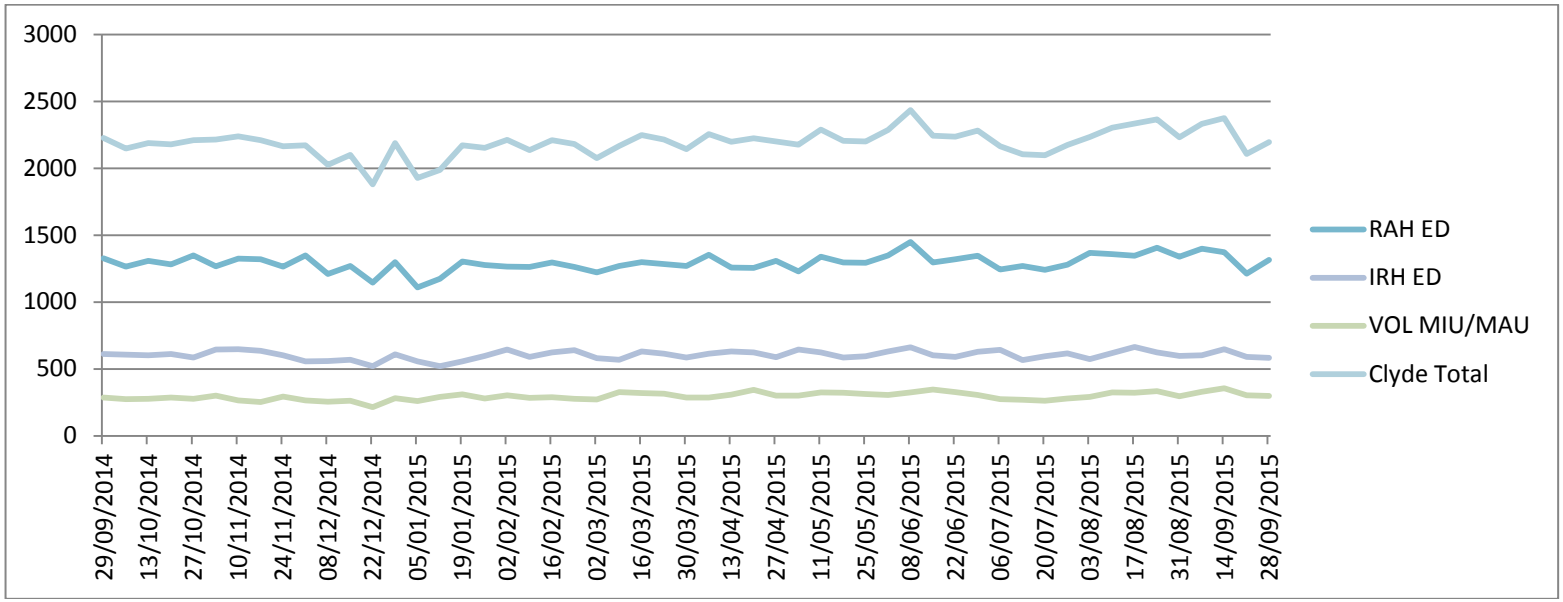
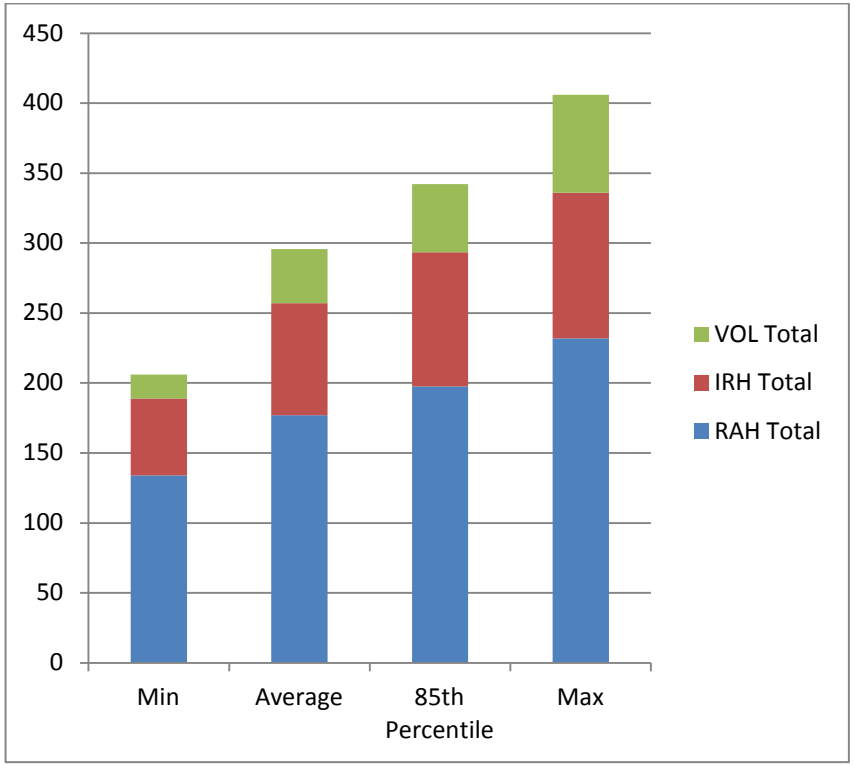
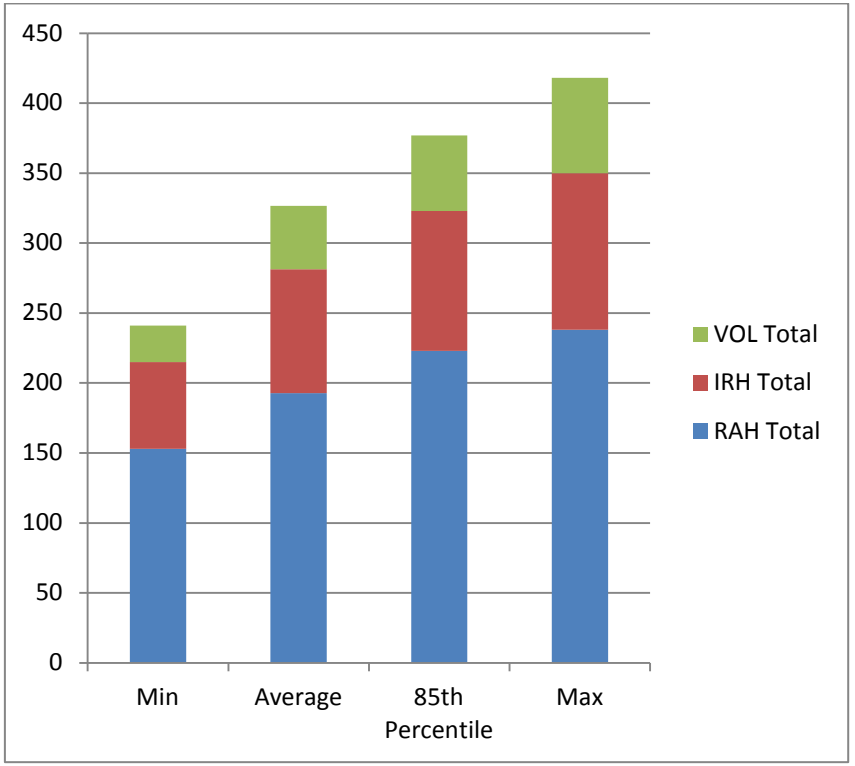


Figure 2 – Comparison in average daily attendances Dec/Jan 2015 and Aug/Sept 2015.

Daily attendances Dec 14 – Jan 14



Daily attendance Aug 15 – Sept 15



4.2 ED Attendances - Winter Trends

Based on the weekly figures, total attendances were up by 1.2% across Clyde during the winter period from week beginning 28th October to week beginning 24th Feb 2015 as compared with the same period in the previous year. The highest average attendances in winter 14/15 were experienced through the first 3 weeks of November. Total attendances were up on all 3 sites with the biggest increase noted at 2.7% on IRH. Figure 1 details total Clyde attendances by year, with figure 2 showing the 14/15 winter attendances by site.

Figure 3 - Weekly ED attendance figures by year – Winter (w/c 28th Oct – w/c 24th Feb)

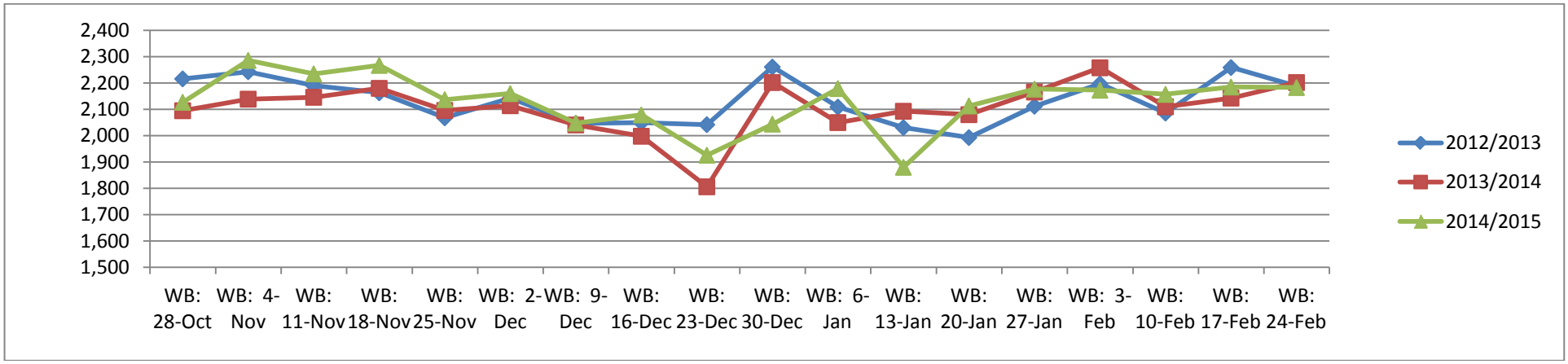
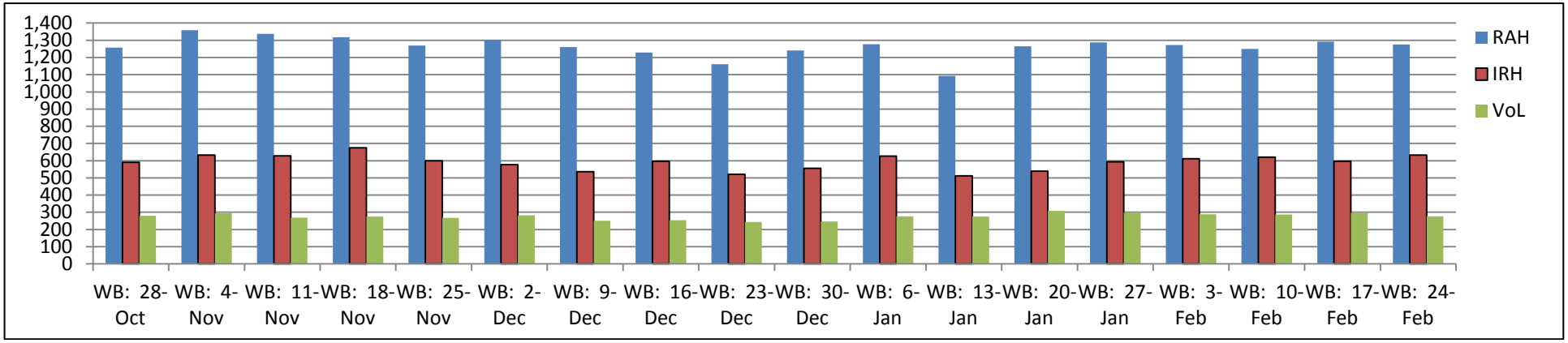


Figure 4 - Weekly Attendances by Site



Of all patients who attended the ED departments across the 3 sites, 36% were classed as minors and the remaining 64% majors. This is fairly typical on IRH and RAH sites but the proportion was quite different on Vale site where the split was closer to 54% minors with 46% majors.

Over the winter period combined attendances at the Emergency departments (including MIU at VoL) averaged 306 per day resulting in an average of 119 daily emergency admissions. The breakdown is as follows:

Table 2 - Average Daily ED attendances by site Winter 14/15

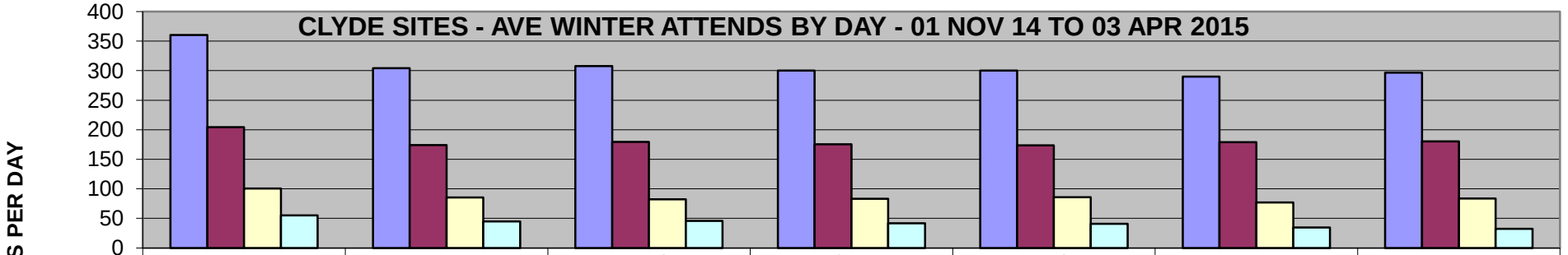
SITE	Average	85th Percentile	95th Percentile	Min	Max
RAH	180	199	214	134	232
IRH	85	100	108	55	123
VOL	41	53	59	17	70
Total	**306**	**352**	**381**	**206**	**425**

4.3 Daily Attendance Admission and Performance

The average daily attendances, based on the day of the week over winter 14/15 are detailed in Figure 2 below. Attendances across all sites increase significantly on a Monday and drop only very slightly over the weekends. In comparison, while this translates to an increase number of admissions on a Monday (Figure 3), the admission rates over the weekend period drop more significantly than the comparable drop in activity. In reviewing the data detailed below there is approximately 30% translation of attendances to admission on a weekday based on the average attendance and admission data. This drops to 28% on a Saturday, and more notable to 26% on a Sunday.

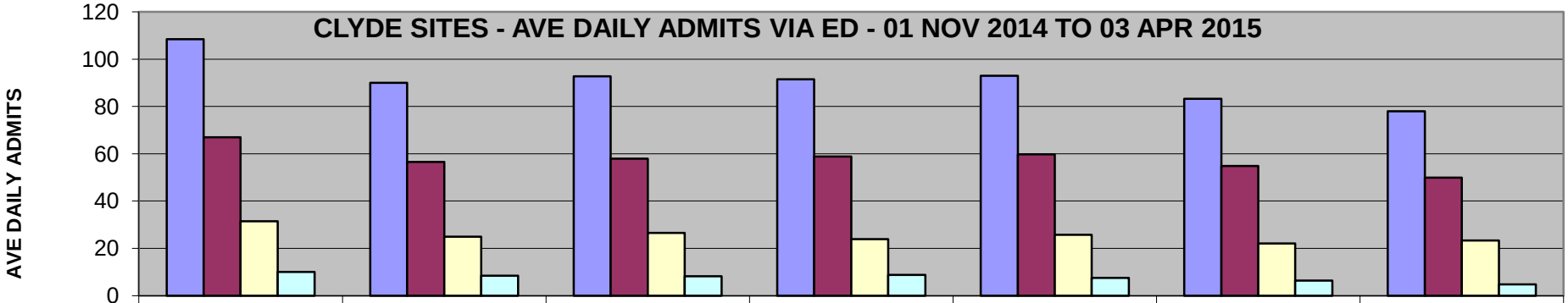
In reviewing this information along with the 4 hour wait compliance figures, Monday is, on average the day of the week with the poorest compliance against the target. Thereafter the weekends show the poorest compliance rates. The compliance data in this respect is detailed in figure 4 below.

Figure 5 - Average Daily Attendances (Winter 14/15)



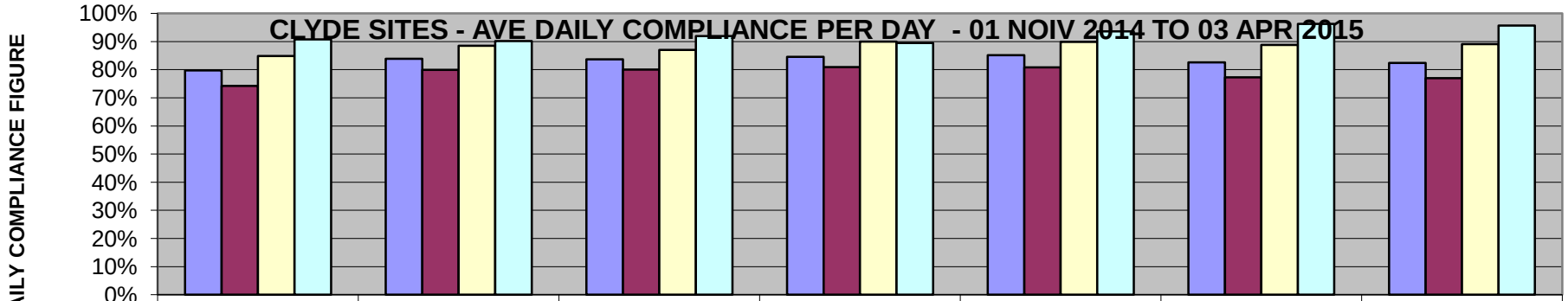
	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
CLYDE	360	304	308	300	300	290	297
RAH	205	174	180	175	174	179	180
IRH	101	85	82	83	86	77	84
VOL	55	45	46	42	41	34	33

Figure 6 - Average Daily Admissions (Winter 14/15)



	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
CLYDE	108	90	93	92	93	83	78
RAH	67	57	58	59	60	55	50
IRH	31	25	27	24	26	22	23
VOL	10	8	8	9	8	6	5

Figure 7 - 4 hour Compliance (Winter 14/15)



	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
CLYDE	79.7%	83.8%	83.7%	84.6%	85.1%	82.5%	82.4%
RAH	74.2%	79.9%	80.0%	80.9%	80.8%	77.2%	76.9%
IRH	84.9%	88.5%	87.0%	89.9%	89.8%	88.7%	89.1%
VOL	90.8%	90.1%	91.9%	89.5%	93.6%	96.3%	95.7%

Historical performance is examined in the next section of the report and shows a decline across the system from Dec 12. Now the new management structure is bedding in, performance is now improving and more recently the RAH has achieved the target over 90% of the time compared with an average of <80% over the last 121 months. The performance metrics along with the reasons for breachers are detailed in the table below. It is of note that the main reasons for breaching the target is a wait for a specialist assessment followed by availability of beds. In terms of bed waits, a large number of beds don't become available until after 4pm.

Table 3 - Recent Performance Metrics

Hospital	**Week Ending:**							
Royal Alexandra Hospital	**02-Aug-15**	**09-Aug-15**	**16-Aug-15**	**23-Aug-15**	**30-Aug-15**	**06-Sep-15**	**13-Sep-15**	**20-Sep-15**
4hr A&E Target Compliance	**93%**	**85%**	**90%**	**93%**	**89%**	**90%**	**91%**	**94%**
A&E patients waiting over 8 hours	**1**	**7**	**9**	**1**	**3**	**5**	**5**	**1**
A&E patients waiting over 12 hours	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total breachers	89	209	140	99	151	134	130	85
Breach - wait for specialist [n/ave wait(mins)]	28(317)	54(342)	44(335)	36(324)	58(345)	46(346)	42(327)	17(329)
Breach - wait for bed [n/ave wait(mins)]	23(321)	52(350)	42(363)	22(320)	18(327)	13(342)	22(352)	17(326)
Breach - wait for 1st assessment [n/ave wait(mins)]	4(321)	49(323)	11(336)	7(296)	32(329)	45(341)	24(319)	10(317)
Inpatient elective admissions	139	148	144	160	158	174	188	187
Elective cancellations	**1**	**0**	**0**	**0**	**0**	**3**	**1**	**3**
Boarders	23	26	78	27	15	25	25	34
Transfers after 8pm	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Beds becoming available after 4pm (Mon-Fri)	136	132	96	137	128	89	117	107
Average Length of Stay	4.7	4.3	4.7	-	4.8	4.4	3.8	-
Delayed patients at end of week	8	11	6	10	8	7	9	10
Average no. patients per day awaiting transfer to DME	3	2	2	0	0	0	2	1
Inverclyde Royal Hospital	**02-Aug-15**	**09-Aug-15**	**16-Aug-15**	**23-Aug-15**	**30-Aug-15**	**06-Sep-15**	**13-Sep-15**	**20-Sep-15**
4hr A&E Target Compliance	**92%**	**95%**	**96%**	**93%**	**94%**	**95%**	**96%**	**96%**

Hospital	Week Ending:							
A&E patients waiting over 8 hours	0	0	0	1	1	1	0	1
A&E patients waiting over 12 hours	0	0	0	0	0	0	0	0
Total breachers	49	27	26	50	37	29	23	24
Breach - wait for specialist [n/ave wait(mins)]	15(326)	9(294)	11(316)	26(351)	23(323)	15(303)	9(309)	8(376)
Breach - wait for bed [n/ave wait(mins)]	0	1(272)	2(277)	2(334)	2(284)	0	0	3(379)
Breach - wait for 1st assessment [n/ave wait(mins)]	21(288)	4(301)	1(256)	7(288)	6(326)	1(390)	1(292)	4(291)
Inpatient elective admissions	31	23	40	40	42	35	34	30
Elective cancellations	0	0	0	0	1	0	0	0
Boarders	5	2	20	48	27	21	15	5
Transfers after 8pm	1	0	0	0	0	0	0	0
Beds becoming available after 4pm (Mon-Fri)	56	58	69	49	60	74	57	35
Average Length of Stay	5.5	7.0	4.9	-	5.6	5.5	6.0	-
Delayed patients at end of week	11	13	9	13	8	8	9	17
Average no. patients per day awaiting transfer to DME	4	6	3	1	0	0	0	0
Vale of Leven Hospital	**02-Aug-15**	**09-Aug-15**	**16-Aug-15**	**23-Aug-15**	**30-Aug-15**	**06-Sep-15**	**13-Sep-15**	**20-Sep-15**
New A&E Attendances	290	302	330	329	349	314	356	365
4hr A&E Target Compliance	99%	97%	98%	98%	99%	100%	100%	99%
Admissions via A&E	37	49	47	52	54	33	49	57
A&E patients waiting over 8 hours	0	0	1	0	0	0	0	0
A&E patients waiting over 12 hours	0	0	0	0	0	0	0	0
Total breachers	3	8	6	5	5	0	1	4
Breach - wait for specialist [n/ave wait(mins)]	0	1(293)	1(344)	0	1(312)	0	0	0
Breach - wait for bed [n/ave wait(mins)]	0	0	0	0	1(345)	0	0	0
Breach - wait for 1st assessment [n/ave wait(mins)]	1(276)	1(283)	3(353)	3(315)	2(270)	0	0	1(322)
Inpatient elective admissions	23	23	21	34	24	34	28	43

Hospital	Week Ending:							
Elective cancellations	0	0	0	0	0	0	0	0
Boarders	0	2	0	3	3	4	1	3
Transfers after 8pm	0	0	0	0	0	0	0	0
Beds becoming available after 4pm (Mon-Fri)	19	16	9	21	25	18	19	29
Average Length of Stay	6.3	4.1	5.1	-	6.8	3.2	6.1	-
Delayed patients at end of week	6	7	12	12	9	7	4	3
Average no. patients per day awaiting transfer to DME	0	0	0	0	0	0	0	0

4.4 Historic Performance Against the 4 hour A&E Wait.

The graphs detailed below show performance across the 3 Clyde sites in terms of meeting the 4 hour A&E wait. The RAH has not achieved the 95% compliance with the 4 hour wait since Nov 2010 and as has been the case across the Board area, performance has been in decline since Dec 2012 with a low recorded in Jan 15 at 71.2%. A similar position is noted at IRH where performance has also been declining since Dec 2012. The lowest performance recorded on IRH site was in Feb 15 where performance against the target dipped to 85.7%. On a more positive note, review of recent performance data for IRH and RAH has shown a significant improvement. RAH performance is now over 90% consistently and IRH is also recently achieving between 94 and 96% of patients meeting the target. On the whole the Vale of Leven achieves the 95% target against the 4 hour wait for patients who attend its MIU. There has been only 1 occasion where this was not the case, again in Jan 15 where performance dipped across all Clyde hospital, and this has impacted on the annual rolling average figure.

Figure 8 - RAH Attendance and Compliance

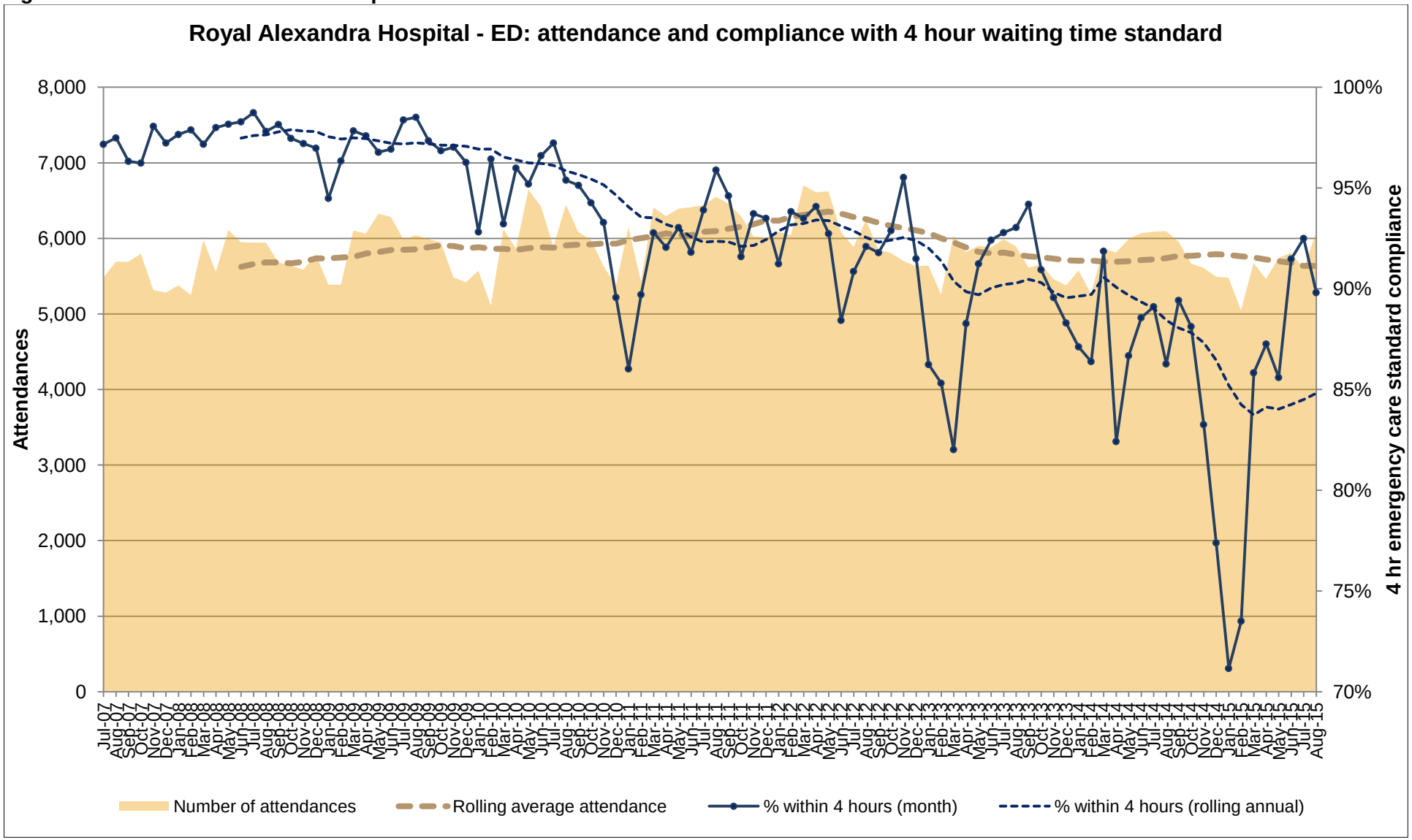


Figure 9 – IRH Attendance and Compliance

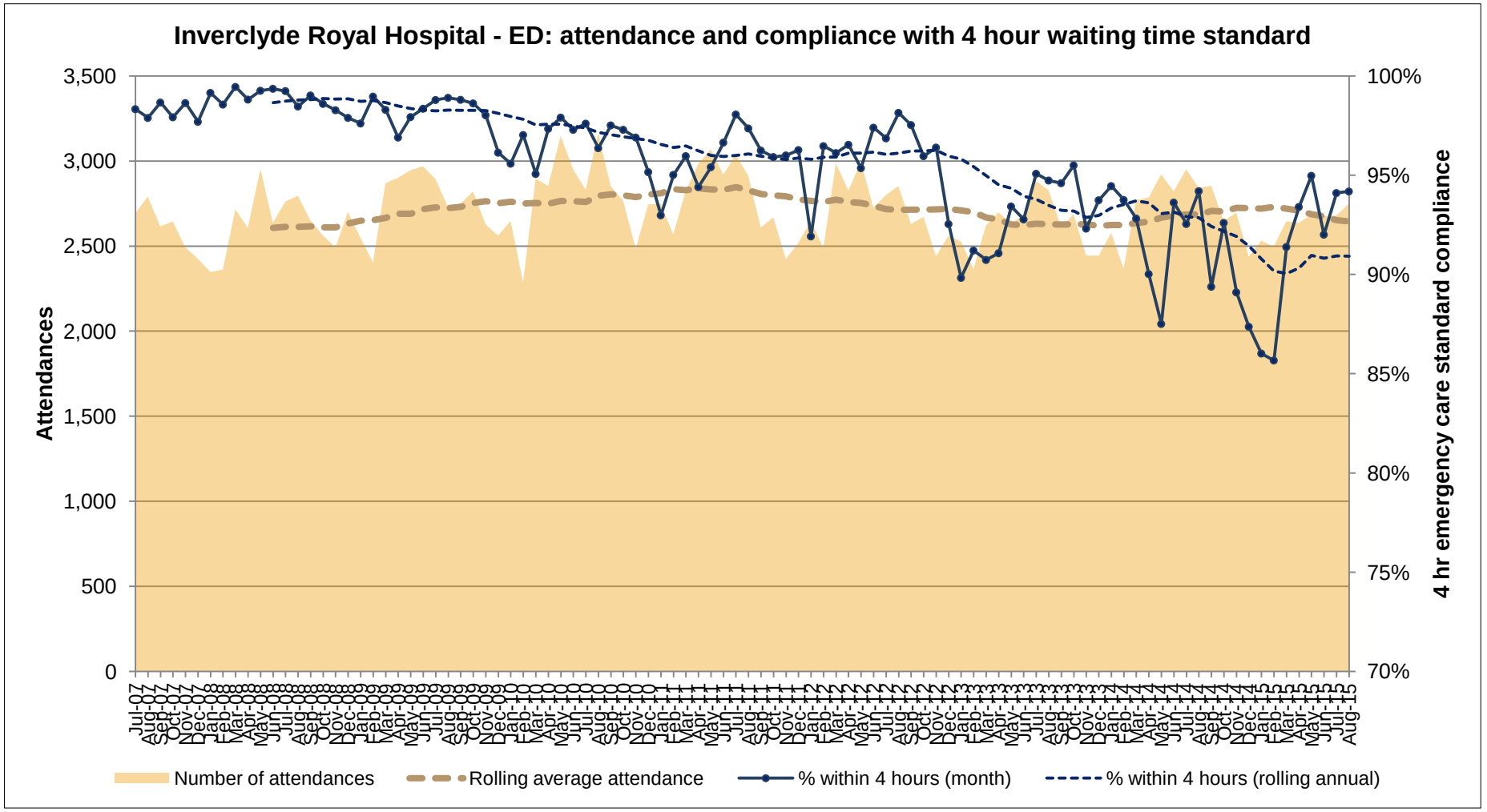
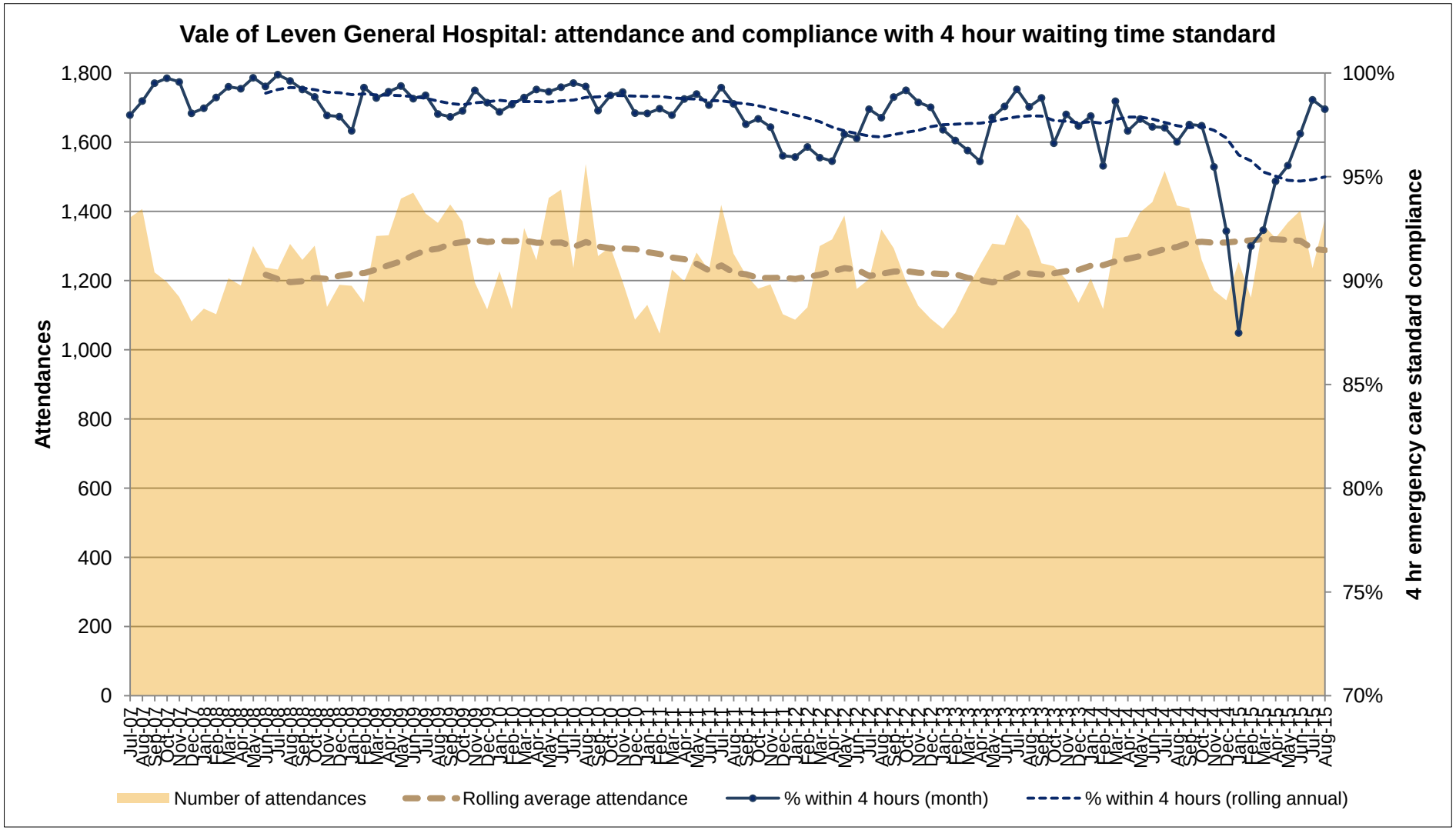


Figure 10 – VoL Attendance and Compliance

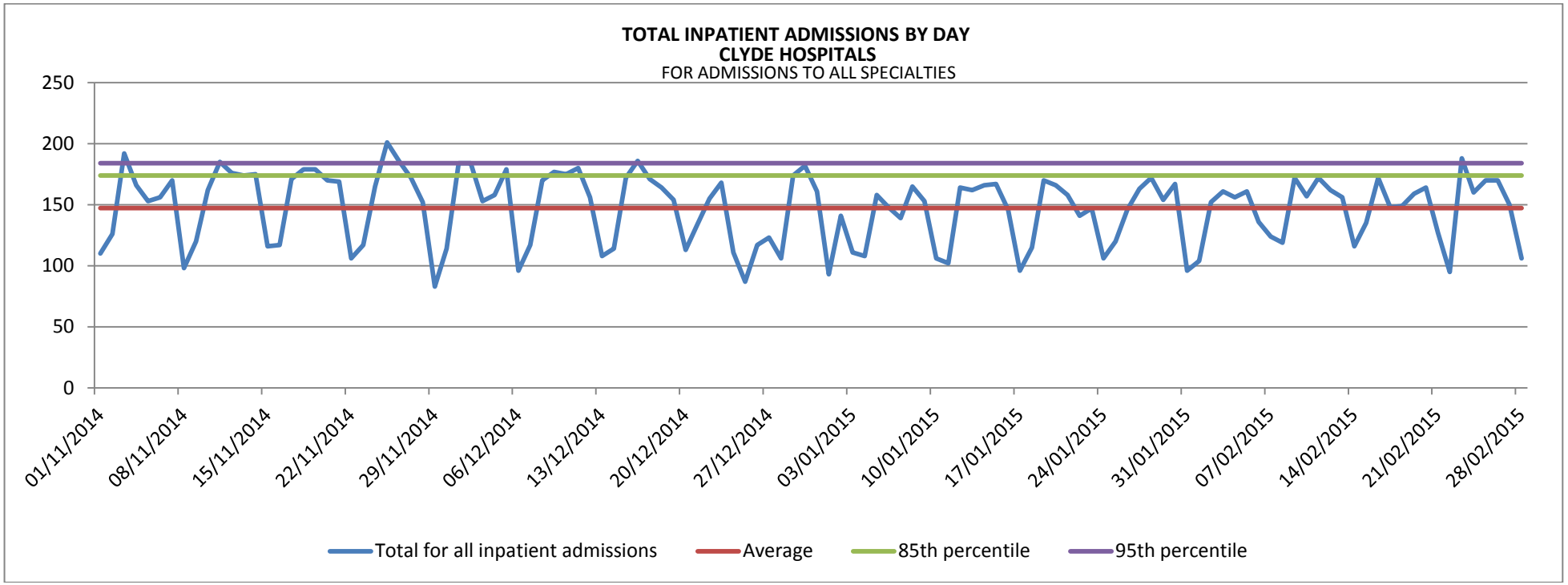


4.5 Admission Rates and Comparisons

Due to changes in recording and to the patient pathways (introduction of MAU at RAH), it is not possible to accurately compare admission data over several years to identify any trends or changes. For the purposes of this report and planning for winter 15/16, admission data is compared between the winters of 13/14 and 14/15. During this time total admissions to the 3 Clyde hospitals over winter (Nov – Feb) decreased very slightly. However while, overall, admissions dropped at IRH and VoL, RAH admissions increased by 2.2% on the previous year. This increase is attributed to an increase in elective admissions as the emergency admission rate dropped on the RAH site. In comparison to this, IRH experienced a 0.4% increase in emergency admissions. Elective workload is being reviewed as part of the winter planning process to ensure that there is a balance between the planned activity and forecast peaks in demand over the winter period.

The graph below details the total admissions pattern (emergency and elective) across all Clyde hospitals during winter 14/15.

Figure 8 – Admissions Winter 14/15



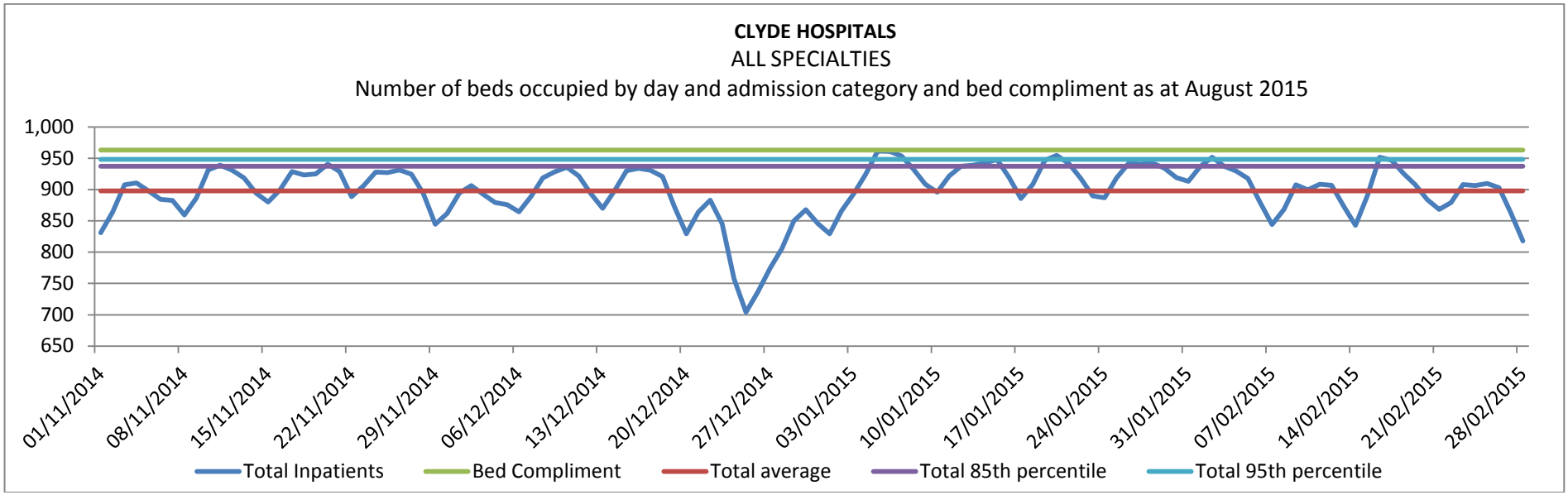
4.6 Inpatient Episodes and beds

Comparing last year's activity with the current bed model, the average beds used on a daily basis was 898. In considering the 85th percentile for Clyde Sector as a whole, there were 19 days in total where the activity in the hospital exceeded this rate. This compares with23 days where the RAH activity was above the 85th percentile rate (i.e., there were at least 561 beds occupied for 23 days of winter 13/14). The average daily information for all Clyde sites is detailed below

Table 4 – Average Daily Beds Uses

SITE	Average	85th Percentile	95th Percentile
RAH	540	561	566
IRH	284	300	307
VOL	74	83	85
Clyde	**898**	**938**	**948**

The chart below details the number of beds occupied on a daily basis, across all Clyde sites over the winter period. There is a clear pattern in this and further analysis of the information should inform staffing profiles across the system based on the daily projections.

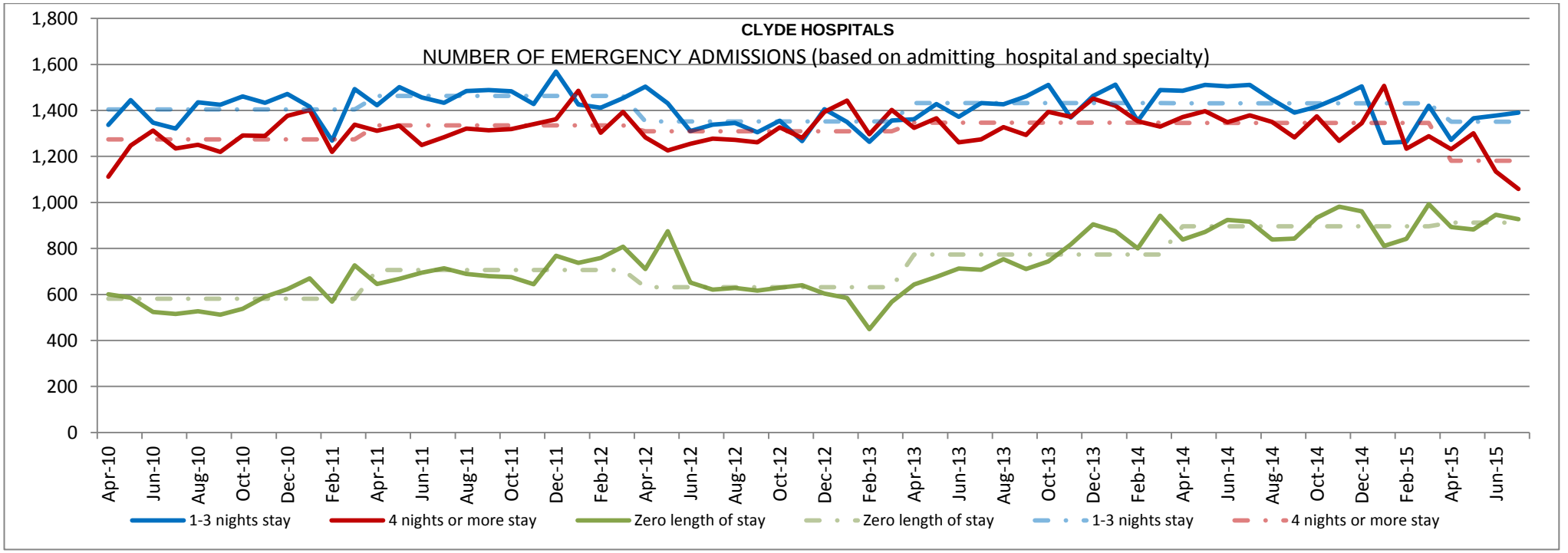


4.7 Length of Stay

The average length of stay across all Clyde sites is higher than average, particularly noticeable on IRH and VoL sites. In reviewing and comparing the data from winter 13/14 with winter 14/15 across the sector, a reduction in length stay of 0.5 days across all Clyde hospitals was achieved. On reviewing each hospital individual, los is down in the VoL and RAH but increased on IRH site. Therefore there is potential to review and improve on this for winter 15/16 and lengths of stay on IRH sites are currently the highest of all 3 Clyde hospitals.

The output from the 'Day of Care' Audit indicates that there is a real opportunity to improve the length of stay across all sites and therefore free up bed capacity. The Day of Care audit at RAH found that around 25% of patients in acute beds did not meet the Acute criteria. This is in line with audits elsewhere. This was significantly higher at the Vale of Leven Hospital where it was 39% on the survey day. There are a number of actions and initiative in place across Clyde Hospital to facilitate earlier discharge and these will continue throughout winter with a view to addressing and improving the position and therefore reduce patient's lengths of stay. The older adult assessment pilot and chest pain unit have both delivered significant improvements in length of staff for patients who meet the criteria required to be assessed in the units. The sector are currently reviewing the output from these pilots with a view to mainstreaming these services and using the learning in other initiatives Additionally the management team continue to review length of stay across our areas of responsibility and are working clinicians to improve these where possible. There are a significant proportion of patients who remain in hospital for 4 nights or more where the reason is that they are waiting for community care packages to be put in place to support them. As such there is real potential to work with HSCP colleagues to address issues.

The table below indicates the average length of stay of emergency admissions patients across the Clyde Hospitals from April 2010. Of note is that zero length of stay rates increase over the period which can be attributed, in part, to the introduction of MAU, Older Adult Assessment Unit and SAU. However there is no real downward trend noted in patients who experience longer lengths of stay.



5. WINTER 2014/15 – ISSUES AND PRESSURES

There were significant pressures across Clyde over last winter. The RAH in particular struggled to meet the 4 hour wait target with average compliance across the winter period equating to only 77%. IRH averaged 87% and the Vale 93%. A review of the reasons for this highlighted that there are a number of factors contributing to the challenges experienced in delivering consistently high levels of unscheduled care performance across Clyde. Some of these are as follows :

- The increasing rate of attendance at Emergency Departments (ED) (including the flow through the minor injuries area at VoL).
- The increase in the total number of admissions in 2014/15 at the RAH from the previous year over the winter period
- The average length of stay for medical services and medicine for the elderly was above the national average across the whole sector.
- There were significant acute bed days occupied by patients who were medically fit for discharge but unable to leave hospital because of social factors.
- There are a number of limiting factors related to the department layout and estate at RAH. In this respect options for longer term solutions have been scoped and costed.

- RAH was used to take GP diverts from IRH
- Limitations in availability of surge capacity beds on RAH site and resulting reliance on/use of surgical beds and capacity.
- Increased reliance on bank nursing staff to support activity
- Volume of Presentation out of hours and availability of medical staff
- Transport difficulties and use of private ambulances

6. CAPACITY PLANNING

The Sector has implemented a number of changes over the last year in an effort to increase efficiency and flow and therefore to create additional capacity in the system to cope with demand and therefore address the performance issues evident. These came from 3 main sources, the RAH support team recommendations, the 14 day challenge and Six Essential Actions Improvement plan, and the work of the Renfrewshire Development Programme (RDP). The key output and actions are detailed below.

6.1 Support Team Recommendations

Actions from the plan developed detailing the support team recommendations have been rolled out across the Sector. In progressing the work, morning and afternoon huddles now take place daily on each site. These provide a focus to allow daily planning to take place to enable patient flows and highlight areas of difficulty. There has been a re-energising of estimated dates of discharge and discharge planning protocol and a multi agency flow hub has been established in the RAH. Additionally the discharge Lounge has been promoted as part of the hospital planning and safety meetings which has resulted in a significant increase in its use.

6.2 Six Essential Actions

The Six Essential Actions plan built on the work already underway as part of the support team recommendations. A detailed action plan is in place with key highlights noted below

EA1 Clinically Focused and Empowered Hospital Management -

A daily site leadership rota has been established which is distributed throughout the sites on a Friday in advance of the following week. The daily site manager provides a formal handover to the on-call manager. Additionally a site manager post has been established at VOL providing leadership and direction across the site. Senior Management leads the daily huddles where immediate hospital issues are raised and discussed. Criteria Led Discharge and Deteriorating Patient/Stroke performance are reported at am Huddle. SCNs report planned discharge lounge activity at am huddle and reviewed at pm huddle where staff will be explain aborted discharges and allow real time actions. Pool bank staff report to huddle and are thereafter assigned to ward areas of greatest need.

EA2 Hospital Capacity and Patient Flow Re-alignment

Admission/Discharge hourly profile reports are reviewed at UCC meetings. AM Discharges/Criteria Led Discharge reports are being produced and this information is now shared at the Safety Huddles. Review of surgical admission profile underway. This can only be considered further in line with increased theatre capacity and a full review of all job plans. Rebalancing elective activity away from Mondays and Tuesdays needs to be balanced against operating on major cases close to a weekend when medical staffing and support services are reduced.

EA3 Patient rather than bed management

The site manager at VOL is leading a review of the current expected date of discharge protocol and repatriation from RAH to VOL to ensure that appropriate processes are in place. Other work under this heading relates to performance on delegated discharge which is currently below expectation, particularly in medical wards.

Proactive discharge management is in place with a focus on increasing pre noon discharge rates to improve ward access and reduce delays. This is achieved through:

- Increased delegated discharge activity
- Increased am use of discharge lounge to improve pre noon discharges and extend measurement process to DME/Surgery

A Multi-agency Patient Flow Hub was established on the RAH site in June 15. The multi agency staff working from the hub will access appropriate treatment and services and improve patient pathways.

There has been a significant push to increase discharge lounge activity. To assist this process SCNs have been asked to bring CHI numbers of predicted and potential patients to am Huddle which Discharge Lounge staff will action. A “Bed Buster” role has been utilised to support proactive discharge.

EA4 Clinical Processes arranged to pull patients from ED

An hourly ED Nurse recording template has been introduced to improve quality of information in relation to current activity. Additionally some of the work completed through the RDP (see below) has seen a fast track pull of patients from ED

Optimising MAU activity through Saturday and Sunday will ensure that the unit is working to full capacity and easing pressure in ED. Where appropriate, MAU staff have been tasked with actively “pulling” patients from ED. Staffing numbers are increased to correspond to Monday staffing levels to increase capacity to accommodate additional activity and patient management in the unit.

EA5 7 Day Services

The Sector has extended AHP services to be available in some areas throughout the week.

There have been plans developed which will allow the RAH to extend/rationalise assessment services on the site and extend the working hours for the MAU in RAH. Work is now underway on the site to facilitate the moves required to allow for this expansion of capacity.

EA6 Ensuring patients are cared for in their own homes

There are initiatives on going within the sector where the key aim is to return patients to their home at the earliest opportunity. This includes the out of hours in reach team which was established as part of the RDP work detailed below.

Additionally a review of patients being referred to GEMS from ED is on going to establish whether the current system is effective. Visits are being arranged to sites with established redirection protocols for shared learning.

6.3 Renfrewshire Development Programme (RDP)

The RDP has been an initiative that has provided a focus for change and efficiency improvements through four main projects. These build on core components identified in the Clinical Services Review (CSR) and meet the objectives of the 6EA action plan. The key areas of development included

1. Older Adults Assessment Unit
2. Chest Pain Assessment Unit
3. Anticipatory care planning
4. Out of hours Community In Reach service

The programme has aimed to connect the different services across primary, community and acute care to develop more effective working arrangements. This in turn improves handover between services and increases the speed of access to required service while reducing bed days and lengths of stay in hospital. An evaluation of the pilots is underway to measure the success factor of each of elements and where indicated, mainstreaming activity within the Clyde sector. The final review will not be available until Jan 2016 and as such the immediate challenge for Clyde, as part of the winter contingency planning, is to continue to run the initiatives during the peak winter period when pressure on beds is at its highest. Where there is strong evidence of improvement to pathways and/or flows, the learning with be shared across the Acute Division.

An early review of the information currently available has demonstrated benefits in flow and improved capacity in some of the areas covered by the pilot. Savings in beds days is evident in the Chest pain unit, the older adults assessment unit has demonstrated a significant reduction in both bed days and boarders in the group of patients who are admitted to the unit, and the out of hours community in reach service has supported an earlier discharge for a number of patients, there is work on going to improve uptake of the service and therefore improve efficiency further.

A key lesson from the RDP programme has been that working collaboratively and taking joint ownership of issues and solutions can deliver improvements. This is also evident in the output from the multi agency flow hub and this theme is continued in our winter planning work.

7. ADDRESSING SECTOR ISSUES AND PRESSURES - OPERATIONAL PLAN

There are a number of issues and pressures across Clyde, many connected with the existing estate. The operational plan to address these longer term and to support surge capacity and increased demand over the winter period is detailed below. The plan includes actions derived from the lessons learned from a review of last year's plans and expected outcomes. A number of key themes are covered in the operational plan and the activity and main function of these are summarised as follows:

Regular review and understanding of activity and projections

- Team awareness and establishment of clear escalation policies
- Multi agency participation in daily huddles.

Maximise Bed Capacity where it can be best used

- Increase Assessment beds on RAH site
- Open winter beds on RAH and IRH site
- Deliver balance between demand for and number of ED sites beds
- Re-alignment of use of surgical beds on RAH site
- Protect Elderly Assessment beds throughout winter
- Protect surgical beds
- Actions to reduce boarding

Enhancing the Front Door, Decision Making and Flow

- Senior Management presence on each site throughout winter
- Extension of senior medical availability on IRH out of hours
- Maximise use of bed busters
- Actions to Maximise Weekend discharge – improve junior doctor cover, ANP weekend cover
- Enhance trauma liaison cover
- Introduce orthopaedic ANP role
- Pharmacy and AHP support to discharge
- Maximise use of discharge lounges
- Review availability of and maximise use of available transport

Reduce Average Length of Stay across all sites

- Work with HSCP partners to address delay issues
- Ensure EDD is being adopted and used appropriately across all sites

- Regular review of patients with extended length of stay
- Maximise use of available out of hours transport options
- Raise awareness of community contacts and services available throughout winter
- Maximise weekend discharge
- Dedicated AHP input to review boarder
- Ortho Geriatrician ward rounds

Maintaining the elective programme

- Minimise cancellation of clinics
- Continue to book/maximise use of elective slots

Objective	Detail	Lead	Timescale	Benefit	Resource Implications	6 EA Link
RAH						
Increase/ rationalise assessment capacity	**Medical Assessment** Extend assessment capacity at RAH:_ Undertake enabling works – W18 Transfer Ward 1 to W18 Extend assessment unit into ward 1 Transfer CPU Extend service to provide full 7 day service	JN	Jan 16	Established pathway from ED department to assessment unit. Ambulatory patients directed to unit without having to attend the ED department. Reduces activity and crowding in ED. Frees up additional winter surge capacity in existing CPU.	Capital Costs TBC Funding stream – unscheduled care fund **£750k for winter** period (full year £1.5 recurring) (This includes costs of 18 beds opened for 12 hours, 10 beds opened for 24 hours, 2.56wte MNPs, 2.56wte Flow co-ordinator, less the funding currently available for MAU 11 (8+3) beds and 6 chest pain trolleys which would all be accommodated within the 18 bed unit. CNS's	EA 2

Objective	Detail	Lead	Timescale	Benefit	Resource Implications	6 EA Link
					previously housed in Ward 14, 1 and 12 will now be part of this unit, freeing up space for 6 beds in each area which can be used for winter surge capacity opening. Costs also include 2.0 consultants (acute care physicians), AHPs, Facilities, Admin and non pay. Costing also incorporates the requirements for the new day unit in W18 (Biologics nurse and support worker).	
	Surgical Assessment Extend surgical assessment unit (W20) opening to include weekends	JS	Oct 15	Improve surgical flow at week-ends. Dedicated medical support to free up receiving team to focus on ED.	0.67 Band 5–£13, 727pa Fy2- cover Surgical Nurse Practitioner between RAH/ IRH- Band 6	EA 4&7
	Older Adult Assessment Unit Protect min of 4 older adult assessment beds over winter period.	JK	Oct – Feb	Established pathway from ED Shorter length of stay for patients who are transferred to unit Quicker access to specialty consultant staff Less elderly boarders across hospital – beds free for medical patients	Funded for duration of RDP project but ongoing service unfunded. Resource implications for Medical and AHP staff 1.5 Consultants 1 Physio 1 OT **Total Staffing Costs Winter - £150k**	EA 2&4
Increase capacity to address	**Medical** Open 12 winter beds in Ward 1	JN	Oct 15	Beds available to deal with expected peak in demand. Reduces boarding to surgical	Pays and non pays (excl medical staffing costs) - £377k	EA 2&3

Objective	Detail	Lead	Timescale	Benefit	Resource Implications	6 EA Link
demand surges	(to transfer to W18) Open 6 winter beds in Ward 14 Open 6 winter respiratory beds in Ward 12 (will transfer to W11)			areas	1 Consultant session for W1 - £5.5k 1 FY1 and FY2 – weekend cover 2 FY2 – 9-5 – check with myra re costs	
Realign Capacity to areas of highest demand	Review use of off ED site beds	JN	Dec 15	Addresses inefficiency	To be confirmed	
	Realignment of surgical beds on RAH site to create additional trauma capacity	JN		Reduces trauma boarders across RAH site and delivers more efficient use of beds on site.	Nil	
Increase Discharge Lounge Activity	Target set for 300 patients per month over winter period	JK	Oct 15	Facilitate am discharges Free up beds earlier in the day	Nil	EA 3&6
Improve AHP support at weekends	Increase establishment by 1 OT and 1 Physiotherapist. 1 healthcare support worker	LW	Oct 15	Supports patient flow through system over 7 days Posts will also be responsible for boarding patients and DME/VoL lists with a view to reducing los	Band 6 OT- £38,458 Band 6 Physio-£38,458 Support Worker **FYE Total - £76,916**	
Establish Transport Hub on RAH site for RAH/VoL	SAS; Red Cross and local transport 7 days per week	MO'R	Nov 15		2XBand 2 Clerical Officers - Contract Costs Red Cross £20k per month	EA 6
Improve surgical patient flow	Increase trauma liaison cover			Improve patient flow from ED to ward or home	0.3 Band 6 for weekend 0.5 band 6 for core hours	EA 2&5
	Introduce orthopaedic ANP role	JS	tbc	Improve patient flow from ED by supporting junior doctors particularly out of hours and at	1wte Band 6 for evenings 1wte Band 6 for Weekends	EA 2&5

Objective	Detail	Lead	Timescale	Benefit	Resource Implications	6 EA Link
				weekends	Total **£76,916**	
	Introduce routine ward rounds by Ortho Geriatricians	JS		Dedicated rounds to assist in the timely assessment and discharge planning for trauma patients with complex medical needs	2 sessions per week in rah	EA 3&6
Release junior doctor time in ortho and surgical wards to support timely specialist assessments in A and E	Introduce phlebotomy support to the surgical wards at the week-end **– Diagnostics -**	JS	Nov 15	Release the receiving team to focus on ED and discharges. Improve position of pre-midday discharges at week-ends with prompt bloods available	4 hours per day Sat and Sun 8 hrs Band 2 total	EA2, EA5 &6
	Additional junior doctor support at week-ends to cover surgery & ortho wards	JS	Nov 15	Additional junior doctor support at week-ends to support receiving team.	FY2- Sat & Sun- 12MD until 12MN	EA 5
Free up beds for admissions at earliest opportunity	Engage dedicated bed busters for winter period.	JB	Oct 15	Supports ward staff to facilitated early discharges. Bed turnaround optimum	Band 5 Nurse	EA2 & 6
	Review bed manager roles to ensure that all the work they are engaged in adds value and supports efficient bed turnaround over 7 days		Oct 15	Facilitate optimum use of beds Minimise boarding of patients at earliest opportunity	TBC	EA1
IRH						
Increase/rationalise assessment capacity	Adopt parts of DSU in IRH to dedicated SAU ** to be confirmed if possible	JS	Nov 15	Surgical assessment – improve flow of surgical patients from ED.	TBC – waiting for feedback	EA2 & 4
Increase Capacity to address	Medical Open winter ward L South (20	JN		Increased capacity to deal with demand surges on IRH site which should reduce the number of GP		EA 2&3

Objective	Detail	Lead	Timescale	Benefit	Resource Implications	6 EA Link
demand surges	beds) Open 12 CoE beds in Larkfield			diverts to RAH site.		
	Surgical Maintain bed capacity on IRH site H Centre open at weekend	JS	Nov 15	Maintain bed capacity at the week-end.	£112,538pa	EA 2&3
Release junior doctor time to support ED	Introduce phlebotomy support to the surgical wards at the week-end	JS	Nov 15	Release the receiving team to focus on ED and discharges. Improve position of pre-midday discharges at week-ends with prompt bloods available	2 hours band 2 Sat & Sun Total £9,223pa **Winter- £4612**	EA 5
Maximise am discharges on site	Establish discharge lounge on site . Target to have 150 per month through lounge (M-F)	JK	Sept 15	Maximises am discharges	FYE £60k (£15)	EA 2, 3, 4 & 6
Free up beds for admissions at earliest opportunity	Engage dedicated bed busters for winter period.	JB	Oct 15	Supports ward staff to facilitated early discharges. Bed turnaround optimum	Band 5 Nurse	EA2 & 6
	Review bed manager roles to ensure that all the work they are engaged in adds value and supports efficient bed turnaround over 7 days		Oct 15	Facilitate optimum use of beds Minimise boarding of patients at earliest opportunity	TBC	EA1
Vale of Leven						
Timely transfer of patients between VoL and RAH	Establish process with RAH to identify Vale patients at point of admission to ensure timely and appropriate transfer back to VoL	MO/ JK			Red Cross money associated with Vale	EA 2&3

Objective	Detail	Lead	Timescale	Benefit	Resource Implications	6 EA Link
	Establish process with Hub to ensure patients fit for discharge are not transferred back to Vale and are discharged from RAH	MO/ JK				EA 2,3 & 6
Deliver capacity to deal with surges in demand	Open ward 6 at weekends at times of peak demand	JS	Nov 15	Maintain bed capacity at the week-end.	Tbc- would need to understand more about patient mix and number of beds	EA 5

8. WORKFORCE PLANNING

There are some particular challenges noted in the analysis above related to higher levels of activity on Mondays and the dip in performance across weekends. As such staff rosters are under review to ensure that there is appropriate flexibility in the now undertaken to factor in staffing demand requirements above the 4% absence levels accounted for in the establishments. In effect this should avoid an over reliance on bank provision over winter and negate the requirement for premium agency..

There are particular pressures associated with medical staff cover over 7 days and options available to the Sector to cover gaps in many cases are limited.

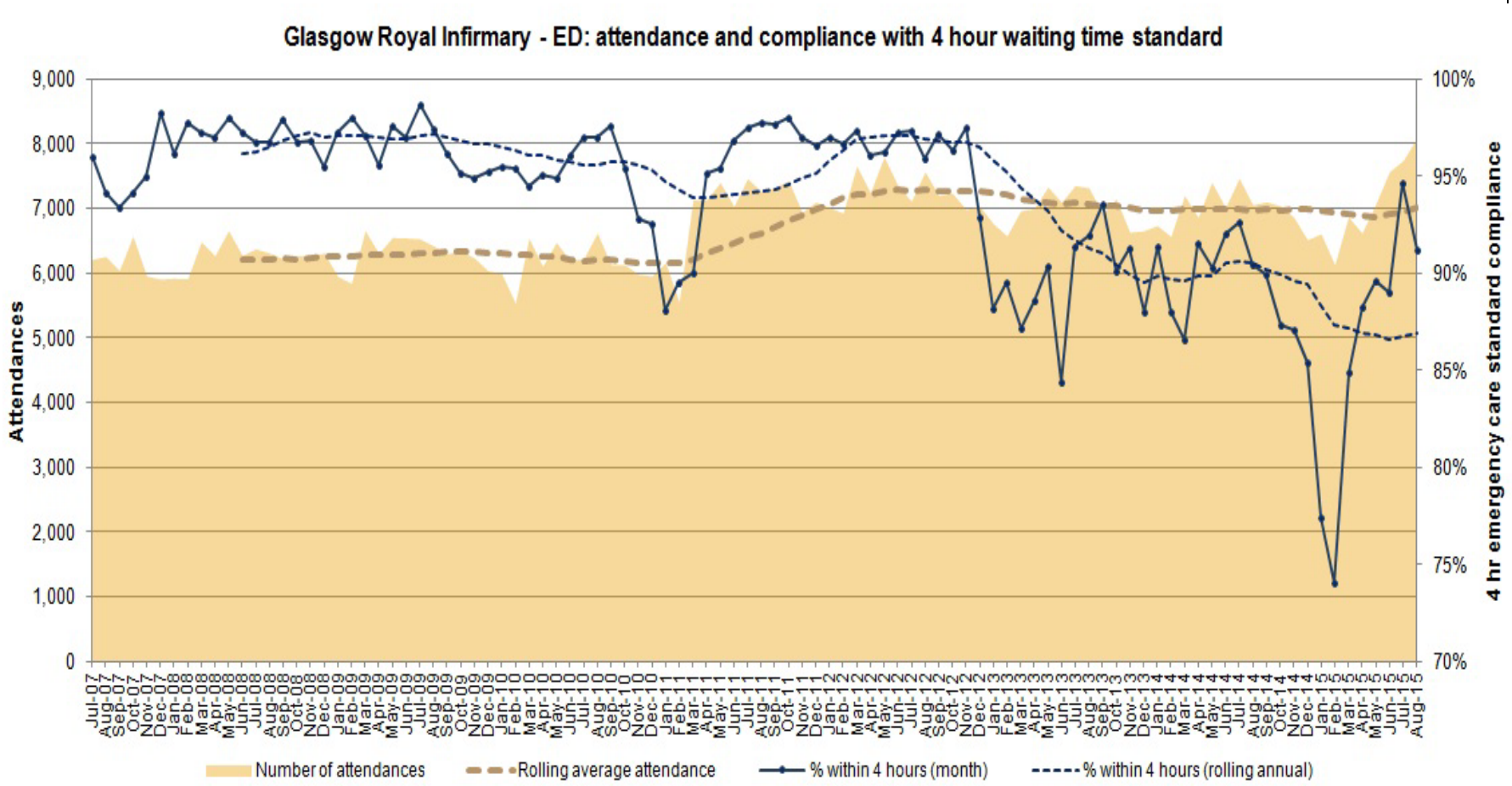
Recruitment is on going to ensure that there are sufficient nurses available to staff to the Keith Hurst workforce model where work concluded earlier this year. Additionally there is a review of turnover and establishment of associated risks in recruiting to cover the winter without relying on high numbers of fixed terms staff.

9. ESCALATION PLANNING

Escalation planning is work in progress and will realise a set of metrics which will be used and reviewed throughout winter to ensure appropriate escalation takes place at appropriate times. In this respect there has been engagement and dialogue with partners from HSCPs to ensure that dialogue and communication lines are clearly indicated and established in advance of winter.

NORTH SECTOR UNSCHEDULED CARE/WINTER PLAN 2015/16

GRI Long Term Performance Trend	The chart below shows the long term GRI performance against the 4 hour A&E wait. The lowest performance was recorded in February 2015 at 74%.



5 Year Activity Trends

The table below summarises the activity trends in recent years for the GRI hospital.

GLASGOW ROYAL INFIRMARY
ADMISSION AND BED DAYS
FOR ADMISSIONS TO ALL SPECIALTIES - EXCLUDING PATIENTS DIRECTLY DISCHARGED FROM MAU/AAU
FOR ADMISSIONS BY ADMISSION DATE, ADMISSION CATEGORY AND LENGTH OF STAY

	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	%age change from 2010/2011	%age change from 2012/2013	%age change from 2013/2014
Admissions								
Day cases	17,227	18,612	18,042	15,372	13,724	-20.3%	-23.9%	-10.7%
Elective inpatients with a zero length of stay	1,023	1,401	1,490	3,018	2,102	105.5%	41.1%	-30.4%
Day cases plus elective inpatient admissions with a zero stay	**18,250**	**20,013**	**19,532**	**18,390**	**15,826**	**-13.3%**	**-19.0%**	**-13.9%**
Elective inpatients with a stay of 1-3 nights	6,363	6,495	6,418	7,113	6,104	-4.1%	-4.9%	-14.2%
Elective inpatients with a stay of 4 nights or more	3,690	3,102	2,749	2,835	2,651	-28.2%	-3.6%	-6.5%
Total for elective Inpatient admissions with a stay of 1 night or more	**10,053**	**9,597**	**9,167**	**9,948**	**8,755**	**-12.9%**	**-4.5%**	**-12.0%**
Total for all elective inpatients	**11,076**	**10,998**	**10,657**	**12,966**	**10,857**	**-2.0%**	**1.9%**	**-16.3%**
Total for all elective admissions	**28,303**	**29,610**	**28,699**	**28,338**	**24,581**	**-13.2%**	**-14.3%**	**-13.3%**
Emergency inpatients with a zero length of stay	5,298	4,622	4,291	4,398	3,942	-25.6%	-8.1%	-10.4%
Emergency inpatients with a stay of 1-3 nights	16,029	14,888	14,757	14,954	13,929	-13.1%	-5.6%	-6.9%
Emergency inpatients with a stay of 4 nights or more	17,265	16,712	17,196	17,096	16,962	-1.8%	-1.4%	-0.8%
Total for emergency Inpatient admissions with a stay of 1 night or more	**33,294**	**31,600**	**31,953**	**32,050**	**30,891**	**-7.2%**	**-3.3%**	**-3.6%**
Total for emergency inpatient admissions	**38,592**	**36,222**	**36,244**	**36,448**	**34,833**	**-9.7%**	**-3.9%**	**-4.4%**
Total for all inpatient admissions	**66,895**	**65,832**	**64,943**	**64,786**	**59,414**	**-11.2%**	**-8.5%**	**-8.3%**
Bed Days								
Elective inpatients with a stay of 1-3 nights	10,779	10,809	10,503	11,554	9,487	-12.0%	-9.7%	-17.9%
Elective inpatients with a stay of 4 nights or more	35,959	27,343	26,257	26,935	26,645	-25.9%	1.5%	-1.1%
Total for elective Inpatient admissions with a stay of 1 night or more	**46,738**	**38,152**	**36,760**	**38,489**	**36,132**	**-22.7%**	**-1.7%**	**-6.1%**
Emergency inpatients with a stay of 1-3 nights	27,197	25,613	25,228	25,632	24,233	-10.9%	-3.9%	-5.5%
Emergency inpatients with a stay of 4 nights or more	280,635	264,830	274,817	265,309	269,337	-4.0%	-2.0%	1.5%
Total for emergency inpatient admissions	**307,832**	**290,443**	**300,045**	**290,941**	**293,570**	**-4.6%**	**-2.2%**	**0.9%**
Total for all inpatient admissions	**354,570**	**328,595**	**336,805**	**329,430**	**329,702**	**-7.0%**	**-2.1%**	**0.1%**

5 Year Activity Trends

The table below summarises the activity trends in recent years for the North Glasgow hospitals.

NORTH HOSPITALS
ADMISSION AND BED DAYS
FOR ADMISSIONS TO ALL SPECIALTIES - EXCLUDING PATIENTS DIRECTLY DISCHARGED FROM MAU/AAU
FOR ADMISSIONS BY ADMISSION DATE, ADMISSION CATEGORY AND LENGTH OF STAY

	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	%age change from 2010/2011	%age change from 2012/2013	%age change from 2013/2014
Admissions								
Day cases	38,589	39,696	39,413	34,474	34,801	-9.8%	-11.7%	0.9%
Elective inpatients with a zero length of stay	1,023	1,401	1,490	3,018	2,102	105.5%	41.1%	-30.4%
Day cases plus elective inpatient admissions with a zero stay	**39,612**	**41,097**	**40,903**	**37,492**	**36,903**	**-6.8%**	**-9.8%**	**-1.6%**
Elective inpatients with a stay of 1-3 nights	6,363	6,495	6,418	7,113	6,104	-4.1%	-4.9%	-14.2%
Elective inpatients with a stay of 4 nights or more	3,690	3,102	2,749	2,835	2,651	-28.2%	-3.6%	-6.5%
Total for elective Inpatient admissions with a stay of 1 night or more	**10,053**	**9,597**	**9,167**	**9,948**	**8,755**	**-12.9%**	**-4.5%**	**-12.0%**
Total for all elective inpatients	**11,076**	**10,998**	**10,657**	**12,966**	**10,857**	**-2.0%**	**1.9%**	**-16.3%**
Total for all elective admissions	**49,665**	**50,694**	**50,070**	**47,440**	**45,658**	**-8.1%**	**-8.8%**	**-3.8%**
Emergency inpatients with a zero length of stay	5,298	4,622	4,291	4,398	3,942	-25.6%	-8.1%	-10.4%
Emergency inpatients with a stay of 1-3 nights	16,029	14,888	14,757	14,954	13,929	-13.1%	-5.6%	-6.9%
Emergency inpatients with a stay of 4 nights or more	17,265	16,712	17,196	17,096	16,962	-1.8%	-1.4%	-0.8%
Total for emergency Inpatient admissions with a stay of 1 night or more	**33,294**	**31,600**	**31,953**	**32,050**	**30,891**	**-7.2%**	**-3.3%**	**-3.6%**
Total for emergency inpatient admissions	**38,592**	**36,222**	**36,244**	**36,448**	**34,833**	**-9.7%**	**-3.9%**	**-4.4%**
Total for all inpatient admissions	**88,257**	**86,916**	**86,314**	**83,888**	**80,491**	**-8.8%**	**-6.7%**	**-4.0%**
Bed Days								
Elective inpatients with a stay of 1-3 nights	10,779	10,809	10,503	11,554	9,487	-12.0%	-9.7%	-17.9%
Elective inpatients with a stay of 4 nights or more	35,959	27,343	26,257	26,935	26,645	-25.9%	1.5%	-1.1%
Total for elective Inpatient admissions with a stay of 1 night or more	**46,738**	**38,152**	**36,760**	**38,489**	**36,132**	**-22.7%**	**-1.7%**	**-6.1%**
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Total for emergency inpatient admissions	**307,832**	**290,443**	**300,045**	**290,941**	**293,570**	**-4.6%**	**-2.2%**	**0.9%**
Total for all inpatient admissions	**354,570**	**328,595**	**336,805**	**329,430**	**329,702**	**-7.0%**	**-2.1%**	**0.1%**

5 Year Activity Trends

The table below summarises the activity trends in recent years for the catchment which is now covered by the North Glasgow hospitals.

NORTH HOSPITALS
ADMISSION AND BED DAYS
FOR ADMISSIONS TO ALL SPECIALTIES - EXCLUDING PATIENTS DIRECTLY DISCHARGED FROM MAU/AAU
FOR ADMISSIONS BY ADMISSION DATE, ADMISSION CATEGORY AND LENGTH OF STAY

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Total for all elective inpatients	**11,076**	**10,998**	**10,657**	**12,966**	**10,857**	**-2.0%**	**1.9%**	**-16.3%**
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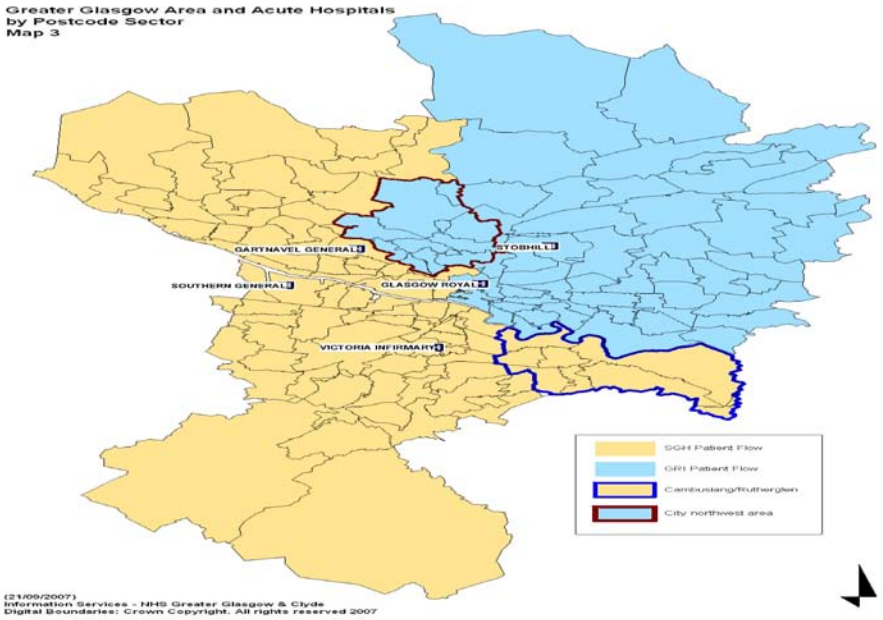
Total for all inpatient admissions	**354,570**	**328,595**	**336,805**	**329,430**	**329,702**	**-7.0%**	**-2.1%**	**0.1%**

Source: SMR01

Hospitals are based on patients aged 0 - 15 going to RHSC, emergency inpatients to Glasgow hospitals split by catchment, elective patients from old SGH, Victoria and Western going to QEUH, elective patients from GRI and Stobhill going to GRI

Admission category and specialty is based on first episode within the spell

Bed days are assigned to date of admission and the hospital and specialty of that first episode

Post OTM Migration Activity Predictions	The patient flows which were predicted for emergency patient activity after the OTM migration are shown below: Projected Flow by Postcode  **PREDICTED POSITION 15/16** Population by postcode: GRI 37.2% SGUH 62.8% A&E Presentations (excluding MIU): GRI 42% SGUH 58% General Emergency Medical Admissions: GRI 43% SGUH 57% General Surgery Emergency Admissions: GRI 46% SGUH 54% Orthopaedics Emergency Admissions: GRI 37% SGUH 63% Urology Emergency Admissions: GRI 37% SGUH 63%

June-August 2015 GRI and QEUH Attendance and Admission Comparison

The table below shows the recorded presentations to ED and AAU and admissions in selected specialties from the June-August Business Intelligence reports detailing the number of presentations and admissions across the two Glasgow receiving sites.

The table also compares the 3 month cumulative split against the expected split from the bed model predicted flows and expresses this as a 3 month variance against the expected split.

ED AAU and Admission Data Jun to Aug 2015 Source Info Services Aug Reports	Modelled split according to	QEUH						GLASGOW	GRI					
		Jun	Jul	Aug	3 Month QEUH Actual	3 Month QEUH Modelled	Variance actual from modelled	3 Month Glasgow Combined	Variance actual from modelled	3 Month GRI Modelled	3 Month GRI Actual	Jun	Jul	Aug
ED Presentations	2013 Bed Model	7074	7147	7649	21870			45229			23359	8071	7728	756
AAU Presentations	Catchment Model 3	2437	2593	2574	7604			12110			4506	1584	1472	145
Total Presentations	QEUH 58% GRI 42%	9511	9740	10223	29474	33256	-3782	57339	3782	24083	27865	9655	9200	901
GM (excl endoscopy) Emergency Admissions	QEUH 57% GRI 43%	2808	2722	2365	7895	8643	-748	15164	748	6521	7269	2437	2377	245
All ECMS (excl endoscopy and ID) Admissions	QEUH 57% GRI 43%	2952	2958	2677	8587	9570	-983	16791	983	7221	8204	2734	2713	275
GS (excl endoscopy) Emergency Admissions	QEUH 54% GRI 46%	757	743	711	2211	2177	34	4033	-34	1856	1822	579	622	62
Urology Emergency Admissions	QEUH 63% GRI 37%	80	127	109	316	340	-24	541	24	201	225	65	75	8
Orthopaedic Emeregency Admissions	QEUH 63% GRI 37%	213	228	201	642	744	-102	1182	102	438	540	200	151	18

This table shows ED/AAU attendances, GM admissions, Urology and Ortho Trauma admissions beyond that predicted and resourced via the OTM programme.

Actual Activity Changes for 2015/16

With only three months of data available, June July and August 2015, at this time it is not possible to draw accurate conclusions about how the activity will increase through the winter of 2015/16, however the table below shows the June, July, August and September 2015 metrics in comparison to those before migration.

A&E AU and MIU Presentations - Pre Migration

Site/Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-1
GRI ED	6855	7394	7007	7456	7047	7092	7035	6853	6508	6591	6122	686
GRI (AAU)	1359	1460	1451	1398	1403	1399	1523	1398	1475	1513	1324	148
GRI Total	**8214**	**8854**	**8458**	**8854**	**8450**	**8491**	**8558**	**8251**	**7983**	**8104**	**7446**	**834**
Normalised to Ave (8334)	**98.5**	**106.2**	**101.4**	**106.2**	**101.4**	**101.8**	**102.6**	**99.0**	**95.7**	**97.2**	**89.3**	**100.**
STO (MIU)	1409	1630	1617	1441	1439	1537	1346	1296	1069	1244	1275	156
North Total	9623	10484	10075	10295	9889	10028	9904	9547	9052	9348	8721	991

A&E AU and MIU Presentations - Post Migration

Site/Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-1
GRI ED	6,613	7,058	7558	7728	8071	7686						
GRI (AAU)	1,383	1,450	1,510	1,473	1,584	1,572						
GRI Total	**7996**	**8504**	**9068**	**9198**	**9655**	**9258**						
STO (MIU)	1,562	1,634	1,628	1,503	1,762	1,655						
North Total	9558	10138	10696	10701	11417	10913						

Emergency Inpatient Episodes - Pre Migration

GRI Episodes	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-1
GM EMIP	3637	3956	4092	4355	4336	4473	4812	4132	4369	4054	3854	441
GS EMIP	646	661	647	710	743	677	736	714	693	667	679	743
Ortho EMIP	202	206	230	218	253	213	245	222	303	260	213	240
Total	**4485**	**4823**	**4969**	**5283**	**5332**	**5363**	**5793**	**5068**	**5365**	**4981**	**4746**	**539**
Normalised to Ave (5134)	**87.3**	**93.9**	**96.7**	**102.9**	**103.8**	**104.4**	**112.8**	**98.7**	**104.4**	**97.0**	**92.4**	**105.**

Emergency Inpatient Episodes - Post Migration

GRI Episodes	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-
ECMS EMIP	4477	4604	4764	4629								
GS EMIP	754	847	905	951								
Ortho EMIP	271	238	295	285								
Total	**5502**	5689	5964	5865								

Emergency Inpatient Admissions - Post Migration

GRI Admissions	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-
Gen Med EMIP	2437	2377	2455									
GS EMIP	579	622	621									
Ortho EMIP	200	151	**189**									
Gyn EMIP	139	85	**211**									
Plastics EMIP	135	125	**124**									
Total	**3490**	3360	**3551**									

June/July/ Aug 2014/2015 Comparisons	From the June 2015 activity data we see the following: GRI AAU Presentations: **Up 4.0%** on June 14 Up 5.4% on Average 14/15 GRI ED Presentations: **Up 7.8%** on June 14 Up 9.5% on Average 14/15 GRI GM EMIP Episodes: **Up 9.4%** on June 14 Up 6.4% on Average 14/15 GRI GS EMIP Episodes: **Up 16.5%** on June 14 Up 8.8% on Average 14/15 GRI Ortho EMIP Episodes: **Up 17.8%** on June 14 Up 15.8% on Average 14/15
	From the July 2015 activity data we see the following: GRI AAU Presentations: **Up 5.1%** on July 14 Up 2.6% on Average 14/15 GRI ED Presentations: **Up 3.6%** on July 14 Up 11.9% on Average 14/15 GRI GM EMIP Episodes: **Up 5.7%** on July 14 Up 9.7% on Average 14/15 GRI GS EMIP Episodes: **Up 19.2%** on July 14 Up 22.2% on Average 14/15 GRI Ortho EMIP Episodes: **Up 9.1%** on July 14 Up 1.7% on Average 14/15
	From the August 2015 activity data we see the following: GRI AAU Presentations: **Up 12.9%** on Aug 14 Up 10.4% on Average 14/15 GRI ED Presentations: **Up 14.5%** on Aug 14 Up 16.7% on Average 14/15 GRI GM EMIP Episodes: **Up 9.8%** on Aug 14 Up 13.2% on Average 14/15 GRI GS EMIP Episodes: **Up 21.8%** on July 14 Up 30.5% on Average 14/15 GRI Ortho EMIP Episodes: **Up 16.6%** on July 14 Up 26.0% on Average 14/15

OTM Bed Capacity Changes

The table below shows the GRI bed base before OTM migration:

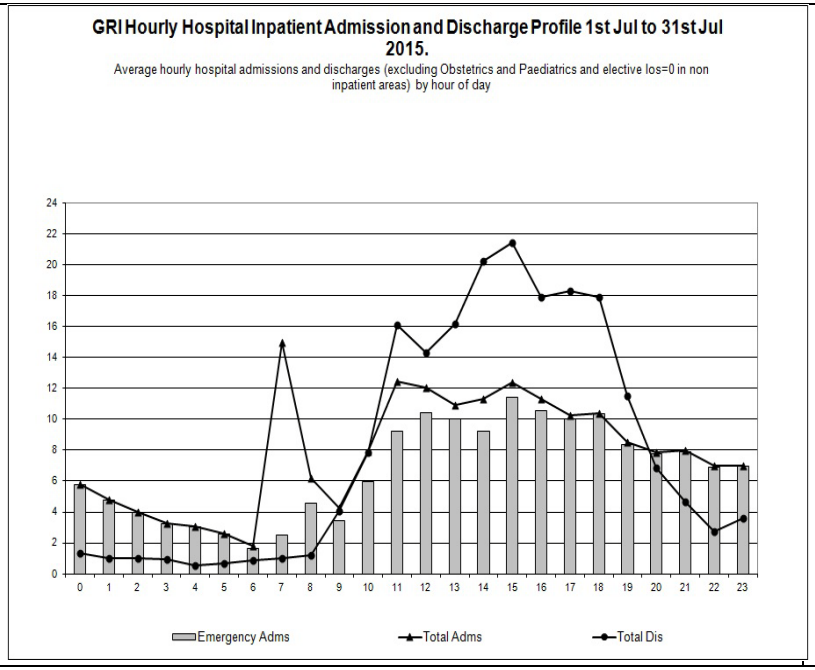
Glasgow Royal Infirmary			
Directorate	**Specialty**	**Ward**	**Current beds**
Rehab & Assessment	Elderly Assessment	*18 / 19*	32
	Elderly Assessment	*20 / 21*	10
	Elderly Assessment	*30*	19
	Stroke	*17 / 31*	19
	Elderly Assessment	*33*	19
	Elderly Assessment	*35*	12
	Elderly Assessment	*36*	19
	Elderly Assessment	*38*	12
	Elderly Assessment	*39*	19
Rehab & Assessment Sub-total			**161**
ECMS	General Medicine	*2*	18
	General Medicine	*3*	17
	General Medicine	*4*	17
	General Medicine	*5*	18
	Respiratory Medicine	*6*	14
	Respiratory Medicine	*7 / 16*	17
	General Medicine	*8*	18
	General Medicine	*9*	19
	General Medicine	*11*	17
	Rheumatology	*14*	0
	Rheumatology	*15*	10
	General Medicine	*23*	12
	General Medicine	*24*	11
	General Medicine / Rheumatology	*28*	12
	General Medicine	*29*	0
	General Medicine - Receiving	*43*	40
	Cardiology	*44*	8
	CCU	*44A*	6
	General Medicine / A&E	*46*	16
	General Medicine	*50 / 51*	46
	General Medicine hdu	*52*	6
	General Medicine	*53*	24
	General Medicine	*St Mungo*	0
	Acute Assessment Unit	*AAU*	0
ECMS Sub-total			**346**
Surgery & Anaesthetics	Orthopaedics - PO	*26*	7
	Orthopaedics - Rehabilitation	*27*	16
	Orthopaedics - Trauma	*61*	30
	Orthopaedics - Elective	*62*	30
	General Surgery - Enhanced Recovery	*63*	38
	General Surgery	*64*	34
	General Surgery	*65 / 67*	38
	General Surgery	*66*	23
	Critical Care	*ITU*	12
	Critical Care	*HDU*	16
Surgery & Anaesthetics Sub-total			**244**
W&C Services	Gynaecology	*56A*	12
	Gynaecology	*56B*	16
	Obstetrics	*68*	16
	Obstetrics	*69 / 70*	21
	Obstetrics	*72*	0
	Obstetrics	*73*	21
	Neonatal Critical Care	*SCBU*	28
W&C Services Sub-total			**114**
	Burns	*45*	13
	Plastic Surgery	*47*	26
	Plastic Surgery	*48*	12
Regional Services Sub-total			**51**
GRI Total			**916**

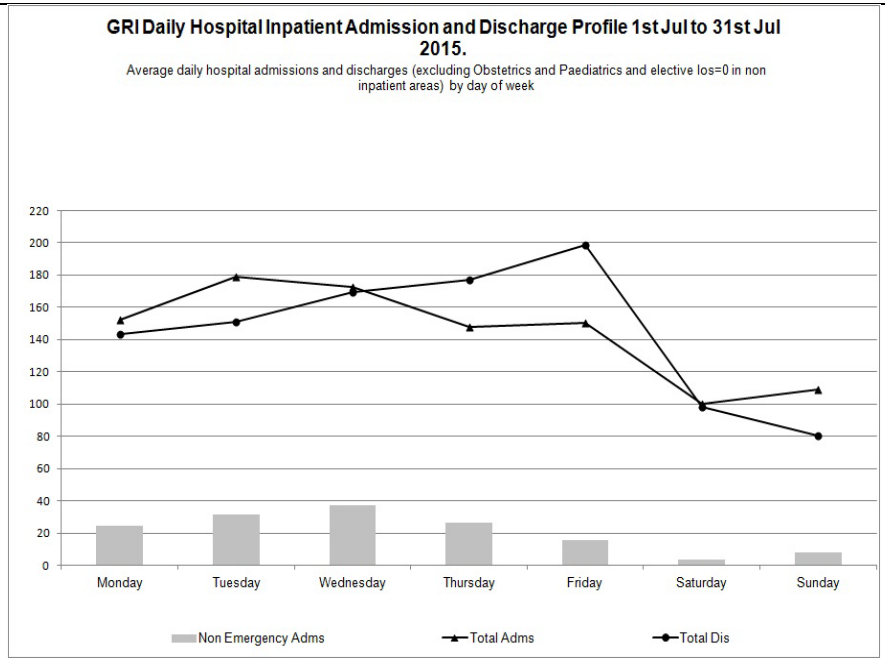
The table below shows the GRI bed base after OTM migration:

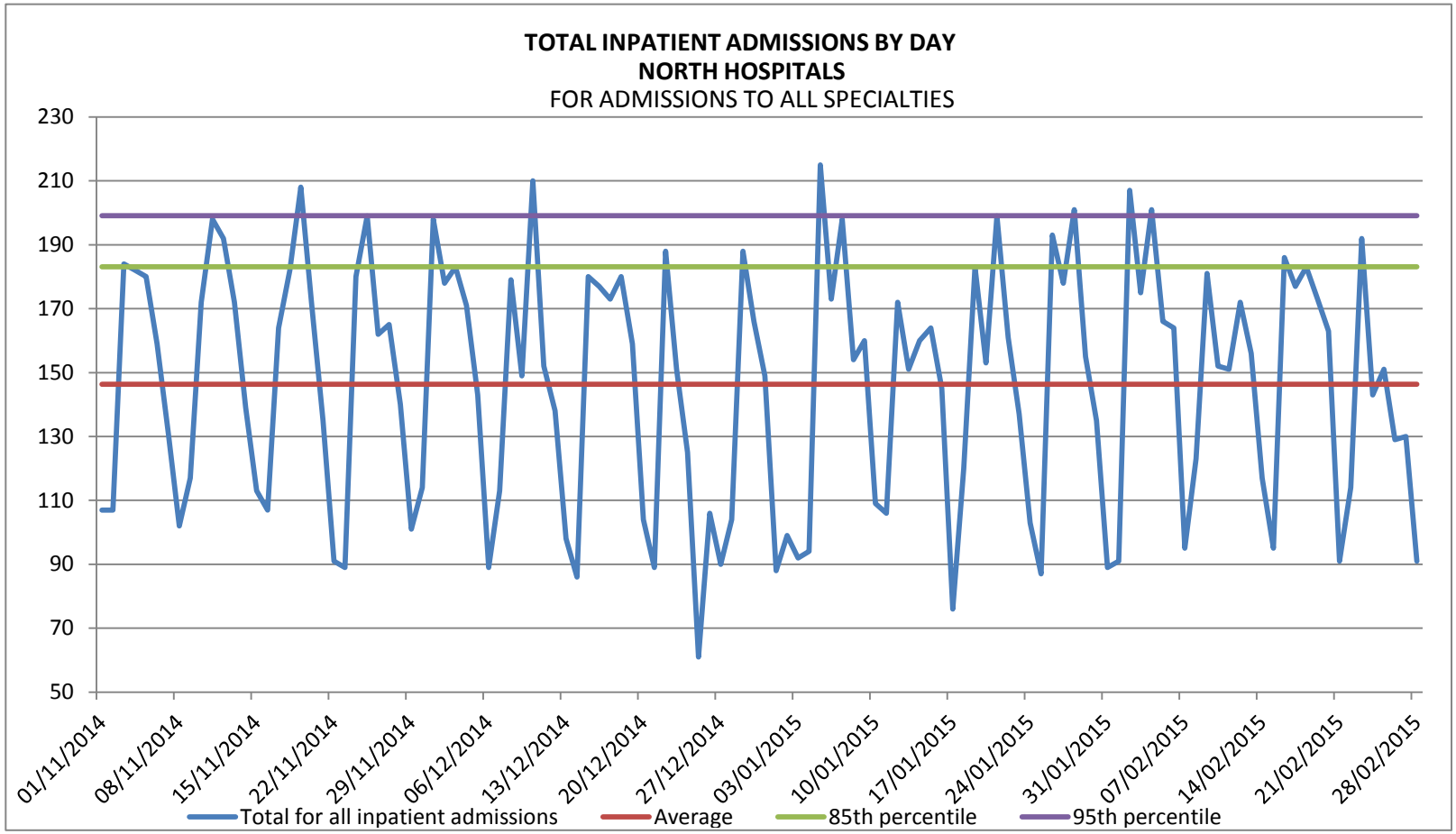
Glasgow Royal Infirmary			
Specialty		**Ward**	**Beds August 2015**
Older People	Elderly Assessment	*18 / 19*	21
	Elderly Assessment	*23*	12
	Elderly Assessment	*29*	12
	Elderly Assessment	*30*	19
	Stroke	*17 / 31*	19
	Elderly Assessment	*32*	12
	Elderly Assessment	*33*	19
	Elderly Assessment	*35*	12
	Stroke	*36*	19
	Elderly Assessment	*38*	12
	Elderly Assessment	*39*	19
Total			**176**
Medical	Respiratory Medicine	*2*	18
	Diabetes and Endocrinology	*3*	17
	Diabetes and Endocrinology	*4*	17
	Diabetes and Endocrinology	*5*	18
	Respiratory Medicine	*6*	14
	Respiratory Medicine	*7 / 16*	20
	Gastroenterology	*8*	18
	Gastroenterology	*9*	19
	Respiratory Medicine	*10*	15
	Gastroenterology	*11*	18
	Rheumatology	*14*	0
	Rheumatology	*15*	10
	Rheumatology	*20/21*	32
	Cardiology	*24*	11
	Rheumatology	*28*	12
	Cardiology	*43*	40
	Cardiology	*44A*	6
	CCU	*44*	8
	General Medicine / A&E	*46*	20
	General Medicine	*50 / 51*	46
	Medical HDU	*52*	8
	General Medicine	*53*	22
	General Medicine - Elderly Care	*53*	Sep
	Acute stroke	*53*	Sep
	General Medicine	*St Mungo*	0
	Acute Assessment Unit	*AAU*	0
Total			**389**
Surgical	Orthopaedics - PO	*26*	11
	Orthopaedics - Rehabilitation	*27*	16
	Orthopaedics - Trauma	*61*	30
	Orthopaedics - Elective	*62*	30
	General Surgery - Enhanced Recovery	*63*	38
	General Surgery	*64*	34
	General Surgery	*65 / 67*	38
	General Surgery	*66*	23
	Urology	69/70	24
	Critical Care	*ITU*	12
	Critical Care	*HDU*	16
Total			**272**
W&C Services	Gynaecology	*56A*	12
	Gynaecology	*56B*	12
	Obstetrics	*68*	16
	Obstetrics	*72*	17
	Obstetrics	*73*	25
	Neonatal Critical Care	*SCBU*	28
Total			**110**
	Burns	*45*	13
	Plastic Surgery	*47*	26
	Plastic Surgery	*48*	10
Total			**49**
GRI Total			**996**

The increases to the bed base, achievable within the constraints of the infrastructure, to partially account of the increase in emergency flow are: **DME**

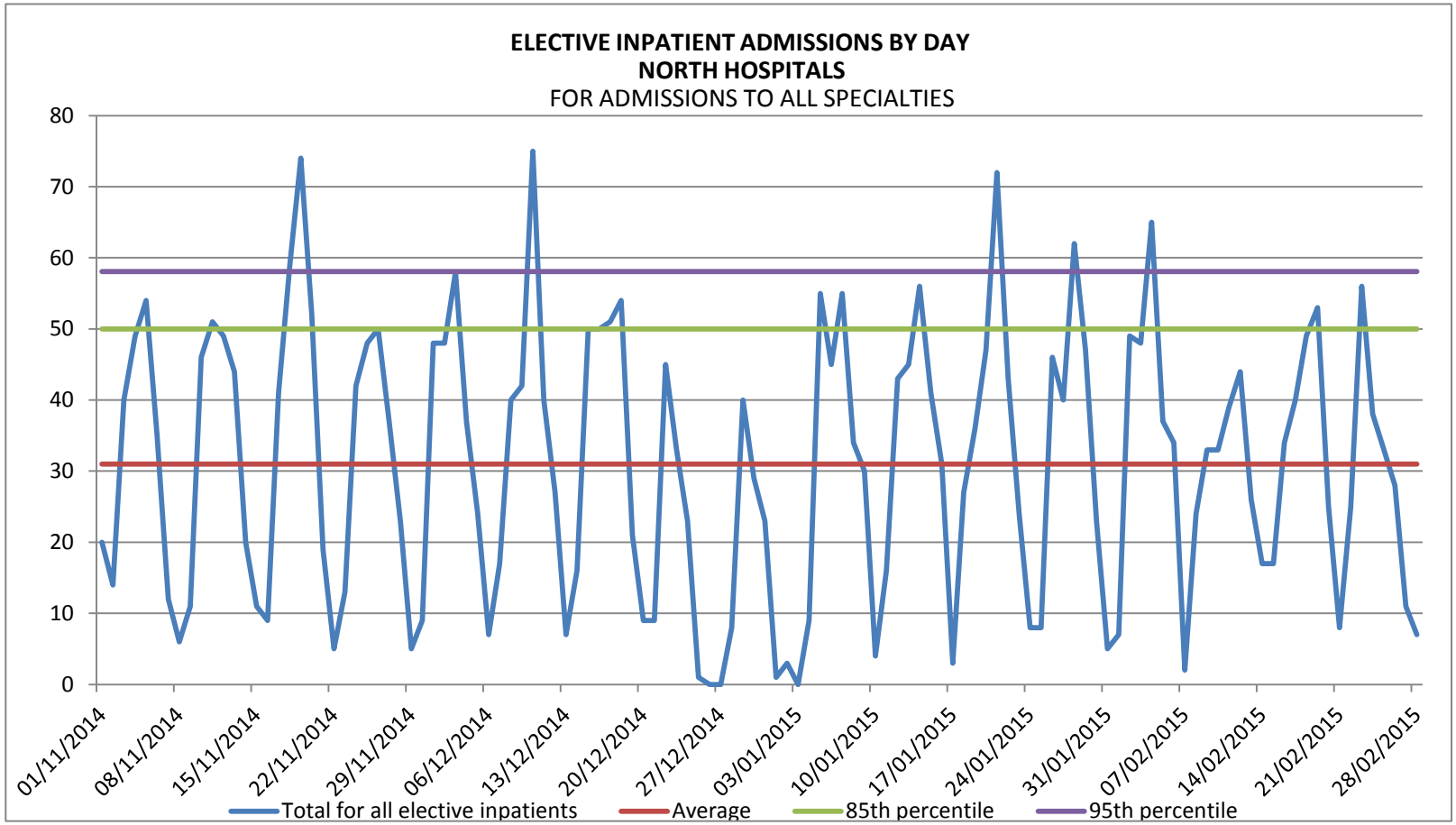
	+15 (+9.3%) ECMS +43(11%) Ortho +4 (+4.8%) GS NIL
Admission and Discharge Patterns	The graphs below show the variation in admission and discharges by hour of the day and day of the week in July 2015



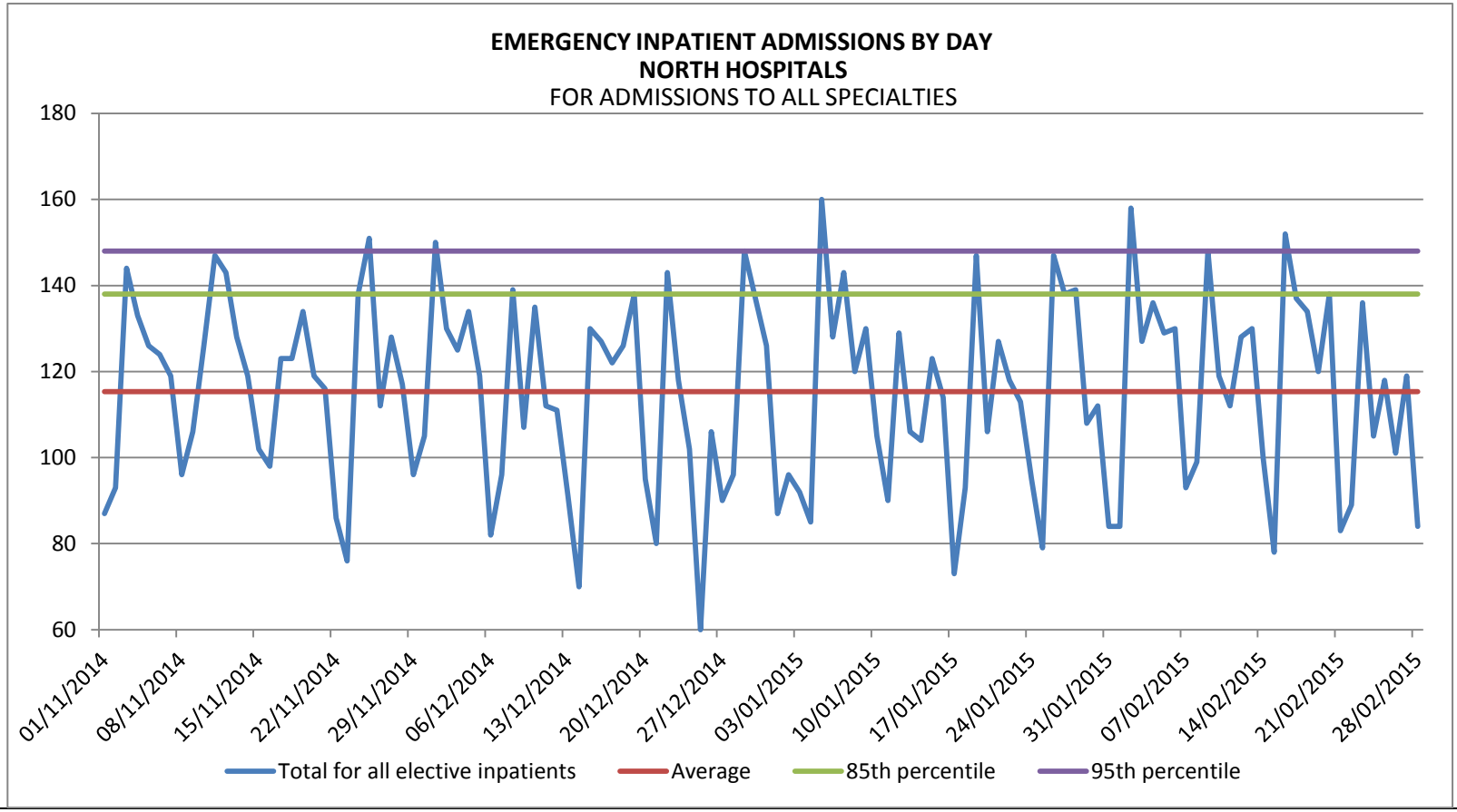


Admissions Prediction	The chart below shows the predicted total number of admissions based on the 2014/15 admissions and the flows as predicted by the bed model. NB: The GRI in June to August is seeing levels higher than predicted. (These charts are available in the source spreadsheet for each specialty)  The chart below shows the predicted number of elective admissions based on the 2014/15 admissions and the flows as predicted by the bed model.

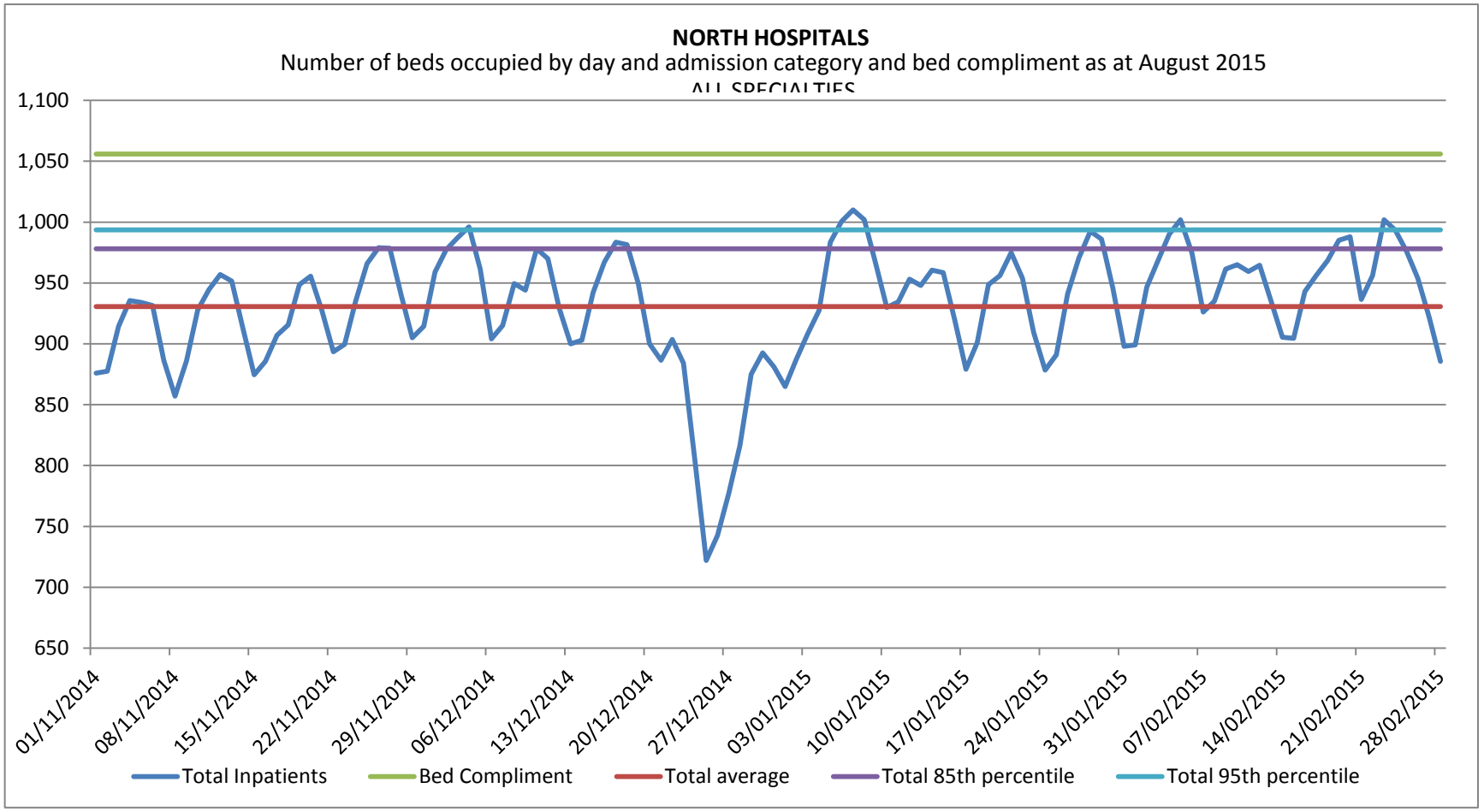
(These charts are available in the source spreadsheet for each specialty)
This shows a predicted elective admission range for North hospitals of from average to 85th and 95th percentiles:
All specialties elective : 31 50 and 58
ECMS elective admissions : 3 6 and 8
GS elective admissions : 9 15 and 20 Ortho elective admissions : 6 10 and 11



The chart below shows the predicted number of non elective admissions based on the 2014/15 admissions and the flows as predicted by the bed model.
(These charts are available in the source spreadsheet for each specialty)
This shows a predicted emergency admission range for North hospitals of from average to 85th and 95th percentiles:
All specialties emergency : 115 138 and 148
ECMS non elective admissions : 81 99 and 105
GS non elective admissions : 19 23 and 27
Ortho non elective admissions : 6 10 and 11



Bed Requirement Predictions	Modelling using the occupied beds data form 14/15 and configured across Glasgow in line with the bed model predictions gives the following chart for GRI :



This chart shows the 95th percentile at 994 beds. This chart shows the 85th percentile at 978 beds. This chart shows the average at 931 beds against a complement of 1056 beds.

The chart shows 12 days across the winter period when the projected requirement for bed days would lie above the 85th percentile and 4 days above the 95th percentile but no day over the bed complement. The highest predicted bed requirement arises from the 7 January activity which would

	require 1010 beds.
Changes Implemented to meet predicted rise in activity	To manage the predicted rise in activity described above, the following changes to services have been implemented across Medicine/DME: • Additional 51 downstream beds – 36 to medicine and 15 to DME • Additional 2 MHDU beds • AAU Zone 3 moved to Ward 46 • Surgical assessment Zone to commence in AAU from 21st September (GP referrals only) • Emergency Ambulatory Care Zone to commence in AAU from 7th September. Surgery and Critical care changes made to accommodate the anticipated workload transfer included the following : • The repatriation of Urology inpatient services onto the GRI site for elective and emergency patient management • The establishment of a Urology diagnostic hub to see and treat patients avoiding admissions • The transfer of Ortho Trauma theatre and consultant capacity including expansion of 4 beds • The establishment of a single orthopaedic trauma co-ordinator role • Development of Day of Surgery Admission area for surgical specialties • Progression of sustainable provision of two consultant receiving model for general surgery • Opening of additional semi elective inpatient theatre sessions during the week

Proposed Phased Winter Plans 2015/16	
Key Challenges	Winter Challenges to address • Activity levels – Team awareness and clear escalation policies • Bed capacity where it can be best used – Increase ECMS beds on GRI site – Maintain DME winter beds from 14/15 – Protect surgical beds – Maintain low boarding – Maintain low delayed discharges – Use Lightburn in extremis

	• Focus on Supporting "Front Door", Improving Flow, Reducing LOS and enabling discharge – SDM presence, emergency theatre access, aggressive ward rounds – Weekend discharge – Pharmacy and AHP support to discharge • Maximise elective programme when and where possible			
Maximising Available Bed Capacity	Winter Plan Key Elements • Maximise Bed Capacity PHASE ZERO (11 Beds) By October 15 – Continuation of 11 winter beds in Ward 18/19 for DME WP D1 PHASE ONE (28 Beds) By December 15 – Additional 4 Urology beds in PRM WP S8 – Ward 14 as 9 bedded ward WP M9B – Enhanced staffing of critical care areas WP S1 – Weekend staffing of Ward 66 and Ward 62 to full complement WP S12 – Dedicated use of 8 Plastics beds in Ward 47 WP S24 – Dedicated use of 4 beds in Ward 56A/B for ECMS WP M25 PHASE TWO (8 Beds) By end of Dec 15 – Additional 8 beds in Ward 71 in PRM WP M24 OPTIONS STILL BEING WORKED UP (21 Beds) – Relocate Gastro Day Activity from St Mungo to Ward 12/12A or StobhillWard B WP M15 • Additional 17 ECMS Beds – Relocate Stobhill Ward B to Lightburn Ward 3 WP D2 • Additional 4 Rehab Beds			
Bed Capacity Proposals	**Proposal Outline**	**Detailed Information to enable costing**	**Expected benefit in performance from investment**	**Measure of effectiveness** *(metric to be tracked to see result of investment)*
M15 **98.5K PCM**	Relocate the Gastro Day Unit from the St Mungo Building to Ward B at Stobhill Establish St Mungo as 17 bedded Medical Ward	Staff and activity to be transferred.	Increase in Medical Bed Capacity on GRI site by 17 beds in the St Mungo Building	4 hour breaches in Flow 3 for wait for bed
M9B	Create the flexibility to	Full staffing cost for nursing	Either adequate downstream bed capacity	ALOS

57K PCM	use Ward 14 as an extended discharge lounge for non ambulant patients (December to March) whilst retaining the ability to switch to 9 IP ECMS beds as surge capacity if required.	and medical costs for 9bedded area Area would be flexed where appropriate to manage discharge provision	to maintain patient from MAU and avoid admission delays from ED OR if discharge lounge – free up beds earlier in day to allow admissions from ED or AAU	Discharge time of day Bed availability earlier in the day
D1 **78.2K PCM**	Continue to staff 11 temporary beds in Ward 18/19	Staffing to reflect nursing and medical costs	Ensure adequate downstream bed capacity to maintain patient flow from MAU and avoid admission delays from ED	4 hour breaches on flow 3 wait for bed
D2 **18.1K PCM**	Transfer 24 rehab beds form Stobhill ward B to 28 beds in Lightburn Ward 3	Staffing transfer and additional 4 beds	Colocate rehabilitation facilities and facilitate bed capacity in St Mungo	
S1 **12.2K PCM**	Additional nurse staffing to support increased level 3 patient management within the critical care beds and provide 100% nursing cover	The flexibility to manage increased numbers of level 3 patients within the ITU requires additional trained and untrained staffing. 3x wte Band 5 1 x HCSW	Current staffing is for 12 ITU and 16 HDU beds on the site. Additional staffing would provide staffing to accommodate an increased number of level 3 patients.	Increased numbers of Level 3 patients accommodated Increased patients admitted and discharged to ITU
S8 **13.8K PCM**	Increase Urology beds in ward 70 by 4 beds	Increase footprint on ward from 24 to 28 beds to allow protection of elective cases. Required Resources: 2 WTE B5 1 WTE B2 Increase pharmacy and sundries budget by 16%	Increased provision for emergency patient access will ensure no cancellation of elective patients takes place. Increased patient numbers through the ward Faster transfer of patient from emergency dept to bed in Urology	Increased patient numbers Reduction in 4 hour breaches for bed wait Reduction in elective patient cancellation for lack of beds Reduction in time delay for emergency patient when bed request made

S12 **21.5K PCM**	Increase HCSW and trained staffing to ensure all beds can be utilised 24/7 and support discharge flow arrangements	**General Surgery:** Increase weekend ward 66 beds from 12 to 23 beds to facilitate increased unscheduled care cases. Resources required : 3.5 WTE B5 1.5 WTE Band 2 Increase pharmacy budget and sundries by 20% **Orthopaedics:** Ward 62 currently staffed to 24 and 18 beds respectively at weekend, to utilise all 30 beds additional staffing required is 1 WTE B5 0.6WTE B2 Increase pharmacy and sundries budget by 20 %	Increased bed capacity at the weekend will reduce bed waits for emergency patients Increased patient activity would be accommodated with limited impact on elective case management	Daily patient numbers to be assessed Reduction in 4 hour breaches for bed wait Reduction in elective patient cancellation rate
S24 **120.1K PCM**	Establish a dedicated 8 bedded area in the plastic surgery ward 47 in Jubilee Building for Surgical Patients (December to March)	As per ward template dependant on bed size. Need to include medical staff cover Noted further discussion required with colleagues in regional services. Staffing to include junior cover and costs for specialty specific consultant cover – 4 sessions	Increase in Surgical bed base to reduce effect of lack of downstream beds during surges	4 hour breaches in Flow 4 for wait for bed
M24	Open an additional beds in Ward 71 in the PRM as surge bed capacity	8 beds to be staffed for whichever cohort of patients are deemed suitable	In extremis increase in GRI bed base	4 hour breaches in Flow 3/4 for wait for bed
M25	Open additional 4 beds in Ward 56A/B in the PRM as surge bed	4 beds to be staffed for ECMS from 1 December	Increase in GRI bed base	4 hour breaches in Flow 3/4 for wait for bed

	capacity												
F1	Facilities costs to support additional winter beds 27.0K PCM	**Hospital**	**Domestic**	**Ward/ Unit**	**No of Additional Beds**	**Total Hours worked in Month**						**Hourly Rate**	**Staff Cost**	**Supplies Costs**
		Staffing Details				**Monday - Friday Standard Hrs**	**Weekend Standard Hrs**	**Monday - Friday Unsocial Hrs**	**Weekend Unsocial Hrs**	**Monday - Friday Night Shift**	**Weekend Night Shift**	11.13		
		Domestic		A.A.U patient feeding	30/45	110	40						1,892	
		Domestic		A&E extra cleaning/trolleys		60	16	55	40.5	150	60		5,913	
		Domestic		Ward 14		190	76						3,384	
		Domestic		Deep cleans for infection		60							668	
		Catering		Ward 14 picking/packing		56	16						890	
													0	
		Porter		5 staff M-F/ 4 W/K END p/t		600	180	28	41	150	60		14,279	
													0	
		Supplies Details											0	
		Catering		provisions for ward 14									0	**£552.00**
				AAU Meals									0	**£300.00**
		Domestic supplies		Cleaning materials/handtowels									0	£260.00
													0	
		TOTAL COSTS FOR MONTH											**27,025**	**1,112**
Enhancing the front door decision making and flow	Winter Plan Key Elements • Enhancing the front door decision making and flow – Extended hour evening consultant presence in AAU WP M3 – Enhanced Flow coordinator role WP M4 – Nursing staff for overflow areas in ED WP M7 – Transport to divert minors to Stobhill MIU WP M23 – Urology stone hot clinic WP S10 – Enhanced surgical middle grades in HAN WP S3 – Enhanced Trauma coordinator role WP S5 – Additional trauma theatre capacity WP S4 – SNP in Surgical Assessment Unit WP S11 – Enhanced theatre on call team WP S2 – Additional hour of emergency endoscopy provision WP S9 – Establish pool of 4 nurses who are deployed via the huddle to pressure areas WP N1 – *Additional diagnostic provision at weekends –to same level as at QEUHWP DG1*												

Front door SDM and flow proposals	**Proposal Outline**	**Detailed Information to enable costing**	**Expected benefit in performance from investment**	**Measure of effectiveness** *(metric to be tracked to see result of investment)*
M3 **10.6K PCM**	Evening AAU Consultant backshift Monday to Friday (December to March)	3 Consultant backshifts 1700-2100 plus annul leave cover Cost 4 weeks @ 5 nights to cover substantive post holders leave.	Reduce admissions / increase discharges from AAU by having senior decision makers present for longer periods of day	Maintain or improve number of patients discharged from AAU
M4 **14.6K PCM**	Sustain the current Flow Co-ordinator and CSW for ED 0800-2000 (December to March)	Flow Co-ordinator - 2.56 WTE Band 5 Clinical Support Worker – 2.56 WTE Band 3	Improve patient flow through ED and onward flow into the downstream wards	4 hour wait performance
M7 **22.7K PCM**	Additional Nursing Staff in ED (trained and untrained) to support overflow of patients in ED/AAU (January to February)	ED Band 5 - 2.56WTE AAU Band 5 – 2.56 WTE and Band 3 2.56 WTE	Provides the flexible ability to deal with high patient numbers experienced during the height of activity surges	Reduction in complaints and datix incidents regarding care in ED
M11 **1.3K PCM**	Transport between MIU @ GRI and MIU @ Stobhill	Require the ability to transfer patients from GRI A&E to Stobhill MIU	Minimise unnecessary minor activity in A&E that can be treated at Stobhill	Number of patients transferred
S10 **5.2K PCM**	Introduce hot stone clinic	Hot stone service put in place to manage patients coming in without having to be admitted to the ward. This would allow for better utilisation of ward 70 beds. Resource required would be: 2 x CT KUB slots per day (Monday – Friday) 0.5 WTE B5 0.5 WTE B2 2.5 Consultant pa sessions. Potentially diverting work to	Admission avoidance for patients presenting with renal stone presentation Direct access from A&E to slots for assessment of patients will turn around this patient group from A&E more quickly	Patient numbers attending the hot stone clinic who have bypassed admission could be recorded Reduction in Urology emergency admissions Reduction in conversion rate for urology presentations to admission Assessment of current patient turnaround time could be made and comparison thereafter

		weekends.		
S3 **27.4K PCM**	Implement Surgical HAN arrangement to ensure sufficient medical cover for inpatient beds	With recognisable challenges with the current weekend and overnight arrangements. it is proposed that the current staffing will be enhanced to ensure two middle grade doctors are available at all times to support the surgical stack, HSU/ surgical assessment /Urology and Ortho 4 x FY2/CT posts to be accessed to cover for the winter period. To support the emergency patient assessment process and ensure timely flow through the department the alloca8tion of an SNP to support the emergency receiving team would be advantageous. This would require an additional 2.5 x SNP staff.	Essential to support the single OOH surgical CMT. Improve medical support to surgical assessment unit and improve utilisation of urology CMT. Response performance for medical review of emergency patients will show improvement	Increased medical staff numbers accessible each night. Response rates for HAN review should be measurable 4 hour wait breaches for surgical specialty review
S5 **8.4K PCM**	Increase to full trauma co-ordinator staffing – requires three staff	1.5 WTE Band 6 staff to support trauma co-ordination until 8pm and also to cover weekends.	Process for trauma patients will be consistent with all GP interaction processed through the trauma co-ordinators. Co-ordination of patients to emergency theatre will improve	Reduction in elective orthopaedic cancellations? Reduction in the number of patients not meeting CEPOD access time.
S4 **6.5K PCM**	Increase Trauma theatre provision with additional full day on Friday in theatre L – requires additional radiographer cover also	The staffing of theatre L for one day includes the following staff profile : 4 trained staff and 1 HCSW • 0.27 WTE B6 • 0.54 WTE B5	Turn around of trauma cases would improve with the ability to access dedicated trauma theatre provision. No of cases scheduled into trauma theatre will increase. Improve consistency of patient	Trauma patient length of stay analysis will show improvement CEPOD response time for trauma cases Patient nos each day not being

		• 0.27 WTE B2 1 Band 5 Radiographer session 0.2WTE 2 consultant EPA sessions	treatment across the week, improvement to trauma patient categorisation to operative procedure time	accommodated in emergency theatre would demonstrate the reduction in numbers and thus increase accessibility for the other specialties particularly plastics to emergency theatre
S11 **9.0K PCM**	Provide additional Surgical Nurse practitioner support to cover 24 hrs	Ensuring that Surgical nurse practitioner care is provided to cover both the Surgical assessment area, support general surgical receiving and urology emergency cases 2.5 WTE additional Band 6 nursing staff are required	SNP provision to support the receiving teams and to cover the emergency patients already admitted will ensure optimum patient pathway monitoring /support Early response /review of all presenting emergency patients Faster turnaround of emergency assessment patients	Increased accessibility could be monitored each day Time to first assessment should be reduced Reduction in 4 hour breaches for wait for first assessment
S2 **48.1K PCM**	Increase theatre nurse staffing to ensure two on call teams at all times	An additional rostered team for overnight and daytime would provide the flexibility to manage both the current plastics emergency workload and that of all other specialties . X wte Band 5 staff X wte Band 2  GRI EMERGENCY THEATRE - ADDITION	Increased provision of emergency theatre capacity. Will reduce the variability created by the current call out system. Improved patient flow through emergency patient pathway for all specialties Improvement in the trauma patient access to emergency theatre	Difference between CEPOD categorisation and meeting demand. Modelling to be undertaken for current performance Reduction in the number of patients not meeting CEPOD access time. Reduction in cancelled elective cases due to emergency theatre demand.
S9 **7.3K PCM**	Increase endoscopy activity by an additional 1 hour to support inpatient activity	Increase non elective endoscopy activity by 1 hour per day to meet increased inpatient demand for	Waiting times for IP non emergency endoscopy, recognised to contribute to delays in discharge. Agreement in place with gastro consultants. Monitor be auditing IP	Activity through the dedicated sessions Current waiting time /delay to scope could

		endoscopy. This will reduce length of stay in medical wards. Resource required would be: 1 WTE B5 0.5 WTE B2 Increase pharmacy and sundries budget by 5% Consultant time would equate to 1.5 EPA	waits and activity undertaken Increased emergency patient numbers managed through the dedicated session	be measured and compared.
N1	A pool of bank nurses 2RN and 2HCSW who are aligned to the huddle each morning and deployed as necessary		Ensure a safe and effective staffing level is maintained	
DG1	*Additional weekend diagnostic provision* *Weekend service at GRI at the same level as currently at QEUH*	*Three consultants on at the weekend covering:* *Sat: one covering 9-5pm one covering 12-8pm and one covering 9-5pm who is also the one on call* *Sun: 2 covering 9-5pm (one covering the on call) and one covering 12-8pm*	*Improved flow and reduction in delays at weekends.* *The work undertaken at the weekend will include:* *Emergency scans from A&E/AAU/wards (plain films/CT/US) within GRI* *Inpatient scans to allow faster throughput of patients* *MRI of spines for acute cord compression and possibly acute MRI inpatients as staffing and skill mix allows.* *Providing supervision for any unallocated cross sectional lists being acquired in the department during this time interval* *Elective reporting activity to complete a full*	*ALOS*

			session equivalent of reporting activity.	
Reducing ALOS and enabling discharge proposals	Winter Plan Key Elements • Reducing ALOS, enabling discharge earlier in the day and at weekends – Additional ward rounds from "boarding team" WP M1 – Enhanced consultant ward rounds WP M2 – Extended cardiology diagnostics WP M6 – Extended discharge lounge in Ward 14 WP M9A – Enhanced OT and Physio at weekends WP S6 – Enhanced DME input to ortho rehab WP S7 – Enhanced AHP cover at weekends WP A1 – Extended opening hours for pharmacy WP P2 – Additional SAS transport for discharge and transfers WP SA1			
Reducing ALOS and enabling discharge proposals	**Proposal Outline**	**Detailed Information to enable costing**	**Expected benefit in performance from investment**	**Measure of effectiveness** *(metric to be tracked to see result of investment)*
M1 **41.3K PCM**	Boarding team – Consultant/SHO/FY1 to look after medical patients in AAU and non medical wards (December to June)	Consultant 1.25 sessions per day Mon to Fri with support from SHO 0.5 and FYI 0.5 Include annual leave cover. *May need to consider costing @ locum rate.	Timely senior review of inpatients in non medical wards to facilitate management plans and prompt discharge. Also establish clear lines of contact to senior decision makers. Need to clarify amount of medical staff time based on expected numbers (1.5 consultant sessions seems to low)	Prevent adverse impact of increase in medical ALOS in boarded patients Measure: Medical patient ALOS in wards
M2 **13K PCM**	Additional weekend Consultant ward rounds (December to February)	4 Consultant sessions 2 for Sat 2 Sun Include annual leave. * WLI rate if this is substantive staff picking up extra work.	Through the implementation of additional ward rounds at the weekend an improvement in number of ECMS weekend discharges	Reduction in medical ALOS Increase in number of medical weekend discharges
M6 **3.7K PCM**	Extension of Cardiology Diagnostics including ETT and Echo	Band 7 Physiologist and Band 3 ATO 4hrs Sat and Sunday Band 2 Porter 4 hrs Sat and Sunday	Reduce delayed discharges for inpatients waiting for cardiology diagnostics	Reduction in ALOS Increase in number of weekend discharges

	into weekends(December to February)			
M9A **16.3K PCM**	Utilise Ward 14 as an extended discharge area. Create the flexibility to use Ward 14 as an extended discharge lounge for non ambulant patients (December to March) whilst retaining the ability to switch to 9 IP ECMS beds as surge capacity if required.	Area would be flexed where appropriate to manage discharge provision	Either adequate downstream bed capacity to maintain patient from MAU and avoid admission delays from ED OR if discharge lounge – free up beds earlier in day to allow admissions from ED or AAU	ALOS Discharge time of day Bed availability earlier in the day
S6 **5.3K PCM**	Additional AHP provision (OT and Physio) to facilitate weekend patient support for increased discharge	Ensuring no downtime to patient rehab and mobility can be achieved through additional AHP staffing. Band 6 Physio 0.27 wte Band 6 OT 0.27 wte	Daily input for rehab management resulting in increased discharges and reduction in LOS	Increased daily discharge numbers Reduction in ALOS Reduction in orthopaedic boarding
S7 **4.1K PCM**	Increased DME consultant provision for Ortho rehab	2 x EPA sessions to deliver additional patient review 0.5 Band 7 nursing would facilitate additional provision of ECON nurses to manage the early identification and transfer of patients for rehab	Senior decision making in identification of patient suitable for transfer to rehab beds, helping patient flow and availability of ortho beds	Increased daily discharge numbers Reduction in ALOS Reduction in orthopaedic boarding
A1 **23.7K PCM**	AHP Team (OT/PT) to support and facilitate discharge including enhanced weekend service	Team will comprise of : • 3- 4wte Band 6 Registered staff • 2 wte Band 3 Generic support workers. Staff will be rostered to provide weekend	Increased support to discharge resulting in reduced length of stay through minimising delays and increasing the number of patients who are ready for	ALOS Number of discharges at the weekend

<table>
<tr>
<td></td>
<td></td>
<td>input both Saturday and Sundays and weekend duties will be supported with the remainder of AHP team with overtime

Team <u>will not</u> be Specialty specific but will respond to the needs of the site :
Tracking down boarders and working closely with the Front door and Elderly AHP teams to identify patients who could be turned around quickly and discharged home with or without community Rehab support.
Strong links with discharge coordinators and the daily Huddle will ensure the Team are responding to identified barriers to flow within the system and ensure a responsive service to supporting discharge.
The Team will provide a service over 7 days and will support existing AHP specialty teams.</td>
<td>discharge at weekends.</td>
<td></td>
</tr>
<tr>
<td>P2
9.1K PCM</td>
<td>Extended Pharmacy opening hours</td>
<td>Following consultation with senior pharmacy staff and on reviewing current activity it is proposed that Pharmacy opening hours are extended as follows:
<table>
<tr><th></th><th>Saturday</th><th>Sunday</th><th>Week days</th></tr>
<tr><td>GRI</td><td>9am -3pm</td><td>9am - 3pm</td><td>8.45am-7pm</td></tr>
</table>
During traditional working hours, the MyMeds model is employed. In this model patients' own medicines are used and dispensing is predominantly carried out within wards and clinical areas. In order to minimise costs, the funding requested for extended hours evenings and weekends is based on a centralised dispensing model where discharge</td>
<td>Better discharge rates both during the week and at weekends</td>
<td>Number of discharges
Lower ALOS</td>
</tr>
</table>

		prescriptions are dispensed in one or two centralised locations, usually the pharmacy dispensary. Attempts will be made to use patients own medicines as far as possible by employing "runners" to collect medicines from patients' bedside lockers for dispensing. Between 9am and 5pm on week days, the majority of prescriptions are clinically screened by the clinical pharmacist with knowledge of the patient's recent history and medicines use. However, the extended weekend and evening service will only include a pharmacist "professional" check e.g. to ensure that medicine doses are within the usual range and that there are no significant drug interactions. It is proposed that in addition to the request for additional funding, flexible working will be introduced on weekdays at GRI with staggered starting and finishing times for staff to extend the traditional working day. The summarised costs are as follows. These costs are based on midpoint of band plus 20% on costs. Costs are for additional hours over and above current services. Based on activity over the last two years, if the extended hours service were to be funded, it is not anticipated that additional resource will be required for winter planning initiatives (unless overall workload increases significantly or there are substantial changes in services).		
SA1 **8K PCM**	Contract SAS to provide an additional	Costed by SAS at 8K per month	Prevent delays to discharge due to lack of transport and enable	Bed occupancy in Stobhill and any allocated wards at GGH

	dedicated PTS vehicle for discharge/transfer every day 0900-1700		timely patient transfers to other sites	ALOS Number of discharges via PTS
Maintaining the elective programme	Winter Plan Key Elements • Maintaining the elective programme – Against backdrop of emergency surgical activity levels – Transfer of elective ortho sessions to GGH WP S13 – Transfer of elective urology sessions to GGH WP S15 – Weekend use of Stobhill ACH WP S17/18 – Use of GJNH or PS WP S16 – Continue to book to every possible slot – Optimise day case and urgent/cancer work in early January			
Maintaining the Elective Programme proposals	**Proposal Outline**	**Detailed Information to enable costing**	**Expected benefit in performance from investment**	**Measure of effectiveness** *(metric to be tracked to see result of investment)*
S13 **0.4K PCM**	Transfer of 4 elective orthopaedic sessions to GGH. All day Thursday and All day Friday	Where sessions are transferring between sites , it is assumed that the base theatre staffing will transfer with them and that bed availability at GGH will be accessible without additional costs . There may be additional costs associated where shared arrangements between theatres are in place Additional 0.2WTE B4 physio support to facilitate discharge	Transfer of elective patient activity will ensure no impact of emergency patient flow, less disruption to elective patient workflow. Reduction in elective cancellations Maintenance of TTG requirements	Cancellation numbers should be reduced Higher bed availability Reduced boarding Reduction in 4 hour breach for wait for bed No TTG breachers
S15 **0 PCM**	Transfer 2 elective urology sessions to GGH Sessions TBC	The recent transfer of stone surgery to GRI makes the options more limited. Two sessions to transfer to cover TURBT patients	Transfer of elective patient activity will ensure no impact of emergency patient flow No patient cancellations from these sessions	Cancellation numbers should be reduced No TTG breachers Higher bed availability Reduced boarding Reduction in 4 hour breach for wait for bed

<table>
<tr><td></td><td></td><td></td><td>Maintenance of TTG requirements</td><td></td></tr>
<tr><td>S18
47.6K PCM</td><td>Maximise use of ACH by weekend working to reduce waiting lists ahead of festive season</td><td>The opening of the Stobhill ACH for multi service use to accommodate TTG patients would release the pressure from the GRI site. Super weekends include the provision of four theatres for both sat /Sunday sessions. The recovery of patients and the use of 23 hr beds will be required if the four sessions are to be maximised

<table><tr><th>Stobhill ACH for 2 theatres</th><th>£</th></tr><tr><td>2 Consultants Surgeons</td><td>2,628</td></tr><tr><td>2 Consultant Anaesthetists</td><td>2,628</td></tr><tr><td>2 Theatre nursing team</td><td>6,436</td></tr><tr><td>1 Assistant</td><td>240</td></tr><tr><td>1 junior medical staff for the Ward (48 hour cover)</td><td>3,848</td></tr><tr><td>Ward nursing staff (2 trained and 1 aux)</td><td>3,404</td></tr><tr><td>Recovery team</td><td></td></tr><tr><td>Domestics, Facilities costs</td><td>1,110</td></tr><tr><td>TOTAL</td><td>20,294</td></tr></table>
Ward staffing
Theatre staffing
Medical cover
Friday to Sunday cover</td><td>Enable the continuation of a high tempo elective programme which is ringfenced from the bed and emergency theatres demands associated with the winter surges in unscheduled care.</td><td>Delivery of access targets</td></tr>
<tr><td>S16
491.2K PCM</td><td>Use private sector/ GJNH sessions to reduce waiting list in November/December</td><td>TURBT 20 cases
Hernia patients 25
Cholecystecomy patients 40</td><td>Waiting list demands reduced in terms of TTG maintenance

Maintenance of cancer target for</td><td>TTG maintained

Planned admission for peak emergency</td></tr>
</table>

		Orthopaedics: To reduce WLI requirements over December January 35 joints would be required in the private sector to ensure that the waiting time target is maintained.	TURBT patients Routine activity could be reduced in the weeks of increased emergency patients	period can be reduced
S17 **9.9K PCM**	Maximise use of Day Surgery and ACH during the period 21 December to 15 January reducing inpatient work to urgent and cancer only	Full staffing to cover the out of hours and full week/weekend period have been set out below : FY2 Band 5 Band 2	Protected capacity at the ACH for elective patient care would be accessible during the challenging period for emergency admissions	Increased activity at ACH

SUPPLEMENTARY PROPOSALS				
Supplementary Proposals (Priority Order)	**Proposal Outline**	**Detailed Information to enable costing**	**Expected benefit in performance from investment**	**Measure of effectiveness** *(metric to be tracked to see result of investment)*
S14 **0 PCM**	Transfer 2 elective general surgery sessions to GGH	Two sessions identified as potentially able to transfer to GGH	Transfer of elective patient activity will ensure no impact of emergency patient flow No patient cancellations from these sessions Maintenance of TTG requirements	Cancellation numbers should be reduced No TTG breachers Higher bed availability Reduced boarding Reduction in 4 hour breach for wait for bed
IC1	Lead Nurse on call to coordinate outbreaks at weekends	TBC		
S21	Dedicated ERCP recovery area to prevent IP admission of outpatient ERCP	Funding required to staff a recovery area for ERCP: This will prevent IP admission of ERCP therefore relieving pressure on GRI surgical beds.	The management of ERCP patients effectively will reduce admission of the patients as emergency patients	

		1 x WTE B5 0.5 x WTE B2	Reduction of prolonged patient stay in either medical or surgical areas	
S22	Transfer recovery space capacity for two HDU bed provision. This Pop Up approach would be challenging to sustain. Implement plan for additional HDU beds through reconfiguration of critical care and general surgical services	Option for "pop" up arrangement – extension of 2 beds in recovery to take HDU patients overnight . For extended cover would necessitate 4.94 WTE Band 5 and 1.64 WTE Band 2 Can only be delivered with the capital element Recurring costs for development within HDU paper. X Band 5 X band 6	Increased HDU capacity	
S23	Transfer IP sessions to ACH fully supported sessions – necessitates the transfer of the ACH beds to IP fully staffed and medically managed beds. Sessions would be facilitated on a three session day basis for Upper Limb trauma and General Surgery sessions	Each evening session would be treated as a WLI session. It is proposed that these would run on a Mon /Tues / Wed for two theatres each night	Transfer of elective patient activity will ensure no impact of emergency patient flow No patient cancellations from these sessions Maintenance of TTG requirements	
S24	Additional AHP support for ACH beds	Physio provision 1 wte	Additional discharges supported	

	for theatre post op management			
S25	Additional trauma staff for flow of patients through fracture clinics and the increased patient numbers through the virtual clinic.	Band 5 x 0.8 WTE nurse for # clinic Band 5 x 0.8 WTE for virtual # clinic.	Accommodation of increased patient numbers through the virtual clinic No significant delay in patient management	Improved patient flow Fewer return patients for fracture assessment

SOUTH SECTOR UNSCHEDULED CARE/WINTER PLAN 2015/16

1. This year's plans are being developed within a significantly different context following the reconfiguration of services associated with the opening of the QEUH and the closure of the former Southern General Hospital, the Victoria Infirmary and the Western Infirmary. These changes make the ability to forecast based on trends more complex. As a consequence, the focus has been on using the limited data available from the summer and focusing on daily run rates from last winter.

2. A key message is that understanding of how the QEUH flow is working is still developing and the expectation is that further redesign work should improve management of the patient journey, improving patient experience and realising efficiencies in capacity.

3. Success of this plan will be measured against the:

   - Achievement of the A&E 4 hour 95% standard
   - Timely and appropriate admission of unscheduled care patients
   - Minimal disruption to the elective programme and maintenance of Treatment Time Guarantees

4. The South Sector is defined as the QEUH, Gartnavel General Hospital (with Drumchapel) and the new Victoria Hospital.

5. The bed capacity within this sector is:

Figure 1: South Sector Bed Capacity

	QEUH	**Gartnavel**	**New Victoria Hospital**	**Total**
Medicine for the Elderly	280	134 (includes 24 SG funded beds)	48	434
Medical Specialties	518	22	0	540
Surgical Specialties	416	57	12	485
Total	**1214**	**213**	**60**	**1459**

6. The QEUH was designed with an extended Emergency Receiving Complex including an Immediate Assessment Unit (IAU) and Acute Receiving Unit (ARU) comprising in total 118 beds.

7. The model establishes new pathways for unscheduled care that were not in operation last winter in all of the previous hospitals. The expectation was that patients would not stay over 24 hours within the IAU/ARUs, with a discharge rate of 40% from the assessment units.

8. Patients admitted to the IAU/ARU are now recorded as 'Admissions' hence seeing a reduction in ED attendances and are now included as part of length of stay and bed occupancy calculations. For the purposes of planning, the QEUH bed capacity described above needs to be understood as:

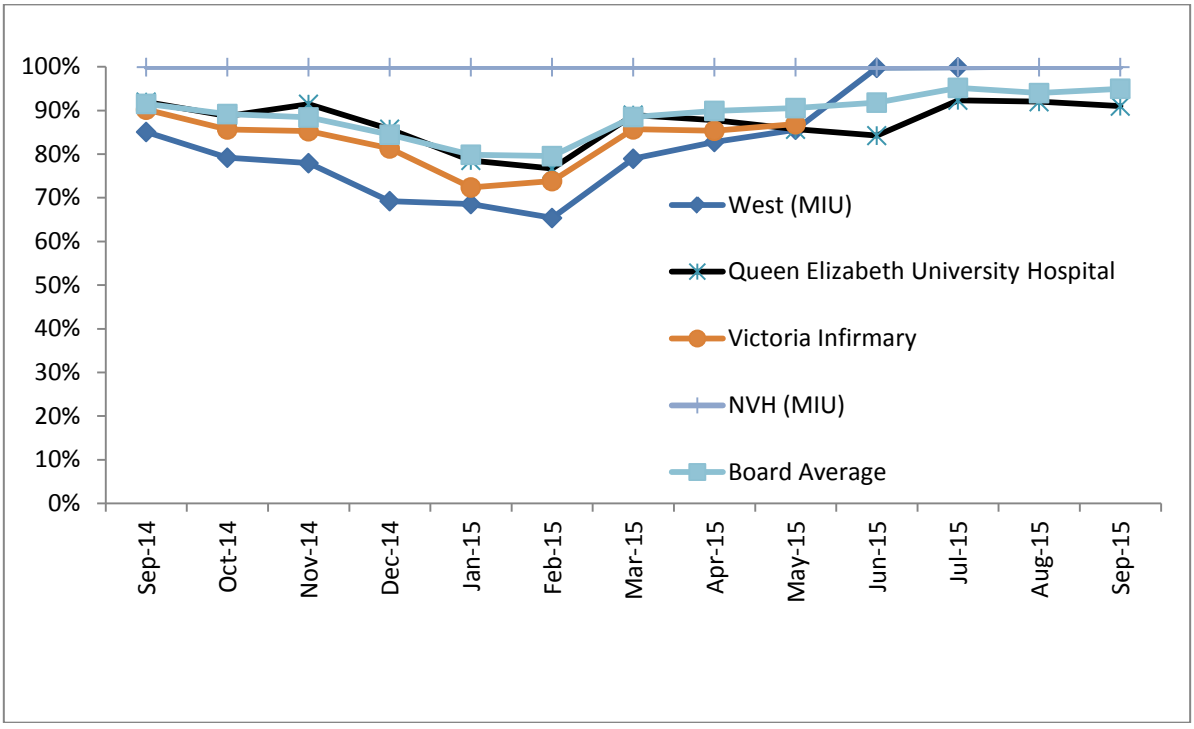
Figure 2 - QEUH Bed Capacity

	IAU	ARU	Inpatient	Total
Medical (Gastro/Resp/General)	24	44	450	518
Medicine for the Elderly		16	264	280
Surgical	4	30	382	416
Total	**28**	**90**	**1096**	**1214**

Priority: rapid assessment & flow. LOS < 24hrs

9. These changes make trend analysis and forecasting more problematic, we have only a few months' data from the new hospital flows to work with. Analysis to date, some of which supported by the Scottish Government is presented below.

Figure 3 - Unscheduled Care Performance – South Sector Sites (Sept 14- Sept 15)



10. Our experience over the summer months has been of significant pressure in keeping patient flow moving and accommodating demand. The challenges for this operating model are:

- Delivering the 95% standard for A&E attendances
- Achieving the expected discharge rate of 40% from the IAU/ARUs.
- Moving patients from IAU/ARU within 24 hours of their arrival.
- Achieving discharges before noon.

11. The sections below provide analysis and proposals informed by the analytical approach of the Scottish Government's Six Essential Actions. The focus is on describing key stages in the patient flow and aligning interventions intended to impact accordingly.

Analysis of Demand & Workflows

12. The Board received analytical support from the Scottish Government to inform understanding of the pressures at the QEUH 'front door'. Data analysed was from June to August. Conclusions are reflected in the commentary below.

A&E

13. Seasonal profiles for A&E over the last three years for hospitals now within the South Sector are consistent with higher attendances during the spring/summer months compared to the winter months. During the months from November through to January, monthly attendances have fallen by between 3 - 5% of the monthly average. This trend is displayed as daily averages in Fig. 4.

14. From May 2015, A&E attendances for the South Sector fell as a consequence of the new pathways for Unscheduled Care with the opening of the QEUH and introduction of the Immediate Assessment Unit (IAU) for GP referrals. The change reflects how presentations are recorded as GP referrals to the IAU are now recorded as admissions. (Fig. 5)

15. Further analysis of August and September 2015 indicates a daily average of 378 attendances (incl. minor injuries) with an 85th percentile of 410. Variance day by day demonstrates that the 85th percentile is hit regularly on Sundays and Mondays. (Fig. 6)

Figure 4 - Comparison of average daily attendances to Emergency Departments in South Sector, includes A&E, Minor Injuries and IAU (2012- present)

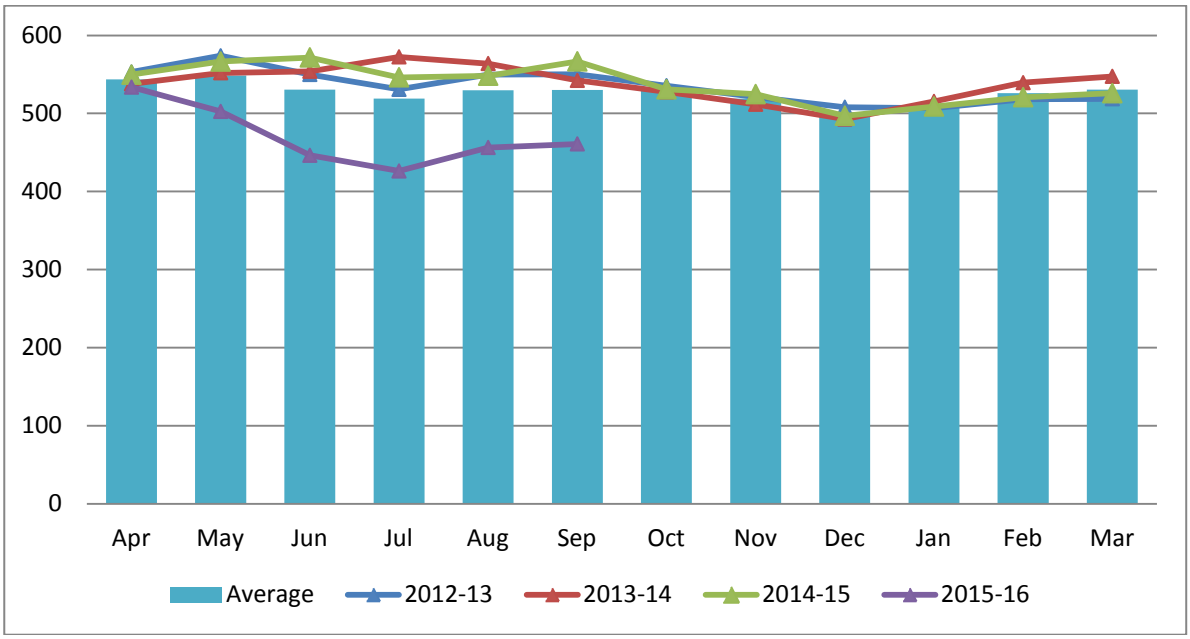


Figure 5 - Weekly Run Rate for A&E Attendances across the South Sector Hospitals (Sep '14 to Sept '15)

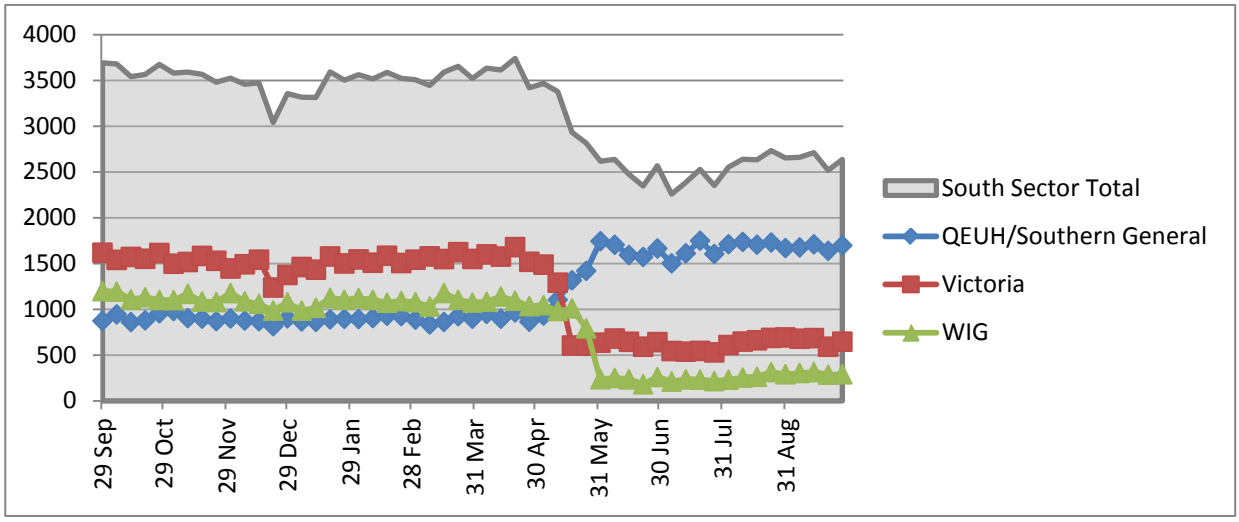
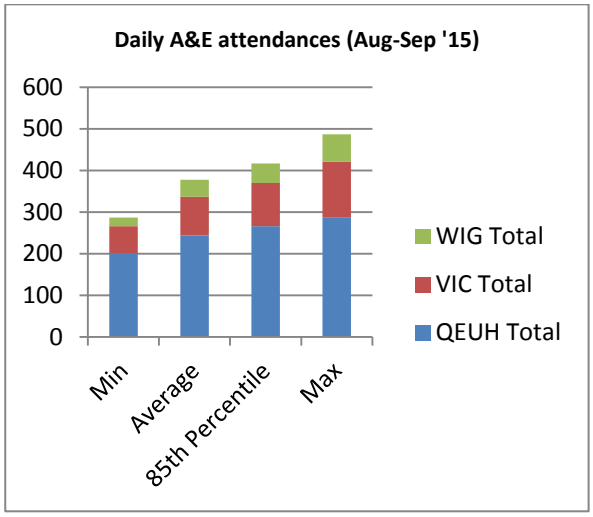
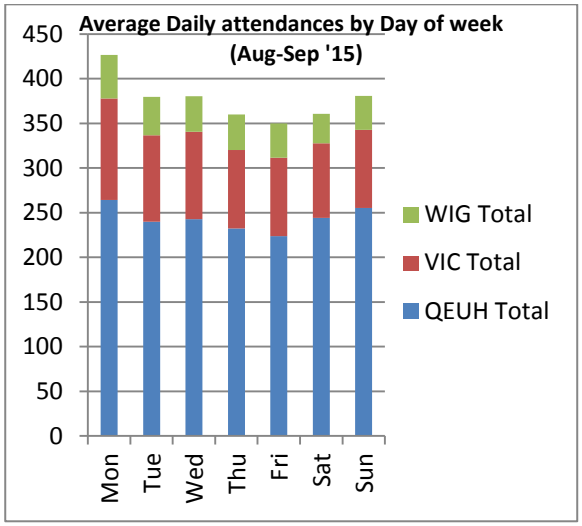


Figure 6 - Daily Variation in A&E Attendances during Aug – Sep 2015





16. The Government analysis provided further detail on time of presentation and on outcomes from the Emergency Department.

- Attendances have a consistent pattern with single figure numbers per hour presenting from 1am through to 8am. The pattern climbs sharply in the following 2-3 hours to a position by 11am when the average grows to between 10 and 15 presentations every hour and is maintained through to midnight. During these times, our experience is of an average 20 to 30 patients in the department.

- Experience from other large hospitals ED length of stay suggests that the optimum average length of stay is in the region of 120 minutes. The current average length of stay for the discharged patient cohort at the QEUH is close to the optimal level. The admitted patient cohort is however significantly higher. This correlates with our breach data which attributes the cause of delay as overwhelmingly 'wait for bed'.

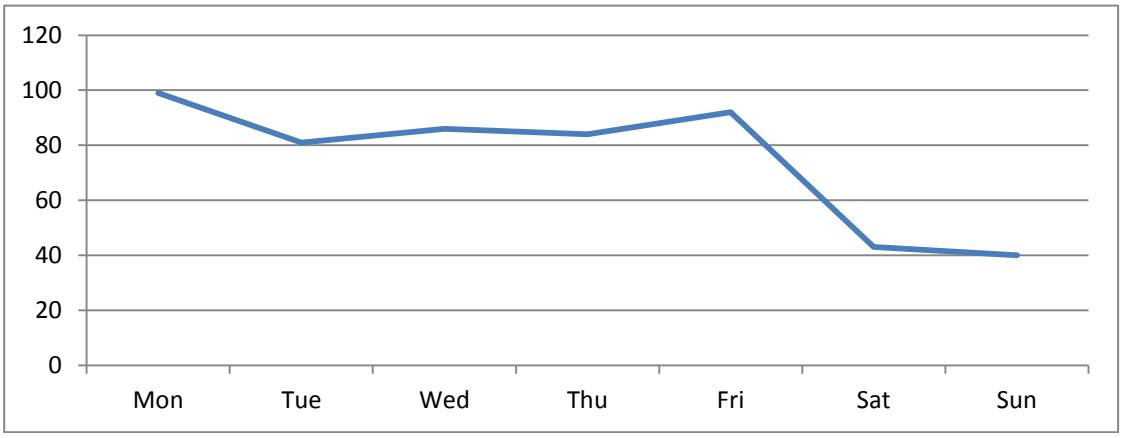
- Discharge rates from A&E are at 68%, consequently we can expect an average of 76 with peaks of up to 93 admissions per day.

Whilst the number of ED attendances does not increase markedly there can be greater variation in the level of variation of a day to day basis , other driven by weather conditions , and the proportion of those who attend ED and are subsequently admitted increases,

Assessment Unit (IAU)

17. Presentations at the new model of assessment unit are recorded as admissions and will include some attendances formerly managed in A&E. Our experience over the last 4 months is of a higher than expected volume of GP referrals through this unit which was planned for a daily average of 59 admissions. Our experience over the last 11 weeks is an average of 75 but with significant variation between weekends and weekdays. Over the last 8 weeks, Mondays have particularly been pressure with IAU admissions of over 110 experienced on at least 3 occasions.

Fig 7: IAU Admissions-average daily numbers between 3 Aug – 18 August



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18. The Scottish Government analysis observations were:

- The number of IAU patients per week who are admitted for on-going inpatient care remains reasonably consistent at around the 68-70 % mark.
- On practically every weekday the average daily occupancy is close to or above the available cubicles within the IAU. Between 11am-7pm, peak arrival time this increases substantially.
- The opening position of the IAU is often in excess of 20 patients on weekdays leaving little scope to cope with the incoming patients in the morning and congestion from lunchtime.
- The length of stay of patients in IAU is on average 6 hours but for this requiring onward admission is on average almost 12 hours.

Admissions

19. Trend analysis from 2010/11 to 2014/15 indicates that non-elective inpatient admissions for Emergency Care & Medicine and Surgery & Anaesthetics for the South Sector catchment have been relatively stable over the 5 year period. The episode count over the period between 2011/12 and 2014/15 shows a more marked change particularly during 2012/13 which has been attributed to changes in recording due to TrackCare.

20. Weekly run rate of admissions over Winter 2014/15 demonstrates the variability from one week to the next. Broadly the average was 1000 per week but as Fig 10. shows includes swings of 5% between weeks.

21. The reconfiguration of services and introduction of the new IAU/ARU models this summer limits the ability to use historic trends to forecast demand this winter beyond any general questions as whether there is an obvious year on year increase (which is not evidenced).

Figure 8 - Emergency Inpatient Admissions to South Sector

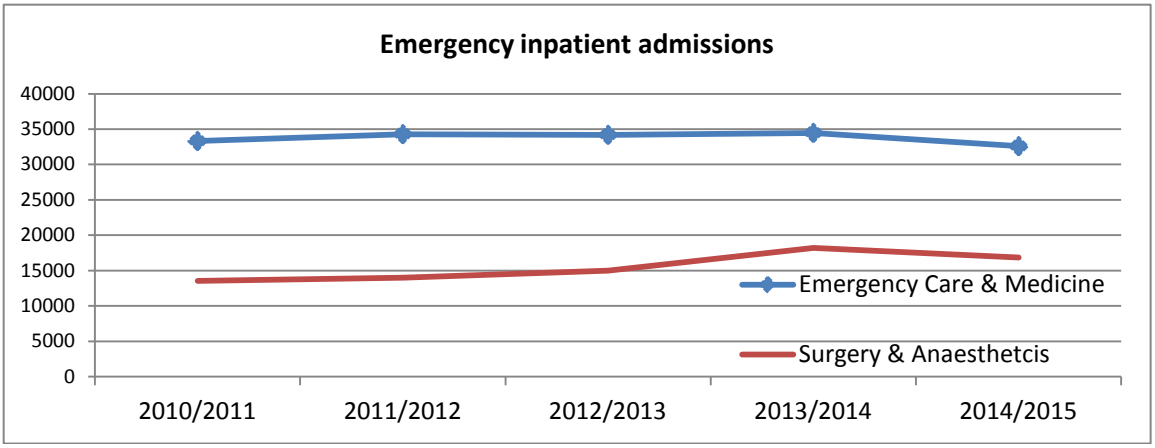


Figure 9 - Emergency Inpatient Episodes to South Sector

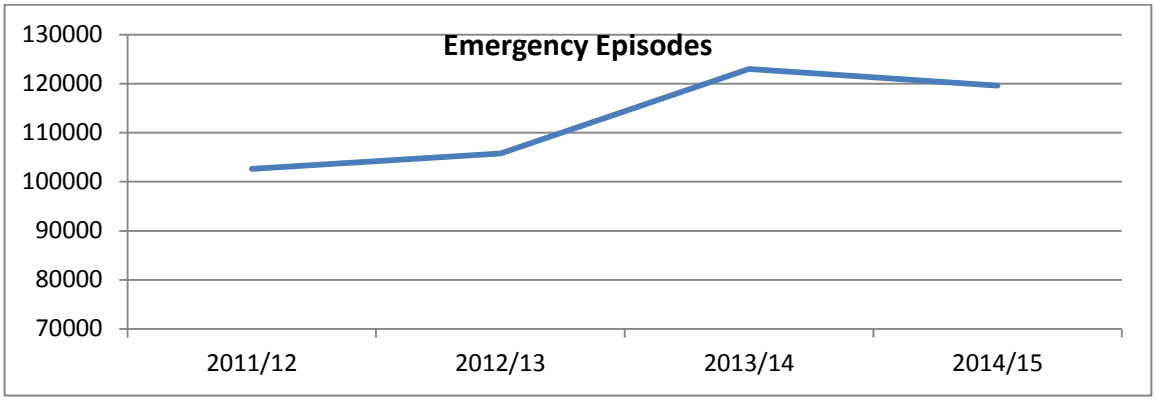
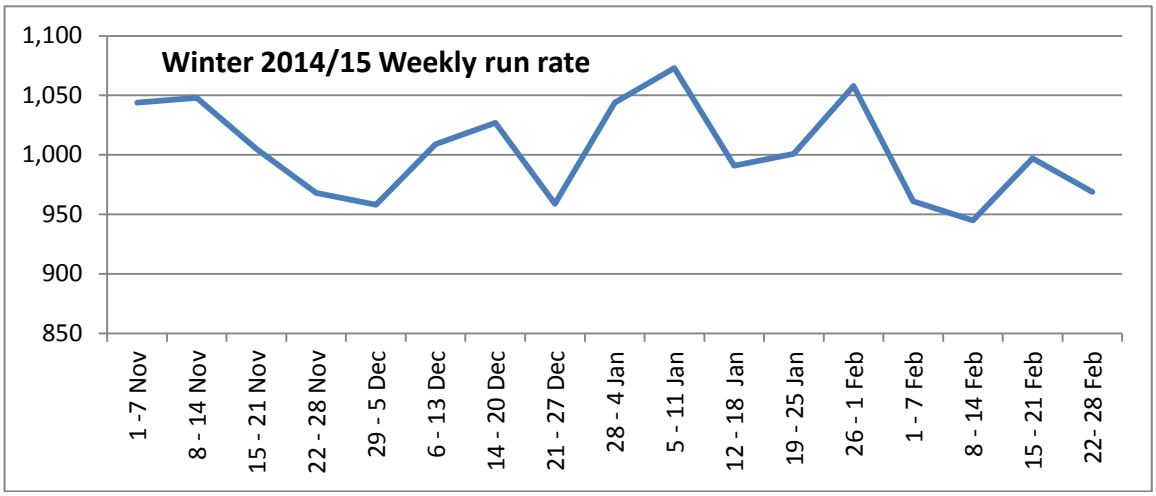
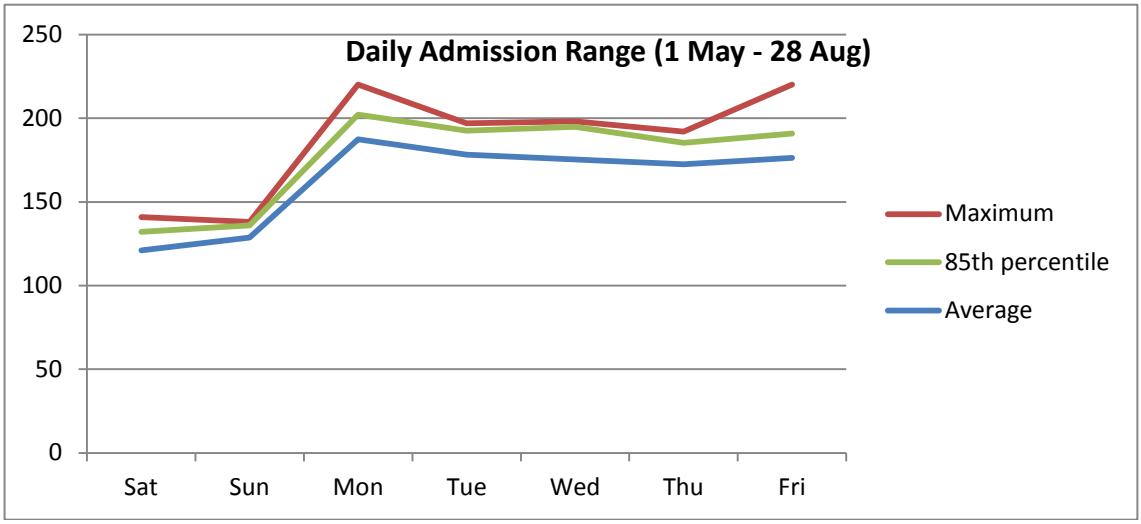


Figure 10 - Emergency Admissions by week to South (Nov 14 – Feb 15)



22. More recent analysis from this summer is helpful to describe the daily variation in non-elective admissions. As Fig 11. demonstrates, the QEUH is admitting an average of 178 patients Monday to Friday but with clear peaks of demand on Mondays and Fridays.

Figure 11 - Range of Daily Admissions to South Sector May – Aug 2015



23. Figure 12 described the profile of daily occupied beds from last winter. The intention is to update this from the summer months but this has yet to be completed. Our best estimate at this stage is the need to improve bed capacity by the equivalent of in region of 50 beds to cope with surge demand and maintain elective throughput.

Figure 12 - Beds Occupied by Non-elective Admitted Patients - Nov'14 to Feb'15

	Average	85th %ile	Max
Emergency Care & Medicine	496	527	588
Elderly Medicine	474	497	502
Surgery & Anaesthetics	280	299	314
Total	1250	1323	1420

Conclusions from Demand & Activity Analysis

24. The analysis above suggests the following parameters and assumptions which should inform the Winter Plan.

A&E Attendances

25. Capacity should be based on a likely range between the average and 85th percentile of August and September's rates. Given annual profiles which consistently show a fall of c. 3-5% during the winter months, planning on this level should be sufficient.

Daily Attendances:	Average	85th Percentile
QEUH	244	266
Vic	94	104
WIG	40	47

IAU

26. There is a shortfall of capacity to manage the volume currently presenting. Experience to date is that IAU demand is higher than anticipated and has considerable variation. Demand on Mondays is peaking at around 110. Averages through the rest of the week are around 75 per day.

27. Onward admission to an inpatient bed will be at a rate of 70%, ie. an average of 58 patients, with an expectation of peaks in the mid 80s on Mondays. Action is required to expedite flow from IAU particularly in the mornings before GP referrals start to attend but also later in the day when the occupancy rates can reach consistent levels of 30 to 40 patients. The key blockage is wait for beds.

Admissions

28. Overall, we should expect to be managing an average of 178 non-elective admissions Monday to Friday but expect regular surge periods of upwards of 200 admissions.

29. Bed occupancy for medical specialties has been 92% over the last 3 months. To reduce this to an optimum rate of 85%, it is estimated that contingency for the equivalent of up to an additional 50 beds for unscheduled care will be necessary to protect elective workflow.

Discharge

30. Delays to discharge linked to social care were a significant feature of the pressures during last winter. Reducing delayed discharges is a key factor to increase bed availability.

Six Essential Actions

31. The Six Essential Actions plan is the framework for the Unscheduled Care Improvement work underway. Its work will facilitate improved flow and management processes through the hospital hence is intrinsic to the Winter Plan.

32. Essential Action 1: Clinically Focused and Empowered Hospital Management

Triumvirate Management team structures are now in place establishing site leadership with Duty Manager on till 8pm. Unscheduled Care Improvement team now established. Bed Management and flow co-ordinator roles reviewed strengthening lines of accountability and communication. Site Safety Huddles are in place and effectiveness being constantly reviewed. Escalation plan for IAU in draft form. Weekend huddles introduced.

33. Essential Action 2: Hospital Capacity & Patient Flow (Emergency & Elective) Realignment

Significant analytical work conducted to support development of Winter Plan. Scottish Government has supported detailed analysis of A&E and IAU flows.

Review of pathways to beds not on QEUH site and escalation process in place to ensure beds are kept fully used. Introduction of internal transfer vehicle to allow speedy patient transfer to other sites and to reduce demand on SAS . Rescheduling of non urgent dermatology admissions in January to allow additional medical capacity

34. Essential Action 3: Patient rather than Bed Management – Operational Performance Management of Patient Flow.

Focus on improving rates of pre Noon Discharge and Delegated Discharge. Improvement work on Ward Rounds underway supported by drive to ensure Wardview is in use on all Wards. Hours of operation of discharge lounge extended till 20.00 each day .

35. Essential Action 4: Medical And Surgical Processes arranged to improve Patient Flow through the Unscheduled Care Pathway

Review of delays in system underway, including addressing variation at weekends. Baseline information established to enable measurement of improvement. Surgical flows improved to expedite flow of patients direct from ARU5. Use of “hot” clinics as alternative

to attendance and admission and use of urgent respiratory out-patient appointments for patients with known disease subject to exacerbations.

36. Essential Action 5: Seven Day Services Appropriately Targeted to reduce variation at weekends and Out of Hours Working

Actions building on work noted above with alignment of services identified to enable reduction of variation, including AHP and facilities services. Pump priming of pahrcamy services to increase hours of work in the evening and weekend. Additional support workers to be in place at weekends to free up medical staff .

37. Essential Action 6: Ensuring Patients are Optimally Cared for in Own Homes or Homely Setting

Redirection services and proposals developing, including Govan GP (below) out of hours redirection protocol and social media campaign to encourage use of Western Infirmary Minor Injuries.

Govan Area pilot: Joint initiative with 4 GP practices in Govan to redirect patients to in-hour GP services currently being piloted. GP surgeries contacting patients by 11am the following day to pick up needs. Pilot commenced in September for period of 3 months.

Use of third sector services to support flow – Red Cross service to take older people home and provide follow up service , Marie Curie palliative care discharge service

Planned Developments to Support Management of Unscheduled Care

38. The following developments are planned to address the identified pressures over the winter period:

Maximising Available Bed Capacity		
Extend Medical Bed Capacity 28 beds		£454,122 Costs from 1st Dec . four months .
Use of 23hr beds in vic ACH for DME patients	Additional staffing	£38,221
Enhancing the Front Door Decision-making and Flow		
Extend Ambulatory Care capacity	Establish sufficient capacity for patients who do not require a bed in IAU. Capacity for 10 at any time.	£103,619 Assume start date 1st December. Costs for 4 months
Relocate Surgical & Urology Assessment	Provide sufficient capacity to accommodate medical demand.	£314,945 for four mths assuming start 1st December.
IAU 'Hot clinics'	Alternative to IAU admission, GP referral of low acuity patients.	£21,667, four months From 1st December
Respiratory Clinic Capacity	Provision of additional (2) slots per clinic to support follow up for early discharge or alternative to admission	no cost
Low Risk Acute Coronary Syndrome	Apply model piloted at RAH to manage low risk Chest Pain	Tbc

	referrals, avoiding admission.	
Additional Clinicians in A&E/ IAU	Strengthen evening/late shift clinical decision-making capacity Medical & Nursing	£241,112 Assume start 1st December Four months
GPOOH	Strengthen evening and weekends clinical decision-making capacity	£91,987 Assume start 1st December.
Reducing ALOS & Enabling Discharge		
AHP 'Hit Team'	Dedicated additional capacity to support flow and 'Boarded' patients.	£32,157 Start date 1st December (four months)
AHP 7 Day service	Extension of AHP support to support flow.	£67,237 Start 1st December (four months)
Pharmacy	Extension of hours, early evening and weekends.	£38,527 To start 1st January
Maintaining the Elective Programme		
Elective Orthopaedics to GGH	Release equivalent of 12 beds for Medical Demand. COSTS INCLUDE STAFFING ADDITIONAL BEDS + SUPPORT	£262,766
Elective cases	use of private sector to allow NHS to focus on unscheduled care	£350,000
Trauma lists	provide additional trauma lists to ensure electives maintained	52,000
Total Cost		**£ 2,411,121**

GP Out of Hours (OOH)

39. The GPOOH service hub is co-located with NHS24, SAS and CPN services facilitating good communication and responsiveness to peaks in activity. Activity profiling has informed workforce planning and targeting of additional resource.

40. Demand between OOHs units is managed to smooth pressures and reduce waits. Patients are offered transport to assist in making this work. This allows balancing of pressures for example, between the Victoria and QEUH.

41. Referral pathways are in place with NHS24, Pharmacists, Dentists, GPs, Minor Injury Units , Emergency Departments and Out of Hours Mental Health Services.

Workforce

42. Our plans are intended to anticipate the impact of increased demand. Throughout the year, normal practice is focused on managing establishment and sickness rates. Further risk analysis will be necessary to consider mitigation in the eventuality of:

- Heavier rates of sickness during period of peak demand
- Changes to skill mix to support wards to manage more diverse casemix (eg. Higher rates of medical boarders in surgical wards)

43. Rotas for the Festive Bank holiday weekends need to be confirmed by the end of October. Experience over successive years also shows that early January is often a period of heavy demand and rotas should ensure that establishment is not diminished by leave plans.

44. The Board has launched its programme for offering flu vaccination for staff. The Scottish Government has set a challenge for Boards to achieve 50% take up rate.

45. Specific proposals are being considered for additional capacity and will have associated workforce plans to ensure effective and safe delivery.

Key Performance Indicators & Escalation Framework

46. The Sector will monitor a consistent set of KPIs throughout the winter months to support performance and understanding of pressures.

47. These KPIs will be part of wider set of indicators that drive day to day operational management and Escalation Framework. The Escalation Framework will be informed by the 'huddles' and be communicated across the Sector. It will also be part of the broader Board Escalation Framework used to inform and co-ordinate action with partners across Greater Glasgow and Clyde.

WOMEN AND CHILDREN'S DIRECTORATE UNSCHEDULED CARE/WINTER PLAN 2015/16

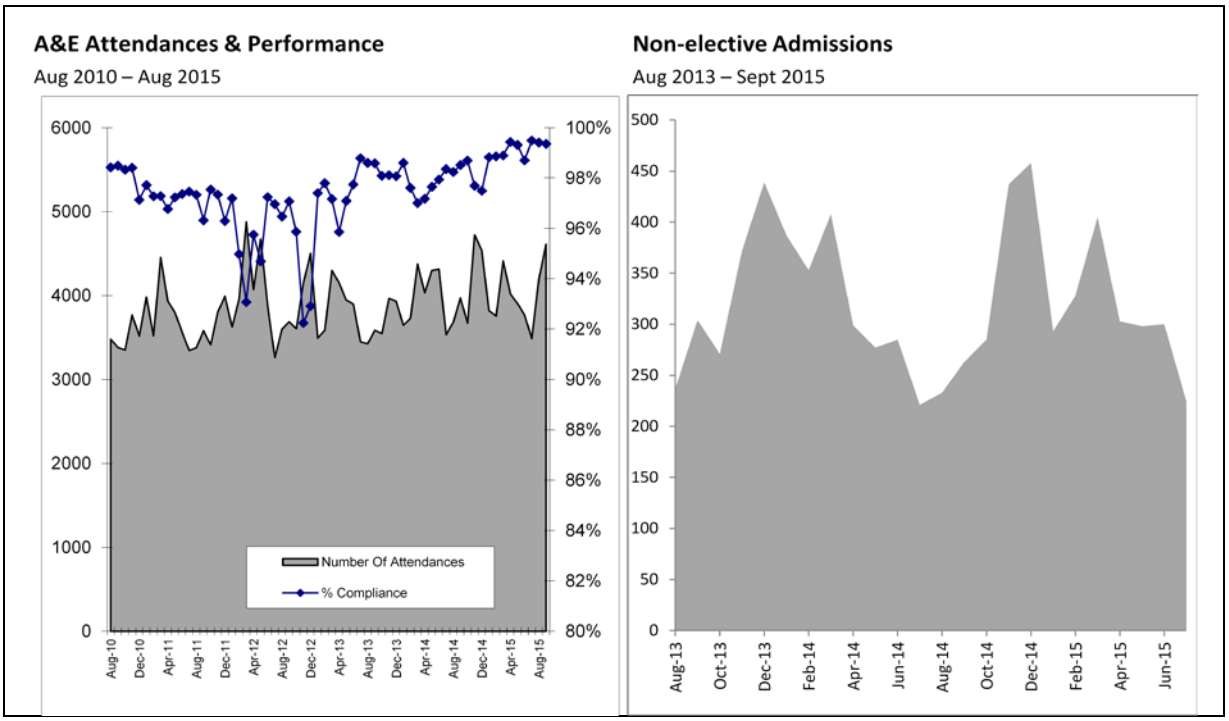
1. Introduction

The new Children's Hospital deals with a substantial Accident and Emergency workload. This is the first year if operation in the new Hospital. In comparison to last winter, the following differences between RHSC and RHC should be noted:

- 40 Acute Receiving beds in RHC, compared to 48 in RHSC
- 20 bed CDU in RHC, compared to 12 bed MAU in RHSC
- 20 ITU and 2 HDU beds in RHC, compared to 17 ITU and 5 HDU in RHSC
- 22 beds from the previous RHSC inpatient complement are now dedicated 23 hour elective beds in RHC, operational Monday - Friday
- significantly increased number of single rooms in inpatient wards. This will be beneficial from an infection control point of view.

2. Performance

The tables below show the performance against target for the Children's Emergency Department and the pattern of admissions we are planning for.



3. Actions

The following developments are proposed to support delivery of the 95% A&E Standards:

Assessment Capacity	- Open further 10 beds in CDU to be used between ED and ARU - Extended hours for Gynae GP Direct Referral - Extend hours and introduce 7 day service for Early Pregnancy Assessment Service
Flow Management	- Extend Bed Management Arrangements to provide 7 day cover.
Optimise Capacity	- Diversion protocol established to manage access between RHSC and RAH, Ward 15 - Extend PICU to full 22 bed ITU capacity (uplift of 2 HDU beds)
Discharge	- Establish RSV/Bronchiolitis nurse led discharge pathway

PARTNERSHIP OVERVIEW

Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. We have agreed through our whole system planning group that each Partnership would produce an operational unscheduled care plan with a particular focus on the winter period. The drafts of these plans cover:

- Delayed discharge
  - Reducing numbers
  - Delivering 72 hour discharge

- Measures to reduce admissions and attendances

- Delivery of key services including:-
  - Single point of access
  - Nursing home support
  - Anticipatory Care
  - Capacity for AWI patients
  - Equipment
  - In reach to hospitals and rehabilitation

- Continuity and resilience particularly ensuring community health and social care services are available when required, including focussed recovery from periods of more limited cover;

- Developing an agreed set of indicators to monitor performance;

- Planning with GPs for the two long bank holidays including:-
  - prioritising emergency patients;
  - Advice to patients with chronic conditions on sources of help;

- Local communication

Specific plans for:

- The festive period: workforce and rotas and post festive surge

- Flu vaccination

Business continuity plans:

- Confirmation of testing of business continuity plans

An important element of this planning is analysing demand and capacity in the same way as we are undertaking for acute services. The 6 essential actions are also relevant to planning delivery of community services and are included in the plans.

RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP WINTER PLAN

1. Introduction

This Winter Plan identifies and addresses the local issues across the primary care and community services for which Renfrewshire Health and Social Care Partnership is responsible, to support the NHSGG&C whole system planning as detailed above. Many of the actions identified are required all year round – additional bank holidays, increased staff absence and additional demand over the festive period and into January will add to year round pressures.

2. Planning Arrangements

The Renfrewshire Development Programme (RDP) has provided a focus for change and efficiency improvements through four main projects: Older adults and chest pain assessment units, anticipatory care planning and out of hours community in reach.

The programme connects different services across primary, community and acute care to develop more effective working arrangements, improving handover between services, increasing the speed of access to required services and reducing bed days and lengths of stay. Evaluation is underway, but early learning will inform this plan. It is anticipated that the main projects will continue throughout the winter period.

This plan has been developed in partnership with service planners and operational managers at the RAH. It will be reviewed and monitored on an ongoing basis by the HSCP Senior Leadership Group.

3. Renfrewshire Actions Against the Scottish Government Key Themes

Scottish Government Key Themes	Renfrewshire Actions
Safe and Effective Admission and Discharge	Avoiding Admission Three RDP projects will continue throughout the winter period. In particular, the older adults' assessment unit supported by the in reach Community OOH Service and the chest pain assessment unit will be supported to prevent unnecessary admissions. We will identify those care homes which have high levels of hospital admission and offer additional support to them. In particular, we will use our pharmacy team, our care home

Scottish Government Key Themes	Renfrewshire Actions
	liaison nurses, community RES and our older adults liaison nurse to target those care homes. We will continue to remind GPs about the need to update the KIS. Our district nurses will support the national campaigns offering advice to patients with chronic conditions. We will continue to encourage DN and RES staff to use clinical portal to access KIS and other relevant information to support care planning and discharge planning. We will share information about community pharmacy services and times with Homecare staff and with the local A&E department. Other services to prevent admission (including Third Sector). <u>Safe Discharge</u> We will continue our existing good practice re discharge planning and avoiding lost bed days supported by a comprehensive social and health care response. The discharge lounge at the RAH is currently operational Monday to Friday. We will explore with acute colleagues the potential for extending this to the weekend, to optimise the community services currently available 7 days/week. We will use Darnley Court as a step-down facility for AWI patients, freeing up capacity in acute inpatient beds. We will continue to participate in the daily huddle meetings at the RAH (and extend this participation to include mental health and addictions). We will formalise and share the key messages/outputs of these meetings on a need to know basis to promote whole system working. <u>Mental Health</u>

Scottish Government Key Themes	Renfrewshire Actions
	i) <u>Adult Inpatients</u> The admission and discharge data for inpatient hospitals has been assessed over the last 5 years through the Mental Health Bed Management system. The bed management systems and bed managers provide daily reports on bed occupancy and availability. These reports also report on any projected ward closures should this be necessary in exceptional circumstances e.g. Norovirus, influenza etc. Annual leave will be managed across the winter and festive period to ensure sufficient staffing to manage demand. The pattern of admissions and discharges over the winter period is similar to the pattern throughout the rest of the year. No special arrangements need to be put in place relating to psychiatric admissions and discharges. ii) <u>Community Services</u> Intensive Home Treatment Team will provide 24 hour 7 day week provision for Mental Health Services which will assess patients for admission and discharge. These services will be in place over the festive period. The services include social care support. The Intensive Home Treatment Team will provide public holiday cover during the festive period. Community Mental health teams will operate throughout the festive period with skeleton staff during public holidays to facilitate discharge and prevent admission The services above receive referrals from Primary Care, Liaison Psychiatry and secondary Acute services. iii) <u>Out of Hours Arrangements</u> Mental Health Services in Greater Glasgow and Clyde provide Out of Hours services which receive referrals from the GP OOH service which triages calls from NHS 24. These services will be in place over the festive period. It is not anticipated that there would be an unusual pattern of referrals to psychiatry based on previous year's information.

Scottish Government Key Themes	Renfrewshire Actions
	iv) <u>Acute Hospital Liaison</u> Liaison Psychiatry Services are provided 7 days a week to Royal Alexandria Hospital by Psychiatric Liaison Nurse services and Intensive Home Treatment Team for deliberate self-harm over weekends and public holidays. This is in addition to direct referrals to the on-call psychiatry staff in psychiatric hospitals which is available to Acute services.
Workforce Capacity Plans and Rotas	All services will plan an enhanced level of cover and annual leave over the festive period, bearing in mind additional pressures and the potential for increased sickness absence. In addition, there is in place review and attendance plans to monitor absence. In the event of staff shortages access is available to the nurse bank. In exceptional circumstances community psychiatric nursing staff may be requested to work in inpatient services. Services will work with trade unions to agree a level of manageable leave. Service managers will be asked to confirm the process in their own area. Most services only allocate annual leave on a weekly basis as demand and capacity are reviewed. The Care at Home service has already highlighted a capacity issue, particularly in commissioned services. The Head of Adult Services is reviewing contracts and leading discussion with these providers to look at increasing capacity. It is likely that this will have a cost implication. We will seek assurances from the nurse bank that steps are being taken to increase capacity and ensure there is equal coverage across the Greater Glasgow and Clyde area. We have reviewed the adverse weather policies of our two host organisations to ensure consistency, and we will circulate them to all staff, emphasising the need for uniform application. Decisions about service changes due to adverse weather will be cascaded in a managed way from the Chief Officer and the heads of service. There is now access to four wheeled drive vehicles and some vehicles will be fitted with winter tyres. In psychiatry, arrangements to ensure that senior staff are on-call and available over the

Scottish Government Key Themes	Renfrewshire Actions
	festive period are in place. The on-call information will be held at each hospital and the centralised telephone service.
Whole System Activity Plans – post Festive surge	A joint meeting of the acute and community service managers is planned for the end of October. Key staff from the HSCP will be involved in the daily huddle meetings (including mental health and addictions) and will cascade relevant information to other health and social care professionals.
Strategies for Additional Winter Beds and Surge Capacity	We will explore (across the system) how to most effectively use the beds at Darnley Court, Ward 36 and residential care homes. This will include simplifying the care pathway where possible and creative ways of supplying nursing, AHP and medical cover (both money and people) within available resources.
Risk of Patients being delayed on their Pathway is Minimised	The availability of community staff over a 7 day period will ensure patients will transfer to the most appropriate care timeously according to individual care pathway.
Discharges at Weekends and Bank Holidays	We will continue to work with acute colleagues to make better use of the homecare weekend hours (currently under-utilised) to assist weekend discharges. We will also explore the potential for extending the days that the discharge lounge is available for (currently only Monday to Friday). We have identified the need for the ASeRT service to be available for the extra Social Work bank holiday. This will have a financial implication. We are currently exploring the cost and practicalities of extending hospital social work services to cover the two extended bank holiday periods and in the early evenings.
Escalation Plans tested with Partners	We will agree a core set of indicators to be shared by acute colleagues as an early alert system. These indicators will alert primary, community and social care services of activity surges.

Scottish Government Key Themes	Renfrewshire Actions
Business Continuity Plans tested with Partners	We are completing an exercise to review and update current business continuity plans in health and social care services. All services will have a robust business continuity plan by the end of October 2015, using a consistent template. Our Clinical Director will remind GPs about need to have robust business continuity plans, as he visits practices. The HSCP is involved in regular Council-led civil contingency meetings.
Preparing Effectively for Norovirus	We recognise that Norovirus has the potential to affect both access to beds and availability of staff. We will follow infection control guidelines. We will ensure business continuity planning takes account of this, as it is known risk every year.
Delivering Seasons Flu Vaccination to Public and Staff	We will encourage all frontline staff to take up the offer of flu vaccination, recognising the different processes for health and social care staff. We will review the contract for commissioned home care to ensure that this staff group is offered vaccination. We will support GPs and community nurses to encourage high update of vaccination among vulnerable groups of patients, particularly the housebound, those in nursing/care homes and those in receipt of home care services.
Communication to Staff and Primary Care	We will use team brief and staff newsletters to share this plan with all staff. We will also widely circulate the Council's Severe Winter Weather Response Guide 2015/16. We will use the planned meeting in November with the 29 Integration Liaison GPs and the GP Forum on 24th November to emphasise the need for robust business continuity planning and winter planning. We will also prepare a single communication for GPs/primary care with details of services available and times over the festive period. We are exploring a system of using group text messaging to communicate simultaneously with large staff groups. The availability and access to Mental Health Services is included in the Greater Glasgow & Clyde Board's public communication information issued for the festive period.

Scottish Government Key Themes	Renfrewshire Actions
Effective Analysis to Plan for and Monitor Winter Capacity, Activity, Pressures and Performance	Key indicators: - Bed days lost due to delayed discharge - Bed days lost due to delayed discharge (AWI) - Emergency admissions 75+ - Uptake of flu vaccinations (staff) - Uptake of flu vaccinations (GP population) - Referrals to services which prevent admission. We will work with acute colleagues to agree a suite of indicators discussed at daily huddle meetings, which can be circulated through the HSCP to influence referral patterns, and respond when acute services and other inpatient sites under pressure. In the event of exceptional circumstances such as a flu pandemic/novovirus/extreme weather conditions then there would be additional costs associated with staff cover including overtime and other costs.

GLASGOW CITY HEALTH AND SOCIAL CARE PARTNERSHIP WINTER PLAN 2015/16

INTRODUCTION

1.1 This draft plan outlines Glasgow City Health & Social Care Partnership's (HSCP) preparations for winter 2015/16 in order to minimise any potential disruption to the provision of health and social care services to patients, service users and carers. This is first such plan for Glasgow City, and therefore the plan will be subject to ongoing review in the light of experience, with regular reports made to the (shadow) Integration Joint Board (IJB).

1.2 The plan has been prepared in the context of national guidance from the Scottish Government on unscheduled care, and guidance from both NHS Greater Glasgow & Clyde and Glasgow City Council. The plan also forms part of the NHS Board's and Glasgow City Council's wider plans to prepare for this winter.

1.3 The plan should been seen as a precursor to the IJB's overall plan to enable delivery of effective unscheduled care from April 2016 onwards. The unscheduled care plan will also describe how the IJB proposes to fulfil its responsibilities for strategic planning of these services, as described in the Integration Scheme for Glasgow City. A draft of this plan will be produced in early 2016 for discussion with clinicians, key partners including secondary care, housing and the third and independent sectors.

2. UNSCHEDULED CARE – PREPARATIONS FOR WINTER 2015/16

2.1 This document focuses on the HSCP's plans to manage the potential additional pressures in the health and social care system, including adult mental health services, that arise over the winter period.

2.2 The plan also articulates the HSCP's actions to contribute towards the mitigating of pressure on the acute hospital system in Glasgow City, and with a particular focus on actions under the twelve key themes in the Scottish Government's winter planning guidance DA (2015) 20, including measures to avoid admissions and manage delayed discharges.

2.3 To manage the delivery of this plan, co-ordinate our activity and initiate appropriate HSCP responses when required, the HSCP has set up a winter planning group. The HSCP winter planning group will meet fortnightly until the end of the financial year and will report to the Operations Executive Group, and the (shadow) IJB.

2.4 Development of this winter plan for 2015/16 is seen as key stepping stone in developing the planning process for 2016/17 and onwards when the IJB formally takes on responsibility for the strategic planning of acute services associated with the unscheduled care pathway as outlined in the integration scheme. The terms of reference and membership of the winter planning group will be revised and expanded in early 2016 to reflect this broader remit, and include input from primary and secondary care, the housing sector and third and independent sectors.

3. CRITICAL AREAS – KEY ACTIONS

3.1 This section of the plan describes the measures being put in place by the HSCP in line with the twelve key themes described in the national winter planning guidance DA (2015) 20. In addition, the actions outlined below have taken into account the health and social care aspects of the *Six Essential Actions to Improving Unscheduled Care Performance*.

i) Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January.

In this winter plan the HSCP has placed a particular focus on preventing admission to hospital. Across all health and social care services in Glasgow City we have systems in place to predict or identify vulnerable patients at risk so that the necessary support can be given to avoid unnecessary admission to hospital, and help people remain in their own homes. Specific elements of this programme include:

(a) Anticipatory Care Planning

- Community nursing, working with GPs to identify patients at risk of admission, and offer assessment and support. Completed anticipatory care plans are uploaded by GPs onto their electronic information system, eKIS;
- We are also scoping the potential to utilise GP capacity in the care homes medical practice to support the delivery of anticipatory care plans for residents in care homes with high hospital admission rates;
- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within eKIS which is shared with acute and the Scottish Ambulance Service.
- The introduction of the Glasgow Community Respiratory Service (£600k from the integrated care fund) to support patients with COPD. The service was tested and evaluated in the North West and is now being introduced across the city. The roll out has been accelerated to ensure that full coverage is achieved by December 2015. Based on activity data from the test site, it is anticipated that initially the service will support between 75-100 referrals per month. These typically comprise 50% referrals related to urgent intervention (either GP rapid response to avoid admission or Early Supported Discharge to reduce acute bed days), and 50% COPD patients who are stable but at risk of deterioration. The service will work with this cohort of patients to develop self-management strategies and the development of Anticipatory Care Plans.
- Within social work, older people's services will seek to identify those considered to be potentially most at risk, and information provided to Social Work Standby Services is regularly updated by social work staff;
- A programme is in place in the North West to provide anticipatory care plans for people in Intermediate Care beds and extend this to other units in the city; and,
- We will also develop a wider programme to extend anticipatory care plans to all care home settings, working with the independent sector, Cordia and others.

b) Admission Avoidance

Specific measures in place to prevent admission in addition to those above include:

- Community Nursing teams working collaboratively with GPs and third sector providers (e.g. Marie Curie Cancer Care) to manage vulnerable patients with nursing needs and those with palliative care needs. Those at greatest risk are subject to frequent clinical monitoring and case review to ensure all measures are in place to avoid admission to hospital. District Nurses will check if other services are attending and if any issues will contact relevant agency;
- The Rapid Response Link within community rehabilitation teams offer the same day access for patients referred by a GP and who are at risk of admission;
- The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team;
- Social Work Services will review all vulnerable elderly people, known to them in the community, though the use of professional supervision. Resource Screening groups will

continue to prioritise care home allocation to those in most needs including vulnerable people living in the community;

- For those at risk of falling, we will pilot in the North East community rehabilitation service and the Scottish Ambulance Service (SAS) an alternative pathway where hospital attendance is not required which if successful we will roll out across the city. Implementation of the pathway will reduce inappropriate hospital attendances, and reduce the number of repeat incidents (emergency callers);
- We will also work with the SAS and acute hospitals to explore the efficiencies in the process of patient arrival at A&E; and,
- Community Mental Health Crisis Services will provide 24 hour 7 day week provision which will assess patients for admission and discharge. These services will be in place over the festive period. The services covering the Glasgow City & Clyde area include social care support. The Crisis Teams will provide public holiday cover during the festive period.

c) Expediting Discharge from Hospital

The HSCP has established a Hospital Discharge Operations Group (HDOG) charged with improving hospital discharge performance and consistency across the three localities in Glasgow. From November 2015 to March 2016 this group will meet on a weekly basis to accelerate the improvement programme, and ensure regular scrutiny of discharge performance and individual case management. We will aim to maintain our current performance (see annex A) over the winter period with a particular focus on the city's two A&E departments.

The work programme includes the following actions:

- development of a detailed action plan for under 65s including patients with complex physical health care needs, mental health and homelessness;
- actions to improve adult mental health Edison recording and improve discharge performance;
- deliver improved performance management for AWI patients delayed due to guardianship applications and correspondingly reduce the number of AWI delays;
- improved hospital interface arrangements including:
    - community team discharges;
    - appropriate completion of specialist multi-disciplinary assessment tool (SMAT);
    - timing of SMAT availability; and,
    - appropriate recording on Edison
- develop palliative care and end of life hospital discharge pathway;
- implement an accommodation-based strategy that seeks to divert demand away from acute care at both admission and discharge ends of the system;
- implement choice protocol for patients refusing to move to intermediate care and ensure appropriately recorded on Edison;
- development of arrangements to facilitate improved discharge to Council managed residential care units;
- agree notification arrangements from homeless liaison team initiated discharges;
- establish focused rehabilitation team input to Intermediate Care units to facilitate patient discharge; and,
- strategically manage care home placement allocations across the three localities to alleviate the areas of greatest pressure and maintain throughput in our intermediate care units.

Other actions to expedite acute hospital discharge include:

- the Marie Curie fast track service which represents a £250k investment via Glasgow's Integrated Care Fund to support people with palliative care needs to get out of hospital as quickly as possible. The service covers the whole city and is projected to support almost 500 patients in 2015/16, equating to around 4,600 visits and almost 15,000 unplanned bed days. In addition, the NHSGGC contract with Marie Curie for Managed Care augments

mainstream community nursing services for people with palliative care needs and avoids unscheduled admissions; and,

- EquipU out of hours service for urgent referrals to avoid potential delays as a result of equipment issues. EquipU will communicate information to all partners in early November, advising store closure dates and order cut-off points. This is supported further by partnership discussion at the Operational Development Group which reviews plans and ensures all services have made provision for public holidays.

d) Other actions:

- Community teams will ensure that people are reminded to order and collect their medications, including repeat prescriptions, in advance of the festive period, and link closely with GP practices;
- a predictive stock order of essential supplies e.g. wound dressings, pharmacy, and syringe drivers plus equipment from EQUIPU e.g. walking aids, toileting aids and mattresses will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.
- in adult mental health Out of Hours services receive referrals from the GP OOH service which triages calls from NHS 24. These services will be in place over the festive period. It is not anticipated that there would be an unusual pattern of referrals to psychiatry based on previous year's information.

ii) <u>Workforce capacity plans & rotas for winter / festive period agreed by October.</u>

Service managers will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity over the holiday period. Community services such as district nursing will operate as normal over the bank holiday weekends supported by out of hours services. Social work stand by will also be in place.

In mental health inpatients, staff leave is planned for the full festive period to ensure appropriate staff cover. In addition, there is in place review and attendance plans to monitor absence. In the event of staff shortages access is available to the nurse bank. In exceptional circumstances community psychiatric nursing staff may be requested to work in inpatient services.

iii) <u>Whole system activity plans for winter: post-festive surge.</u>

The HSCP will contribute to the whole system activity planning and ensure representation in Board-wide winter planning arrangements. The HSCP Chief Officer links closely with acute and other HSCP Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action. Acute situation reports (SITREPs) will be regularly reviewed at the HDOG, and shared across community services to monitor performance and inform appropriate actions that might be required.

iv) <u>Strategies for additional winter beds and surge capacity.</u>

The HSCP has introduced an intermediate care model and capacity in the city. An intermediate care improvement plan is in place. A commissioning strategy is also being implemented with a view to establishing core and flexible arrangements. Over the winter period there is the potential to spot purchase additional intermediate care placements to relieve any surge in appropriate referrals from the acute system.

In mental health inpatients, the admission and discharge data has been assessed over the past five years, and daily reports on bed occupancy and availability are assessed. These reports also report on any projected ward closures should this be necessary in exceptional circumstances e.g. Norovirus, influenza etc. Annual leave will be managed across the winter and festive period to ensure sufficient staffing to manage demand. The pattern of admissions

and discharges over the winter period is similar to the pattern throughout the rest of the year. No special arrangements need to be put in place relating to psychiatric admissions and discharges.

v) <u>The risk of patients being delayed on their pathway is minimised</u>

Arrangements will be put in place to ensure that areas where there is a potential for delays are reduced, particularly in respect of the adults with incapacity. There is also ongoing work at the primary / secondary care interface within rehabilitation services to improve the sharing of information, and reduce the need for reassessment at points of transition that could lead to a delay in the patient's pathway.

vi) <u>Discharges at weekend & bank holiday.</u>

The HSCP will put in place a skeleton integrated response team, with access to home care, over the Sunday and Monday of the two holiday weekends to respond to particular pressures that might arise, and with a view to easing pressure as services get back to normal after the holiday weekends.

The HSCP will work with acute hospitals to anticipate discharges that may require home care services during the two holiday weekends. There are well established arrangements with Cordia for cover over public holidays and this is well communicated to community teams.

Red Cross will be working throughout festive period, supporting admission avoidance from A&E from the main acute hospital sites in Glasgow including supporting transport of patients' discharge to home and to and from Intermediate Care.

Community rehabilitation teams will work every day other than Christmas Day and New Year's Day, and will support A&E admission avoidance, provide a GP rapid response service from GP out of hours and Intermediate care.

In mental health, Liaison Psychiatry Services are provided Monday to Friday to acute hospitals and Psychiatric Liaison Nurse services for deliberate self-harm over weekends and public holidays. The Deliberate Self Harm community psychiatric nursing service will receive referrals directly from acute medical wards over the public holiday and weekend for the festive period. This is in addition to direct referrals to the on-call psychiatry staff in psychiatric hospitals which is available to acute services.

vii) <u>Escalation plans tested with partners.</u>

The HSCP will monitor performance of the health and social care system over the winter period, including the actions in this plan, through a robust set of arrangements that include:

- monitoring of delayed discharges through weekly meetings of the HDOG;
- fortnightly meetings of the winter planning group that produced this plan to ensure its implementation;
- reports on winter planning performance to the weekly HSCP Executive Team;
- regular review of locality performance at Locality Management Team meetings;
- a rota of senior management cover over the winter period to ensure an appropriate management response when required;
- Clinical Director liaison with a network of GP "spotter" practices to monitor levels of flu within primary care; and,
- Care Homes and Intermediate Care Units will identify any issues that require to be escalated.

viii) Business continuity plans tested with partners.

We are currently working on an integrated HSCP emergency plan that will link to the business continuity arrangements in each service. The current business continuity arrangements for each service area will remain in place and will be revised in relation to responsible people and accommodation e.g. the development of the new 120 bedded care homes and the subsequent buddy arrangements.

GP Practices and Pharmacies have business continuity plans in place that include a 'buddy system' should there be any failure in their ability to deliver essential services. These are currently being updated to ensure they are robust.

ix) Preparing effectively for norovirus.

The NHSGGC Norovirus Escalation plan will be followed across all HSCP services including inpatient areas and care home settings. Staff will be reminded of the need to remain absent for 48 hours post last symptom of Diarrhoea and vomiting.

x) Delivering Seasonal Flu Vaccination to Public and Staff

All health and social work staff, including home care staff, will be reminded to encourage elderly and vulnerable people to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination
Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided across the city.
Home care staff will be advised as to how they can receive the vaccination if they so choose.

xi) Communication to Staff & Primary Care Colleagues

To ensure that all HSCP staff, primary care and partner agencies are kept informed, the HSCP will:

- ensure information and key messages are available to staff through communication briefs, specific newsletters and communications, team meetings and electronic links;
- circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices;
- collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board;
- Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices; and,
- we will promote use of the community services app to raise awareness of service availability and contact information;
- Other arrangements to provide simple access to services include Social Care Direct for all GCC enquiries and service specific access points for NHS provision. A CHP App is also available which gives smart-phone and desk-top users rapid access to service contact numbers across Glasgow;
- Based on previous work on developing a single point of access to NHS services, it was agreed that many of the systems currently in place provide quick and easy access to services. Examples include the community rehabilitation and mental health duty system. The District Nursing service is currently the subject of a project to develop a single point of access for Glasgow. The infrastructure for this system will be complete by December and

will begin operating in early 2016. It is expected this will provide faster access to District Nurses and also free up professional time that will be re-invested in anticipatory care; and,
- Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP and Glasgow City Council.

xii) <u>Effective analysis to plan for and monitor winter capacity, activity, pressures and performance</u>

The HSCP will put in place a robust performance management system to under pin the arrangements described in vii above the key features of which will be to:

- monitor system and service performance / demand across the city and in localities;
- inform our capacity planning and the need for any surge capacity; and,
- Report on performance against agreed targets / KPIs.

Attached at annex A is a draft of the metrics to be used as part of our performance regime.

CONCLUSION

This draft plan outlines the actions the HSCP is taking in preparation for winter 2015/16 in line with national guidance, and guidance from NHSGGC and Glasgow City Council. The HSCP has robust monitoring and performance management arrangements in place to minimise any potential disruption to health and social care services, patients, service users and carers over the winter period. Regular reports and updates will be made to the shadow Integration Joint Board.

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP WINTER PLAN 2015/16

Planning Activity

1. The HSCP management team reviewed national and NHSGGC guidance: reflected on performance and issues from last winter; and have put in place a number of actions to strengthen the HSCP unscheduled care performance.

2. In addition, planning for delayed discharge and unscheduled care had already been identified as a priority area by Strategic Planning Group. It approved the establishment of four distinct task and finish 'Safe and Supported' work groups using improvement methodology.
   a) Prevention and Anticipatory Care
   b) Point of Possible Admission
   c) During Admission
   d) Discharge from Hospital

3. Partners in the task and finish groups, in line with integration legislation, include third sector, independent sector, carers, health and social care staff and managers, GPs and acute clinicians. The tasks and finish groups will report back at the beginning of December on a range of additional improvement opportunities they have identified. Prioritised actions will be tested over the winter period and learning captured and incorporated in the Implementation Plan for 2015-18.

Planned Actions

i. Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January

Admission Avoidance

4. A series of measures are in place to avoid admissions:
   - Home care managers are authorised to increase care packages in and out of hours to avoid admission.
   - Third sector partners have been directed to triage and fast track urgent referrals to single point of access or direct to RES team.
   - Information of services and supports have been developed and shared with in house out of hours and partner services.
   - Single point of access team receive urgent referrals and rapidly refer to multidisciplinary Rehabilitation and Enablement clusters who identify the most appropriate professionals to undertake rapid assessment and immediate access to preventative supports and care packages. This includes access to step up care home respite with rehabilitation support.

Anticipatory Care Planning

5. There are a number of anticipatory actions established across all health and social care teams. In particular,
   - Rehabilitation and Enablement Cluster Teams have systems in place to predict or identify vulnerable patients at risk of admission so that the necessary support can be given to avoid unnecessary admissions and help people remain in their own homes.
   - Advanced Nurse Practitioners lead anticipatory care planning for patients with long term conditions this work has been successful in avoiding unnecessary admissions. ANPS and District Nurses will update ACPs and optimise just in case prescribing.

- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with acute and the Scottish Ambulance Service.
- Community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period.
- A predictive stock order of essential equipment from EQUIPU, wound dressings, pharmacy, and syringe drivers will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.
- Homecare services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users. Council staff from less priority areas can be redirected to support this service and ensuring essential staff can get to and from work.
- Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP, East Renfrewshire Council, and relevant Third Sector websites. This will include "Know who to turn to" and NHSGG&C winter website link.

<u>Expediting Discharge from Hospital</u>

6. Tested measures and additional capacity have been put in place to expedite safe discharge from hospital and avoid re-admission.
   - Inreach social work capacity has been increased from 1 to 2 workers reaching into the new Queen Elizabeth hospital. The role of the workers is to identify people as early as possible (prior to fit for discharge) and commence planning for discharge.
   - A re-ablement home care worker is in place to identify people who would benefit from our re-ablement services and arranging home care cover.
   - A similar model of in reach into the RAH which has been very successful at bringing down delays and supporting people home will continue.
   - For the few people who might benefit from an extended period of assessment or rehabilitation care home beds with inreach from Rehabilitation and Enablement teams are available. This is a real step down model that enables us to do home visits and phased returns home – minimising the risk of readmission and maximising the success of returning home.

ii. Workforce capacity plans & rotas for winter / festive period agreed by October

7. Health and Community Care Service Managers will ensure that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods. This will be monitored via the Health and Community Care Managers meeting and reported to the HSCP Management Team.

iii. Whole system activity plans for winter: post-festive surge

8. The HSCP will continue to contribute to the whole system activity planning and ensure representation at winter planning groups. The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.
9. Situation reports (SITREPs) will be shared between the Community and Acute services to inform escalation pressures.

iv. Strategies for additional winter beds and surge capacity

10. The HSCP will respond where possible to support Acute services in managing surge capacity. There is additional capacity in the local care home market due to speculative development that could be utilised if required.

v. The risk of patients being delayed on their pathway is minimised

11. HSCP in reach services will continue to pro-actively plan discharge, indentifying and tackling any potential issues and barriers in advance of discharge.

vi. Discharges at weekend & bank holiday

12. The Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

vii. Escalation plans tested with partners

13. The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments as a result of a particular illness or virus, putting a strain GP services.

14. Regular meetings and phone calls to Care Homes from the commissioning team will be used to share information and identify any issues that require to be escalated.

viii. Business continuity plans tested with partner

15. HSCP staff have participated in a Council wide winter planning exercise to test plan locally. Lessons learned have been incorporated into the HSCP Business Continuity Plan and East Renfrewshire Council Severe Weather/Winter Plan.

16. GP Practices and Pharmacies have Business Continuity Plans in place that include a 'buddy system' should there be any failure in their ability to deliver essential services.

ix. Preparing effectively for norovirus

17. Information for Care Homes will be shared by the Independent Sector Integration Lead and

x. Delivering Seasonal Flu Vaccination to Public and Staff

18. All health and Homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions.

19. The HSCP is undertaking peer immunisation for nursing staff and offering immunisation to home care staff.

xi. Communication to Staff & Primary Care colleagues

20. To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;
    - Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
    - Circulate updates on services available over festive period, including pharmacy open times, to GP practices
    - Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xii. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

21. The actions set out in this Winter Plan will be monitored and analysed on a fortnightly basis by the HSPC management team. If pressures increase this will increase to weekly or daily meetings as required.

    Particular measures that will be monitored include;

    - Bed days lost to delayed discharge
    - Bed days lost to delayed discharge for AWIs
    - Emergency admissions age 75yrs+
    - Percentage uptake of flu vaccinations by staff
    - Percentage uptake of flu vaccinations by GP population
    - Referrals to Re-ablement Services
    - Referrals to Hospital Inreach Team
    - Referrals to Single Point of Access
    - Demand and capacity (including GP practices)

22. A report analysing the activity, performance and pressures will be produced and reviewed at the end of the winter planning period.

EAST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP WINTER PLAN 2015/16

Winter Planning Arrangements

A Winter Planning Group has been established and meetings have been arranged to take place on a monthly basis. The purpose of the meeting is to discuss the delivery of the Winter Plan and identify any issues that require to be addressed, or escalated, to enable appropriate actions to be put in place and ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges throughout the winter, and in particular, the festive period.

Key Themes

The local planning arrangements are described under the twelve key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20).

In addition, the planning arrangements described have integrated the relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance*

xiii. Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January.

(b) Admission Avoidance

Teams have systems in place to predict or identify vulnerable patients at risk of admission so that the necessary support can be given to avoid unnecessary admissions and help people remain in their own homes:

- The Community Nursing teams have introduced *Patient Status at a Glance* Boards that are updated daily. The board displays details of vulnerable patients as well as patients with changing needs. The nursing teams have daily meetings to identify vulnerable patients and those at risk of admission. The nurses will link with GPs to identify patients who may potentially be vulnerable during the long bank holidays.
- The Social Work team maintain a register of vulnerable people known to them living in the community. The Social work out of hours Standby Services have a copy of the information regarding these individuals to ensure appropriate supports can be provided if required outwith office hours, including weekends and Public Holidays.
- The Community Rehabilitation team and Older Adults Mental Health team maintain a list of patients at risk of admission to assist in daily scheduling of visits during adverse weather periods.
- The Rapid Assessment Link within the rehabilitation team offer same day access to service for patients referred by the GP before 4pm who are at risk of admission.
- Community and Acute Services will be asked to predict service users who will be discharged and require Homecare services during the two long weekends as Homecare will stop accepting referrals 48 hours prior to each Public Holiday.
- The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team
- Social Work Occupational Therapy is staffed daily and can respond to prevent escalation leading to potential admission. This provision is maintained across the holiday period with the exception of the public holidays.

- Contacts with private providers of Homecare services include monitoring their capacity for delivering services as commissioned.
- The HSCP Older People's Programme Board will continue to work in partnership, with GPs, Acute services, Independent Sector including links with Care Homes, and Third Sector organisations including Older People's Access Line, Carers Link, Ceartas, Marie Curie, Befriending Plus and the Red Cross, to help people remain in their own homes, or homely setting, when it is safe to do so.

(c) Anticipatory Planning and Care

There are a number of anticipatory actions established across all health and social care teams. In particular,

- Local intelligence and SPARRA information is used to identify patients at risk of admission. These patients are offered assessment and support from the Community Nursing service. Complete anticipatory care plans are uploaded by GP practices onto their electronic information system, eKIS. Work is underway with local GP colleagues to extend this over the winter period to include specific long term conditions.
- Anticipatory structures within Social Work Older People's services seek to identify those considered to be potentially most at risk across this time and information provided to Social Work Standby Services is regularly updated by social work staff.
- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with acute and the Scottish Ambulance Service.
- Community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period.
- A predictive stock order of essential equipment from EQUIPU, wound dressings, pharmacy, and syringe drivers will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.
- Homecare services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users.
- The East Dunbartonshire Council Roads Department has agreed that an HSCP service manager can inform them of remote vulnerable service users who cannot be reached by car or foot during severe weather and actions will be taken to clear the road and enable access, thereby preventing a potential avoidable hospital admission.
- Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP, East Dunbartonshire Council, and relevant Third Sector websites. This will include "Know who to turn to" and NHSGG&C winter website link.

(d) Expediting Discharge from Hospital

A weekly operational discharge meeting has been established to review all individual hospital delayed discharge cases and ensure that the collective resources are appropriately directed to create improved joined up working that will minimise and reduce future delays. There are a number of activities that the group will explore and enact including:

- Promotion of legal powers in relation to adults with incapacity;
- Further exploration of the use of 13ZA under 'deprivation and liberty' Mental Health (Scotland) Act;
- Weekly discussions regarding those people currently in hospital and the issues that require to be resolved;
- Access to Trakcare;

- Anticipatory AWI meetings;
- A dedicated process for allied health professionals and home care organisers to identify and highlight issues to the Team Manager, Older People's Team, regarding individuals, living in the community, who lack capacity and legal powers.
- The use of delayed discharge monies to employ a Resource Worker role that will support the Joint Delayed Discharges group by arranging meetings; gathering and comparing information across various systems (Trakcare, Carefirst etc); analysing case notes and highlighting issues that could prevent discharge;
- The use of delayed discharge monies to fund care placements in the short term while financial disputes are settled;
- The use of delayed discharge monies to fund the services of a solicitor (via Citizens Advice Bureau) to undertake a short term episode of processing power of attorney applications

xiv. Workforce capacity plans & rotas for winter / festive period agreed by October.

Service leads will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods This will be confirmed by an assurance memo in October.

xv. Whole system activity plans for winter: post-festive surge.

The HSCP will contribute to the whole system activity planning and ensure representation at winter planning groups.

The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.

The HSCP Planning Manager attends the North Sector UCC Winter Planning Group meetings to share planning arrangements and discuss issues with the North Sector Acute Services and East Dunbartonshire HSCP.

Situation reports (SITREPs) will be shared between the Community and Acute services to inform escalation pressures.

xvi. Strategies for additional winter beds and surge capacity.

The HSCP will respond where possible to support Acute services in managing surge capacity. The Hospital Assessment Team will provide a reduced staff rota the week between the public holidays with a minimum of two staff on duty to support surge activity. Additional capacity to respond to particular increases in service demand can be resourced from the wider local social work teams if required.

xvii. The risk of patients being delayed on their pathway is minimised.

Anticipatory structures have been supported to ensure that potential areas of need, particularly in respect of the adults with incapacity (AWI) are best met and AWI delays minimised. The Integrated Care Fund has supported additional capacity, including Mental Health Officers and a part time Solicitor, to facilitate the process around Power of Attorney and Guardianship orders to minimise delays for AWIs.

There is ongoing work at the primary secondary care interface within rehabilitation services to improve the sharing of information and reduce need for reassessment at points of transition that could lead to a delay in the patient's pathway.

xviii. Discharges at weekend & bank holiday.

The Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

xix. Escalation plans tested with partners.

Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues.

The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments as a result of a particular illness or virus, putting a strain GP services.

The Hospital Discharge team will provide a reduced staff rota the week between the public holidays where a minimum of two staff are on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required.

Commissioned services have emergency arrangements are in place and the Independent Sector Integration Lead has agreed to act as a link between the HSCP, the commissioning team , and Care Homes to share information and identify any issues that require to be escalated.

xx. Business continuity plans tested with partners.

Business Continuity Plans (BCP) for both Health and Social Services will be harmonised into a single BCP by March 2016. Until this process is complete and tested, each organisation will continue to work within the remit of their own business continuity arrangements.

As part of the Winter Planning process, service leads have been asked to review their individual BCP service plans by November 2015.

Links have been established with East Dunbartonshire Council's winter planning arrangements to support the continuity of all partnership services throughout the winter period.

GP Practices and Pharmacies have BCPs in place that include a 'buddy system' should there be any failure in their ability to deliver essential services.

xxi. Preparing effectively for norovirus.

Information distributed to Care Homes will be shared by the Independent Sector Integration Lead

xxii. Delivering Seasonal Flu Vaccination to Public and Staff

All health and Homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination

Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided in KHCC, Milngavie Clinic and Stobhill.

Homecare staff will be advised as to how they can receive the vaccination if they so choose.

xxiii. Communication to Staff & Primary Care Colleagues

To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;

- Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
- Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices
- Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board.
- Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xxiv. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning.

Particular measures that will be monitored include;

- Bed days lost to delayed discharge
- Bed days lost to delayed discharge for AWIs
- Emergency admissions age 75yrs+
- Percentage uptake of flu vaccinations by staff
- Percentage uptake of flu vaccinations by GP population
- Referrals to Rapid Response and Rapid Assessment Link team
- Referrals to Hospital Assessment Team
- Demand and capacity (including GP practices)

A detailed rolling action log will be maintained and updated at each Winter Planning Group meeting. This will be submitted monthly to the HSCP Senior Management Team meetings.

A report analysing the activity, performance and pressures will be provided at the end of the winter planning period.

INVERCLYDE HEALTH AND SOCIAL CARE PARTNERSHIP WINTER PLAN 2015/16

1. Winter Planning Arrangements

A Winter Planning Operational Group has been established and meetings have been arranged to take place on a weekly basis. The purpose of the group is to discuss the development and subsequent delivery of the Winter Plan and identify any issues that require to be addressed, or escalated, to enable appropriate actions to be put in place. This will help to ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges throughout the winter, and in particular, the festive period.

In addition to our Winter Planning Operation Group we will make use of our already established local Operational Hospital Discharge Group and Strategic Discharge Group which meet on a weekly and fortnightly basis respectively, involving staff from across community, primary and secondary care, to harness collective resources to manage demand and capacity.

3. Key Themes

The local planning arrangements are described under the twelve key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20).

In addition, the planning arrangements described have integrated the relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance*

The 12 Key Themes are:

1. Safe and effective admission/ discharge continues in the lead up-to and over the festive period and also into January
2. Workforce capacity plans and rotas for winter/festive period are agreed in October 2015
3. Whole system activity plans for winter: post-festive surge/ respiratory pathway
4. Strategies for additional winter beds and surge capacity
5. The risk of patients being delayed on their pathway is minimised
6. Discharge at weekends and bank holidays
7. Escalation plans tested with partners
8. Business continuity plans tested with partners
9. Preparing effectively for norovirus
10. Delivering seasonal flu vaccination to public and staff
11. Communication plans
12. Effective analysis to plan for an monitor winter capacity, activity, pressures and performance

Key headlines relating our areas of action are as follows:

From late summer/autumn each year we begin to see an increase in admissions over the winder period and associated increased in bed days used. Once admitted to hospital, the longer the older persons length of stay becomes, the more likely the deterioration in their ability and independence. This impacts on the chances of their ability to return to live independently and increases the risk of hospital acquired infection. **The primary focus of our winter plan, therefore, is to ensure that people avoid admission to hospital wherever possible and have as speedy a journey through secondary care as possible should an admission be unavoidable.**

xxv. Safe and effective admission/ discharge continues in the lead up-to and over the festive period and also into January

- We have developed a *Home First Strategic Discharge Action Plan* for our area which facilitates partnership working across primary and secondary care. We use our *Home First Strategic Discharge Action Plan* at each Operational and Strategic Hospital Discharge Group to drive joint action in relation to improved hospital discharge
- Ongoing close joint working with colleagues in Inverclyde Royal Hospital (IRH), including making good use of the 'Huddle' model, continues to demonstrate the effectiveness of early commencement of assessment regarding future care needs in achieving an appropriate, timely and safe discharge. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed medically fit for discharge, including those requiring home care packages or a residential care placement.
- We are building on work we are already undertaking linked to the Inverclyde Interface Working Pilot from 2014/15. We intend to link work-streams related to High Resource Initials (HRI), demand and capacity data analysis and intervention space analysis to augment our intelligence across the winter period, and crucially in the post-festive surge which is anticipated. We know that making best use of our the data we have and lessons we have learned will provide richer intelligence about how our local population access and make use of services across the system, meaning we can be more tactical in our approach to managing this.
- Our focus on modernisation and continuous improvement is a core factor in our winter planning, and planning for joint actions related in unscheduled care generally. In order to meet the increasing demand on services related to the aging population, particularly, we have continued to develop new services and increase capacity with existing services. Despite this we do continue to see an overall rise in unplanned admissions to hospital. It remains extremely challenging to consistently reduce the level of delayed discharged and lost bed days which these admissions.
- We continue to progress integrated actions to improve the secondary care journey, transitions across branches of the system, and specifically the hospital discharge process.
- We are actively exploring the potential for staff in A&E to have access to SWIFT (the social work client management database used in Inverclyde). This would allow for real time access to information about the person's current community supports and packages of care and inform decisions around admission. Linked to this we are progressing the development of access to the clinical portal for relevant teams to aid communication and information sharing, alongside data linking programmes with the LIST team from ISD
- We are building on the recent redesign of the hospital discharge social work team inform a review of nursing input to hospital discharge.

xxvi. Workforce capacity plans & rotas for winter / festive period agreed by October

- Service leads will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods This will be confirmed by an assurance memo in October
- We are actively scoping the range of nursing/medical interventions in the community to ensure arrangements are fit for purpose and aligned well to support admission avoidance.

xxvii. Whole system activity plans for winter: post-festive surge.

- The HSCP will contribute to the whole system activity planning and ensure representation at winter planning groups.
- The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.

xxviii. Strategies for additional winter beds and surge capacity.

- The HSCP will respond where possible to support acute services in managing surge capacity. HSCP Assessment and Care Management will provide a reduced staff rota the week between the public holidays with a minimum of two staff on duty to support surge activity. Additional capacity to respond to particular increases in service demand can be resourced from the wider local social work teams if required.

xxix. The risk of patients being delayed on their pathway is minimised.

- Anticipatory structures have been supported to ensure that potential areas of need, particularly in respect of the adults with incapacity (AWI) are best met and AWI delays minimised.

xxx. Discharges at weekend & bank holiday.

- The Adult Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

xxxi. Escalation plans tested with partners.

- Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues.
- The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments.
- The Hospital Discharge team will provide a reduced staff rota the week between the public holidays where a minimum of 50% staff are on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required.
- Commissioned services have contingency arrangements in place and link between the HSCP commissioners and strategic commissioning team, and providers to share information and identify any issues that require to be escalated will be utilised.

xxxii. Business continuity plans tested with partners.

- Business Continuity Plans (BCP) for the HSCP are in place and are being reviewed.
- GP Practices and Pharmacies have BCPs in place that include a 'buddy system' should there be any failure in their ability to deliver essential services.

xxxiii. Preparing effectively for norovirus.

- Information distributed to Care Homes will be shared by the HSCP Strategic Commissioning Team. We will do this for all providers as and when any Long Term Care providers advise us of any infection outbreak etc.

xxxiv. Delivering Seasonal Flu Vaccination to Public and Staff

- All HSCP staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination
- HSCP staff are actively encouraged to be vaccinated and local peer vaccination sessions are in place.

xxxv. Communication to Staff & Primary Care Colleagues

- To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;
  - Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
  - Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices
  - Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board.
  - Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xxxvi. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

- The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning.

Particular measures that will be monitored include;

- Staff levels/absence etc
- Bed days lost to delayed discharge
- Bed days lost to delayed discharge for AWIs
- Emergency admissions age 75yrs+
- Percentage uptake of flu vaccinations by staff
- Percentage uptake of flu vaccinations by GP population
- Demand and capacity (including GP practices)
  - Bombardment rates for key services, such as homecare and community nursing at point of discharge where no package previously in place
  - Long term care bed occupancy and vacancies
  - Admissions to hospital from care homes
  - Referrals to Discharge Team (at point of medical fitness etc)

- A detailed rolling action log will be maintained and updated at each Winter Planning Group meeting. This will be submitted each week to the HSCP Senior Management Team meetings to provide the up to date position and how we are responding.
- A report analysing the activity, performance and pressures will be provided at the end of the winter planning period.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP WINTER PLAN 2015/16

Winter Planning Arrangements

A Winter Planning Group has been established and meetings are taking place regularly and report to the HSCP Senior Management Team. The purpose of the meeting is to discuss the delivery of the Winter Plan and identify any issues that require to be addressed, or escalated, to enable appropriate actions to be put in place and ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges throughout the winter, and in particular, the festive period.

CORE TASKS	ACTIONS
1. Safe & effective admission / discharge continue in the lead-up to and over the festive period and also into January.	**1 Admission Avoidance** Teams have systems in place to predict or identify vulnerable patients at risk of admission so that the necessary support can be given to avoid unnecessary admissions and help people remain in their own homes: • The Community Nursing teams have introduced *Patient Status at a Glance* Boards that are updated daily. The board displays details of vulnerable patients as well as patients with changing needs. The nursing teams have daily meetings to identify vulnerable patients and those at risk of admission. The nurses will link with GPs to identify patients who may potentially be vulnerable during the long bank holidays. • Our Integrated Teams maintain a register of vulnerable people known to them living in the community. The Social work out of hours Standby Services have a copy of the information regarding these individuals to ensure appropriate supports can be provided if required outwith office hours, including weekends and Public Holidays. • Our Integrated Rehabilitation and Older Adults teams maintain a list of patients at risk of admission to assist in daily scheduling of visits during adverse weather periods. • Teams can access rapid day care assessment and community bases assessment within the rehabilitation team which offers same day access to service for patients referred by the GP before 4pm who are at risk of admission. • Our early assessor service identifies patients who will be discharged and require Homecare services which we provide rapidly and will continue to provide including until close of play prior to public holidays. • The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team • Contacts with private providers of Homecare services include monitoring their capacity for delivering services as commissioned. • Locality Groups will continue to work in partnership with GPs, Acute services, Independent Sector including links with Care Homes, and Third Sector organisations including Link Up, Marie Curie, and the Red Cross, to help people remain in their own homes, or homely setting, when it is safe to do so and to return them home safely on discharge. **2 Anticipatory Planning and Care** There are a number of anticipatory actions established across all health and social care teams. In particular, • Local intelligence and SPARRA information is used to identify patients at risk of admission. These patients are offered assessment and support from the Community Nursing service. Complete anticipatory care plans are uploaded by GP practices onto their electronic information system, eKIS.

CORE TASKS	ACTIONS
	Additional nursing and social care support has been recruited to identify high risk patients, undertake single shared assessment and put in place supports which will maintain people at home. • All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with acute and the Scottish Ambulance Service and our extended Palliative Care Team (Nursing, Homecare and Pharmacy) provide additional support. • Community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period. These include additional homecare, respite, nurse led beds in local care homes and step up/down placements. • Additional equipment and supplies are ordered and available for clinical staff. • Homecare services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users. • The West Dunbartonshire Council Roads Department has agreed that an HSCP service manager can inform them of remote vulnerable service users who cannot be reached by car or foot during severe weather and actions will be taken to clear the road and enable access, thereby preventing a potential avoidable hospital admission. In addition, they will clear and grit access roads and parking areas around health facilities as a priority. • Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP, West Dunbartonshire Council, and relevant Third Sector websites. This will include “Know who to turn to” and NHSGG&C winter website link. **3 Expediting Discharge from Hospital** • Our services are available via a single point of access and provide direct referral for OT, physiotherapy, nursing, social work, home care and care at home, pharmacy team and step up/down beds. • Our hospital discharge team has an early assessor function to allow identification where possible prior to fit for discharge status and speedy assessment. Dedicated MHO staff provide support for adults with incapacity and we provide multi-disciplinary post-discharge support. • Routine daily review of 13Za cases to ensure discharge is fast-tracked where the legal framework allows. • West Dunbartonshire HSCP has commissioned 10 NHS beds for access by Acute for patients delayed whilst awaiting legal powers and these will be active when RMO cover is advised by Acute.
2. Workforce capacity plans & rotas for winter / festive	Service managers are responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity throughout the winter and during the festive period, and immediately

CORE TASKS	ACTIONS
period agreed by October.	following the four day holiday periods.
3. **Whole system activity plans for winter: post-festive surge.**	• The HSCP will contribute to the whole system activity planning and ensure representation at winter planning groups. • The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action. • Situation reports (SITREPs) will be shared between the Community and Acute services to inform escalation pressures.
4. Strategies for additional winter beds and surge capacity.	• The HSCP will respond where possible to support Acute services in managing surge capacity. • Our Hospital Discharge Team will provide services between the public holidays to support surge activity. • Additional capacity to respond to particular increases in service demand can be resourced from the wider local teams if required. • Additional care at home respite and nurse-led beds will be available over the period.
5. The risk of patients being delayed on their pathway is minimised.	• Our SPOA will be fully resourced to accept referrals. • All referrals are assessed and allocated daily. • Patients identified by our early assessor team will have care packages in place timeously. • Access to rehabilitation and nursing services will be available throughout the period. • Home care services are managed alongside district nursing services and home based pharmacy support to ensure continuity of care post discharge.
6. Discharges at weekend & bank holiday.	• The Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.
7. **Escalation plans tested with partners.**	• Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues. • The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments as a result of a particular illness or virus, putting a strain GP services. • The Hospital Discharge team will provide staff during the weeks between the public holidays where a minimum of two staff are on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required. • Commissioned services have emergency arrangements are in place and the Independent Sector Integration

CORE TASKS	ACTIONS
	Lead has agreed to act as a link between the HSCP, the commissioning team , and Care Homes to share information and identify any issues that require to be escalated.
8. Business continuity plans tested with partners.	• Business Continuity Plans are in place across HSCP services and shared with locality representatives. • Managers have been asked to review their individual BCP service plans by November 2015. • Links with West Dunbartonshire Council's winter planning arrangements to support the continuity of all partnership services throughout the winter period are well tested with support from the Council's Emergency Planning Team. • GP Practices and Pharmacies have BCPs in place that include a 'buddy system' should there be any failure in their ability to deliver essential services and alternative premises have been identified. •
9. Preparing effectively for Norovirus	All care homes have participated in action learning sets and have plans and processes in place to manage these. In emergencies, there will be additional capacity available. Information distributed to Care Homes will be shared by the Independent Sector Integration Lead
10. Delivering Seasonal Flu Vaccination to Public and Staff	• All health and homecare staff have been offered vaccination. • All health and homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. Information has been provided to community groups on the benefits of vaccination. • The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination • Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided in all Health Centres.

CORE TASKS	ACTIONS
11. **Communication to Staff & Primary Care Colleagues**	To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will: • Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links • Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices • Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board. • Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet and on the HSCP and Council websites. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.
12. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance	The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning. Particular measures that will be monitored include; • Bed days lost to delayed discharge • Bed days lost to delayed discharge for AWIs • A&E attendances • Emergency admissions all ages • Emergency Admission age 65yrs+ • Emergency admissions age 75yrs+ • Percentage uptake of flu vaccinations by staff • Percentage uptake of flu vaccinations by GP population • Referrals to Rapid Response and Rapid Assessment Link team • Referrals to Hospital Discharge Team and time to assessment and provided care. • Demand and capacity on community services, including GP practices, and community health services. A detailed rolling action log will be maintained and updated and reviewed monthly by the HSCP Senior Management Team. A report analysing the activity, performance and pressures will be provided at the end of the winter planning period.