

## WINTER PLAN 2016/17

### NHS Greater Glasgow & Clyde Board Overview

#### 1. INTRODUCTION

This plan is the product of a programme of detailed review of Unscheduled Care across acute and community services, primary and social care. The Plan builds on continuous learning from previous years and adoption of best practice. It has been produced within the oversight of Board Chief Executive, Chief Officers and Directors across our system. As the work has developed it has been scrutinised by the Board and by IJB's and this final plan will be formally reported and published.

Our objective is to meet the national target to deliver care to 95% of Accident and Emergency attendees within 4 hours, within a coherent system focused on high quality patient care.

The Board established a whole system review of unscheduled care, built around the six essential actions with a remit that focused on Acute Division and its interface with its partners, the HSCPs and Scottish Ambulance Service. The outputs of the review provide the platform for the Board's unscheduled care plan and tests of change that will operated through the winter.

Within this framework the constituent parts of the Board, the 6 HSCPS and the Acute Division (comprising North, South and Clyde Sectors, Women & Children's and Diagnostics Directorate) have developed their final plans, building on lessons from last year and the six essential actions.

#### 2. RESOURCES

The Board is operating under significant financial pressures and we our plan is to prioritise supports to winter pressures within the resources allocated by Scottish Government .

#### 3. PERFORMANCE REVIEW

The Board will closely monitor the delivery of Unscheduled Care throughout the Winter Period with and we will have whole system communication based on the approach last winter of routine conference calls across the Board area. This will be informed by the range of metrics developed over previous years and enhanced by analysis produced through the Whole System Review.

#### 4. FLU VACCINE

The Board launched its Flu Vaccine campaign for staff and patients in October. Progress and uptake is continually reviewed to ensure the highest possible uptake.

## 5. COMMUNICATION

All year round, NHSGGC promotes Know Who To Turn To messages on our social media platforms including Twitter, Facebook and YouTube. We will continue this throughout the winter period with specific messaging for out of hours and the holiday season. We will supplement this with the following activity:

### 5.1. November

Staff campaign on winter, including Staff Newsletter, Staffnet, Core brief, hot topics and winter preparedness web portal for staff to continue throughout winter(using government resilience messages)

Promotion of Flu vaccination uptake messages to staff and the public.

Know who to turn to video will be run in TV screens (with sub-titles) throughout our hospitals and health centres and promoted via social media

### 5.2. December

Publish the next edition of Health News with a major focus on winter messages. Health News has 20,000 direct subscribers and is hosted on the NHS GGC website. Specific winter articles will also be promoted via the board's social media sites.

Produce the winter booklet as usual and distribute to GP surgeries and social work colleagues to share with their clients. 80,000 copies are produced and distributed each year. Booklet advises the public of how to use the NHS services over the holiday period including details of pharmacies open on bank holidays. 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
- Support NHS24 national winter campaign via local news releases, distribution of campaign assets to local community services including sports centres, libraries as well as community health services
- Liaise with the HSCPs to arrange for key winter messages to be published on their websites and social media

## HSCP OVERVIEW

6. Each HSCP has conducted a process to evaluate the current unscheduled care and winter arrangements within an agreed framework of priorities designed to deliver better management of older people and chronic disease in the community:

- Improving pre hospital care including support to GPs;
- Improving systems and services to deliver early discharge;

- Improving care in nursing homes;
- Extended and integrating arrangements for domiciliary support;
- Reshaping out of hours services;
- Action to enable patients to die at home;
- Identifying care pathways which can be modified to reduce reliance on hospital services;
- Delivery of the Paisley development programme outputs in each HSCP area
- Shifting care from an unplanned to planned basis;
- Further reducing delayed discharges.

7. Each HSCP has produced a Winter Plan incorporating the priorities specific to their populations. These are included as attachments to the document.

## ACUTE DIVISION OVERVIEW

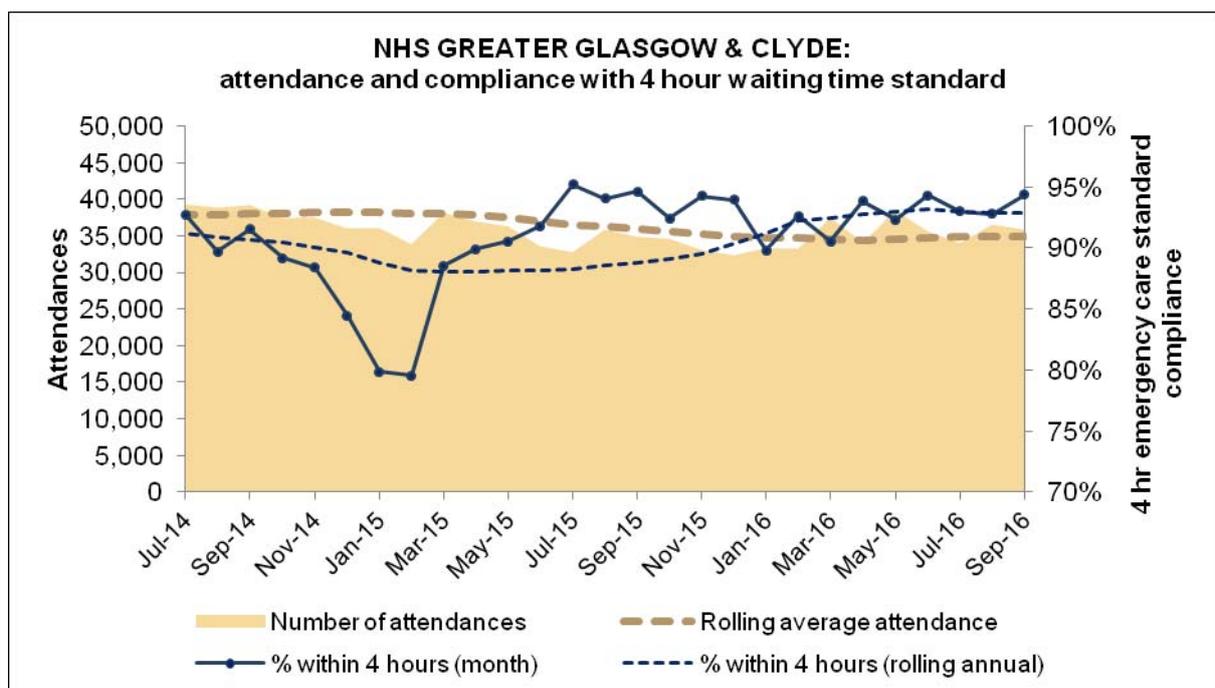
### 8. INTRODUCTION

This section describes the context of the planning for 2016/17, including an understanding of the profile of demand and our capacity to meet this. The appendices include the more detailed sections specific to each of our geographical sectors and operational units.

### 9. CURRENT PRESSURES

The Board's performance in delivering the A&E 4 hour standard has steadily improved over the last 12 months and has been consistently above 92% since February this year. Demand has fluctuated around an average of 35,000 attendances per month.

Figure 2: Unscheduled Care Performance

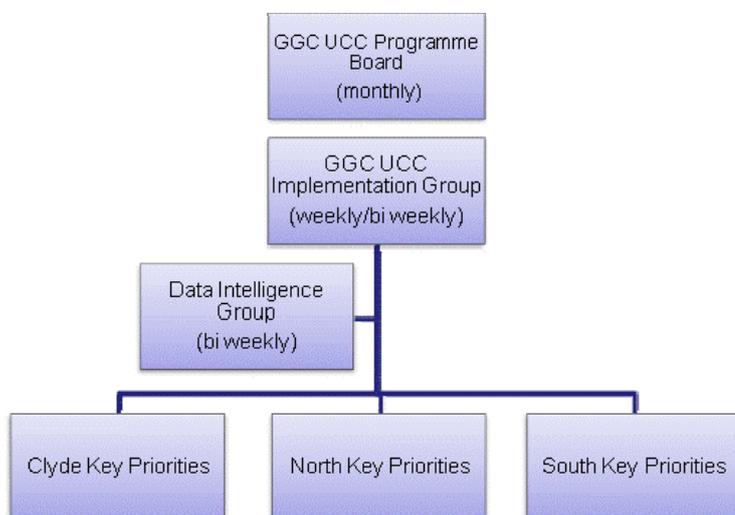


## 10. ANALYSIS OF CAPACITY & DEMAND

Last year, a significant challenge was understanding how flows of demand would operate within the new configuration of services following the opening of the new Queen Elizabeth University Hospital. We now have 12 months of experience of the impact of these changes.

The Board commissioned an in depth review of Unscheduled Care, The Deputy Medical Director for the Board, David Stewart, was appointed to lead the programme with support provided from colleagues across various disciplines, including Public Health and Health Information & Technology, in addition to the UCC Clinical Leads, Sector Directors and their respective teams.

Figure 2: UCC Governance structure



The review incorporated the ‘Building Block’ analytical methodologies developed by the Scottish Government and applied these to our main sites. This work has been further supported by other modelling and analytical tools to triangulate findings and understand the improvements and reprofiling of services of the hospital pathways.

The Implementation Group was established to facilitate Board wide support for UCC, helping to develop, design, implement and deliver a programme of work across GGC. This group liaised with identified clinical representatives to ensure leadership, guidance, engagement and communication is achieved to drive the UCC plans at a local level. The members are actively sponsoring the delivery of a programme of work, agreed by the Board and the Sector Directors, with the support of their local UCC/Winter Planning Group to deliver change and improvements across the board. As the programme is system wide, the group has identified areas of Primary Care, Secondary Care and the SAS to collaborate with and develop UCC opportunities and recommendations.

The summary below shows the ED + AU's attendance level for 2013/14, the predicted and actual emergency activity (ED + AU's) for the first year of operation post reorganisation (2015/16). Actual activity levels within the North, South and for Children's services were less than predicted whereas the Clyde Sector experienced a 5.5% increase. This analysis sets the context for the demand anticipated for the coming winter.

Sector	2013/14	Total Predicted	15/16 Actual	Predicted Diff %	
North	118,367	133,940	129,185	-4,755	-3.6%
South	196,383	178,038	167,887	-10,151	-5.7%
RHC	45,660	53,713	53,104	-609	-1.1%
Clyde	115,007	n/a	121,303	actual increase of 6,296 (5.5%)	

## 11. Patient Flow Improvement

The Programme identified a series of improvements identified from the patient flow model, that have been proposed as projects to be rolled out across GGC. Each of these has been developed as tests of change within the various Sectors with outcomes that have resulted in patient flow and/or quality improvements. These will now be taken forward.

### 11.1. Immediate Discharge Letters - RAH

The purpose of the Clyde immediate discharge letter (IDL) project is to improve efficiency and reduce errors when discharging patients from the Acute Medical Unit (AMU) at the RAH. In doing so this will improve the quality and accuracy of information provided to GPs by reducing the number of transcription errors within IDLs related to patient prescriptions.

Critically, the change will also reduce the administration input required from clinical staff in the AMU by significantly reducing the time taken to produce the IDLs, facilitating a quicker discharge process. This is achieved by: standardising the letter templates with clear headings to facilitate a more concise IDL, and transcribing **only** the changes/additional medications (max 3 changes) on the IDL which will be clearly highlighted.

The main driver of the project was the RAH pharmacy review of 500 scripts which showed that 28% of all discharge prescriptions contained errors. The outcomes of this internal audit demonstrated that these errors expose the patients to harm, increases the time taken for pharmacy to review, increases the risk that the error is unseen and transfers to the IDL, and increases the time taken for GPs to review the IDLs and contact the hospital to clarify or correct the errors.

In addition, it is well known that some clinical staff with responsibility for writing IDLs regularly create excessively long and detailed discharge letters. Often these are wordy and narrative, using time that could be better spent on other tasks. While many ward patients have had long,

complex admissions, patients discharged from the AMU often have a more simplistic presentation, not requiring many lines of narrative.

The combination of these factors make IDLs a key target for safety and efficiency improvements in an UCC setting for patients whose stay is less than 48 hours.

### **11.2. Adopting ED TrakCare Functionality in the Assessment Unit - QEUH**

While TrakCare functionality has been successfully employed in the QEUH ED, assisting in patient clinical management, the technology has not been previously extended to other on site UCC units. The purpose of Immediate Assessment Unit (IAU) TrakCare project involves extending the ED functionality to the QEUH IAU to improve patient safety in the assessment unit.

The QEUH IAU admits on average between 80 and 120 patients per day. These admissions are managed within a standard TrakCare floor plan, making it difficult to effectively track patient care for a wide range of clinical management and logistical reasons, foremost of which is the large number of patients at various stages of assessment and investigation process.

Implementing the TrakCare platform in the IAU is an attempt to address these UCC limitations and offer better patient management functions to the assessment unit. The functionality allows enhances staff awareness of patients in the unit, with the ultimate goal of improving patient safety. The change also helps facilitate improved efficiency in the unit, reducing delays in assessment.

#### **Exemplar Ward Approach at the QEUH**

The purpose of the exemplar ward project is to improve the quality of patient management and care at ward level in the QEUH, and as a result facilitate increased number of patient discharges earlier in the day.

Following the release of the Scottish Government Improvement Team's paper in May 2016 'The Dynamic Discharge', the QEUH UCC Improvement Team have tailored and adopted the paper to meet local needs. This has been restructured into 'The Dynamic Discharge Toolkit'. The toolkit sees the introduction of the various 'Dynamic Discharge' elements, launched across all ward areas in a structured, timed and whole system approach.

The implementation structure of the 'Dynamic Discharge Toolkit' has seen the development of 4 'Exemplar Wards' which received a high degree of UCC Improvement Team and Organizational Development focus over the weeks following the inception of the project. The goal is to create a gold standard Exemplar Ward product in terms of implementation and sustainability. This will then be showcased to other wards to teach good practice and drive forward mass implementation across the entire hospital. The main components of the Exemplar Ward strategy are outlined below:

- Structured Ward Rounds
- Board Rounds 9am and 3pm
- Ward Round Templates
- Criteria Led Discharge

- Discharge Lounge promotion
- IDL Templates
- Organisation Development, staff development and team approach

It is hoped that the implementation of the Exemplar Ward approach at the QEUH will result in greater numbers of direct pre-noon discharges occurring and an increased use of the discharge lounge. These factors will accelerate the frequency in which beds at ward level will become available, minimising any delays in transferring patients from the ED earmarked for admission, and as a result improve patient flow in the ED.

It is also hoped that the approach will enhance team dynamics at ward level, increasing discharge task ownership and improve staff morale, factors that will directly affect patient experience.

### **11.3. Scheduling of Unscheduled Care, Telephone Triage – RAH and GRI**

Despite the unscheduled nature of the majority of emergency hospital attendances, there is a small subset of patients for whom care can be safely delayed and arranged out with peak periods. In light of this, both the GRI and RAH have introduced the Scheduling of UCC project. This is aimed at reducing peak demand through the introduction of a telephone triage and escalation process to stream patients through the most appropriate care pathway and avoiding immediate assessment unit attendance in suitable cases. This will be achieved by engaging with GPs and establishing if it would be safe for the patient to stay at home and be given an appointment the next day for a scheduled assessment. We are also working with our colleagues in the SAS to provide patient transport for the arranged assessments.

The alternatives to immediate admission will be explored via telephone triage by an experienced member of the clinical staff **only** if the patient is deemed to be stable. The triage is usually performed by a senior nurse, although other NHS boards have trialled this with a consultant. The triage process is in no way an attempt to refuse admission but rather try to ensure each patient is kept in the most appropriate, safe and comfortable environment, rather than spending unnecessary time in a queue.

The premise is that by scheduling some aspects of UCC, the sites in the pilot will be able to redistribute their assessment unit's attendances throughout the day. It is hoped this will contribute to a reduced strain on the department at peak times, increasing NHSGGC's ability to comply UCC demands during busy periods.

### **11.4. Scottish Ambulance Service Advanced Bloods at the RAH**

Across NHSGGC every attempt to safely speed up the UCC patient journey through acute settings and emergency care units is being explored. But within the Advanced Bloods pilot at the RAH this UCC improvement concept is being applied before the patient reaches the hospital. The premise of the project is enabling the SAS to expedite and assist in the emergency unit diagnostic process by taking a patient's bloods on route to the RAH.

The pilot is targeted at GP urgent patients being brought to the AMU. Suitable patients will have an admission set of bloods taken by the SAS crew en route to the hospital. These bloods will

then be transfer to nursing staff on arrival and should allow a patient's bloods to be sent to the lab while the patient is being clerked in. The expected benefit of this change is to speed up the diagnostic process, meaning when medical staff first reviews the patient, they should already have a full set of blood results to direct treatment options. It is hoped that this will result in patients receiving the most appropriate treatment sooner, minimising unnecessarily delays in patient care attributed to awaiting the outcomes of blood tests.

#### **11.5. Ambulatory Care Pathways – All sites**

The purpose of the ambulatory care pathway project is to develop predefined standardised patient pathways for common, low risk presentations to UCC units throughout all sectors in NHSGGC. The pathways themselves will be informed by best practise and have been designed to ensure that patients receive the most appropriate care at the earliest possible opportunity. This will help minimise inappropriate overnight hospital admissions, reducing the strain of emergency units at peak times when the 4 hour target is most likely to be breached.

The pathways are being developed through ambulatory care groups within each sector who: review previous activity and clinical conditions managed within the assessment units, scope activity across the front door with the potential consideration of patients accessing the ambulatory care flow through areas, define specific criteria for ambulatory care, and work in conjunction with other project groups where there is sufficient service cross-over to produce an agreed service model. Common conditions targeted for the development of ambulatory care pathways include but are not limited to: Deep vein thrombosis, simple chest pain, headaches, pulmonary embolism, hyperkalemia and cellulitis. However, this list can be extended to include any low risk and low probability for admission related conditions.

The main driver of the project was the recognition that patients treated by receiving units had a greater length of stay than patients treated by an assessment unit care pathway. In addition, the standard protocol for treating common low acuity conditions is recognised as being different across some acute sites, a factor that indicates best practise protocols are not being implemented consistently in emergency units throughout GGC.

It is hoped that the introduction of the ambulatory care pathways will provide advanced direction to clinicians in the treatment of both GP and ED patients in the emergency care units that will ensure equity of patient care, irrespective of arrival point, a factor that will ultimately reduce peak service demand.

#### **11.6. Enhanced Escalation Model – QEUH**

The purpose of the project is to equip the QEUH a clear and robust escalation policy that will enable the hospital's emergency units to deal more effectively with fluctuations in demand and capacity. Its introduction will better allow the sector to manage clinical risk within acceptable limits in circumstances of crowding and reduced patient flow.

The policy is designed to incorporate the escalation status setting, bed capacity, trigger points and action plans for the whole sector, as well as providing clear governance structures and

communication plans to escalate issues if required. These factors will enhance the QEUH's ability to:

- Identify capacity problems at the earliest opportunity
- Develop proactive rather than reactive responses to pressures
- Create clear and concise actions for staff to follow
- Define responsibilities and communication mechanisms when escalation is required

The premise behind developing such a policy is the recognition that when the ED or assessment unit in any acute site is crowded, there is a high risk that it impacts on NHSGGC's ability to safely assess new patients. This means that existing patients are neither being managed in an ideal environment nor receiving specialist input to the same degree as in normal ED conditions. Published data also shows that ED crowding is linked to increased morbidity and mortality<sup>1</sup> as those in need of specialist input are often the most vulnerable members of the ED population.

As such its introduction is considered crucial in allowing the QEUH to adopt a consistent and co-ordinated approach for clinicians and managers to effectively escalate risks when faced with disruption from high levels of demand or capacity management issues, improving patient safety and flow as a result.

#### **11.7. X-ray porter – GRI**

The X-ray porter pilot involves increasing portering capacity within emergency units of the GRI to improve patient flow. The addition is solely for the purpose of transferring patients to and from the x-ray department in an attempt to create efficiency savings within the emergency care setting.

The premise of the project is that having a dedicate WTE porter transferring patients to and from x-ray in a timeous manner at peak times may facilitate a quicker patient flow through the ED throughout the day. Internal audits indicate that the best times to introduce the porter would be between 10:00-19:00hrs. It is anticipated that the introduction will help eliminate any delays in patient x-ray's that result from portering backlogs for patients in the ED, majors, minors and AAU. This would facilitate a quicker turnaround of diagnostics within the emergency care units.

The main driver of the project was the recognition that there may be a significant time lapse from the request of x-ray and a porter being made available to transfer the patient to and from diagnostics for their investigation. This was highlighted in a recent review of ED patient transfer processes at the GRI. The outcome of such a delay may result in breach of the 4 hour target, especially those that fall within the 4-4.5hr breach time, and may have negative consequences from a patient safety perspective. In addition, it has also suggested that many members of the nursing staff transfer patients to and from x-ray when porters are not available within a reasonable time frame, detracting them from their clinical duties. Thus, addressing these limitations would likely improve the delivery of UCC in at the site.

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<sup>1</sup> Sun et al 2013, Effect of Emergency Department Crowding on Outcomes of Admitted Patients  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3690784/>

## 12. RESOURCES FOR ACUTE DIVISION

The Acute Division is significantly overspent which makes additional spending for winter challenging beyond resources which will be allocated by Scottish Government.

## 13. ESCALATION PROCESSES & ACTIONS

The Unscheduled Care Programme Board included a review of Escalation processes. Arrangements will be finalised, based on the evidence generated through this process.

## 14. 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.

<i>December 2016/ January 2017</i>			
<i>Day</i>	<i>Planned IP Theatre Service</i>	<i>Day</i>	<i>Planned IP Theatre Service</i>
Friday 23 <sup>rd</sup>	Normal Service	Friday 30 <sup>th</sup>	Trauma and Emergency, Elective cancer, urgents and long waiters
Saturday 24 <sup>th</sup>	Trauma and Emergency only	Saturday 31 <sup>st</sup>	Trauma and Emergency only
Sunday 25 <sup>th</sup>	Trauma and Emergency only	Sunday 1 <sup>st</sup>	Trauma and Emergency only
Monday 26 <sup>th</sup>	Trauma and Emergency only	Monday 2 <sup>nd</sup>	Trauma and Emergency only
Tuesday 27 <sup>th</sup>	Trauma and Emergency only	Tuesday 3 <sup>rd</sup>	Trauma and Emergency only
Wednesday 28 <sup>th</sup>	Trauma and Emergency, Elective cancer, urgents and long waiters	Wednesday 4 <sup>th</sup>	Trauma and Emergency, Elective cancer, urgents and long waiters
Thursday 29 <sup>th</sup>	Trauma and Emergency, Elective cancer, urgents and long waiters	Thursday 5 <sup>th</sup>	Trauma and Emergency, Elective cancer, urgents and long waiters

## 15. DIAGNOSTIC SERVICES

Diagnostics during peak activity over the winter months endeavors to extend Imaging services in particular CT activity to support inpatient patient pathways. Where appropriate CT support is extended until 8pm and is available at weekends for inpatients. These arrangements are worked into the Sector Plans. From a Laboratory Medicine perspective Point of Care RSV Virology is provided for vulnerable groups such as Oncology patients. Diagnostic Services are pivotal to patient pathways and the team work collaboratively with clinical colleagues to expedite diagnosis and reduce lengths of stay.

## **16. GP OUT OF HOURS (GPOOH)**

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.

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.

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

## **17. KEY PERFORMANCE INDICATORS**

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:

- 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

The analysis conducted as part of the Unscheduled Care Review will provide further context to these indicators. Specific elements of the 'Building Blocks' methodology will be revisited as considered appropriate to support understanding of patient flow and the impact of improvement actions taken.

## **18. NOROVIRUS & FLU VACCINATION**

Infection control procedures have been reviewed following last year and learning incorporated from experience of operating within the Single Room environment of the QEUH. Systematic monitoring arrangements are embedded into our operational practice and clinical governance.

The Flu Vaccination Programme was initiated at the beginning of October. All Staff are being encouraged to take up the offer and arrangements in place to facilitate this.

## **19. STAFF BANK**

Preparations for the Winter to ensure adequate staffing have been developed within the context of the need to avoid use of Premium Rate Staff. Approximately 70% of the NHS GGC Staff Bank are substantively employed by the Board and our focus is to ensure that we draw on this pool of staff and reduce reliance on external agencies. Recruitment to the staff bank includes a drive to bring in newly qualified nursing during the September/October period and an added focus on recruitment of band 2/3 Health Care Support Workers. There has been significant engagement with our staff to

encourage more to join the bank. Further work with Sector Management teams is building greater understanding of bank and agency usage, enabling better targeting of bank staff and a focus on staffing 'hot spots' to reduce reliance where possible on non-substantive positions.

## **APPENDICES**

1. South Sector
2. North Sector
3. Clyde Sector
4. Women & Children's Directorate
5. Glasgow City Council HSCP
6. East Dumbartonshire HSCP
7. West Dumbartonshire HSCP
8. East Renfrewshire HSCP
9. Renfrewshire HSCP
10. Inverclyde HSCP

## **APPENDIX 1**

### **South Sector**

#### **2016/17 Winter Plan**

##### **Introduction**

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1. This paper summarises the expectations of demand and the plans established to manage Unscheduled Care over the coming Winter in the South Sector.
2. This will be the 2<sup>nd</sup> winter period experienced in the Queen Elizabeth University Hospital. The plans reflect the learning from last year and supported by detailed analysis of demand and patient flow. A major programme of service improvement, the “Unscheduled Care Transformation Programme” was initiated in the summer and will contribute significantly to our operational plans.

##### **Activity and Demand Assumptions**

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3. Considerable analysis of demand and patient flow has been conducted over the last year, supported by the Scottish Government and employing the ‘Building Blocks’ methodology.

##### **A&E Demand**

4. Our working assumption from last year was that the profile of seasonality is of more A&E attendances during summer months than over the winter period. Continued analysis of week by week attendances over the last year shows this is still a valid assumption with an average of 1786 per week.
5. Are planning for this winter builds on this profile and is informed by more recently analysis of daily attendances.

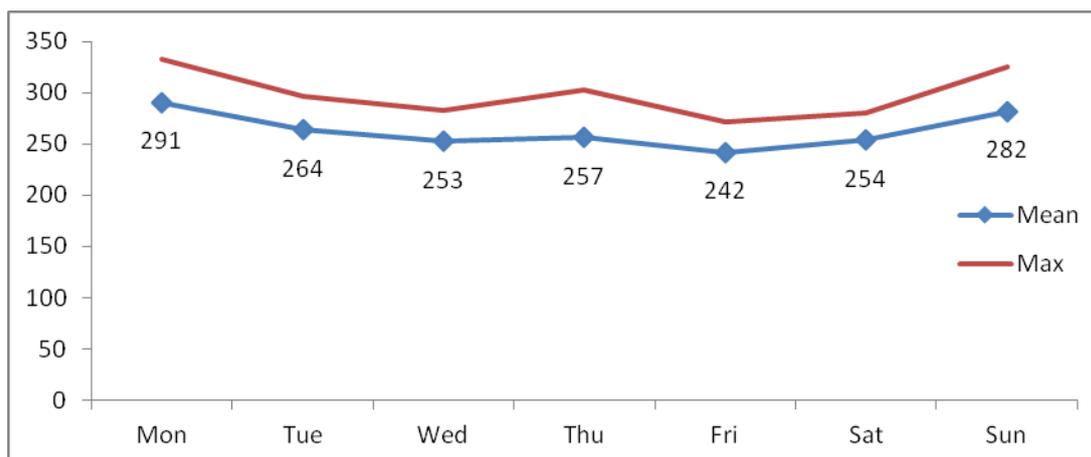


Figure 1: Range of daily A&E attendances at QEUH between 1/4/16 and 30/6/16

### Admissions

- GP Admissions via our Immediate Assessment Unit (IAU) last year proved higher than our planning had anticipated. This contributed significantly to the difficulties in managing patient flow. We now have detailed analysis of activity levels through the IAU to inform our assumptions for this year.

Summary Statistics							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Minimum</b>	53.0	73.0	72.0	57.0	81.0	31.0	31.0
<b>25th percentile</b>	101.0	82.0	85.0	78.0	92.0	43.0	36.0
<b>Median</b>	111.0	92.0	89.0	92.0	100.0	45.0	40.0
<b>85th percentile</b>	<b>114.2</b>	<b>102.6</b>	<b>100.8</b>	<b>103.0</b>	<b>106.4</b>	<b>55.4</b>	<b>49.8</b>
<b>Maximum</b>	117.0	130.0	105.0	105.0	108.0	58.0	62.0
<b>Median</b>	111.0	92.0	89.0	92.0	100.0	45.0	40.0

Figure 2: Range of IAU Admissions per day (28/03/16 to 30/06/16)

- The weekly trend in Unscheduled Care admissions over the last year shows variance around an average of 961 with maximum and minimum figures of 1053 and 853 respectively. This is consistent with weekly figures from 2014/15.
- On a day to day basis, our experience indicates we should be anticipating between 150 and 170 unscheduled care admissions every day.

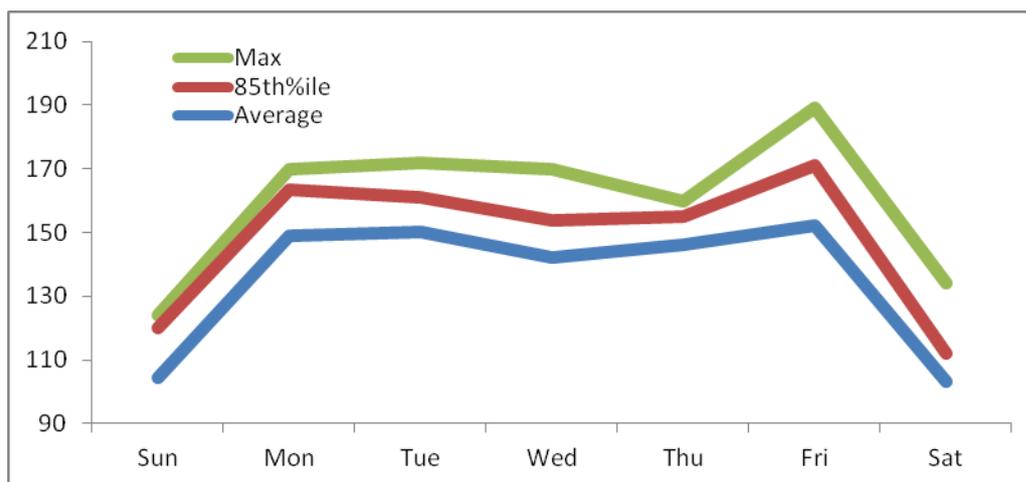


Figure 3: Range of Unscheduled care Admissions at QEUH between 1/01/16 and 31/03/16

Performance

- Our performance against the 4hr A&E target over the last year has been around the 90% level with improved performance on some weeks but others where delivery has been more challenging.

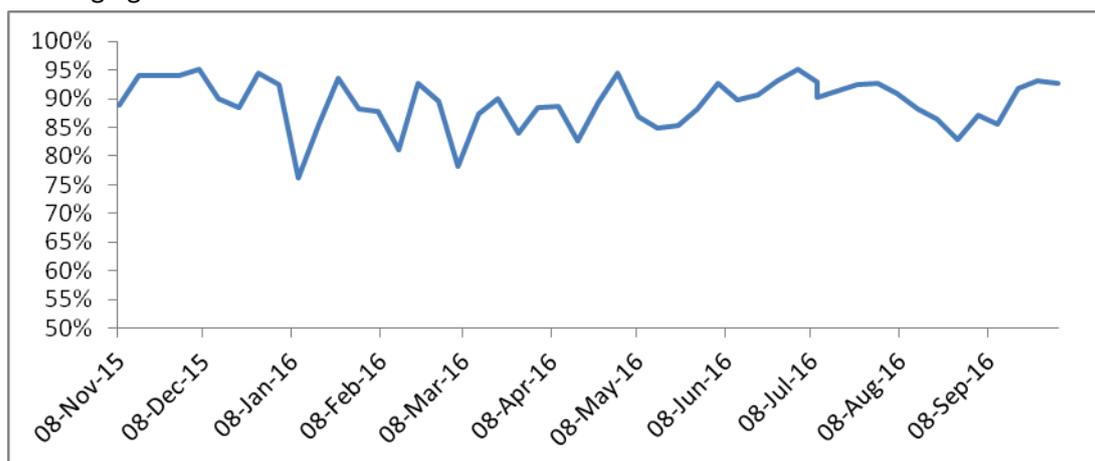


Figure 4: 4hr A&E Target Compliance

**Capacity and Operational Contingencies**

- Bed capacity across the Sector is set out in the table below:

	QEUH	GGH	Vic	Total
<b>Medicine</b>	547	22		569
<b>Elderly</b>	280	132	48	460
<b>Surgical</b>	405	73	12	490
<b>Total</b>	<b>1232</b>	<b>227</b>	<b>60</b>	<b>1519</b>

Figure 5: Current Bed Establishment for South Sector  
[Note: Surgery includes 49 Critical Care Beds]

11. The “Unscheduled Care Transformation” Programme is overseeing a number of improvement projects aimed at improving patient flow.
  - a. At the ‘Front Door’ current triage and assessment processes have been reviewed with the aim of ensuring all patients receive equitable treatment irrespective of access route. The team are reviewing and refining the telephone triage process ensuring patients are directed to the most appropriate service avoiding lengthy waits for treatment. This includes telephone triage with the potential to reduce the number of people who need to be admitted to hospital when it may be more appropriate to be seen in an ambulatory care facility or specialist clinic with rapid access to diagnostic.
  - b. The Clinical Decision Unit has been re-launched as an Ambulatory Care Facility with clinical pathways that to enable patients to be seen and discharged without the need for an inpatient stay.
  - c. Multiple movement of patients is disruptive to care and poor patient experience. For patients who have a stay less than 24hours, processes are being streamlined to avoid unnecessary transfers downstream to inpatient beds.
  - d. The “Exemplar Ward” project encompasses core elements of the 6 Essential Actions to improve patient flow on wards [including Structured Ward Rounds; Scheduled Board Rounds; Criteria led Discharge]. Evidence from the initial cohort of wards to complete the programme has demonstrated measurable improvement in the rate of pre-noon discharge, utilisation of discharge lounge and criteria led discharge.
  - e. Frailty has been identified as an independent risk factor for six month mortality and is associated with a longer hospital stay. There is evidence to show that older patients admitted to a ward providing comprehensive geriatric assessment (CGA) have an increased likelihood of being alive and living in their own home at up to 12 months. To improve our management of these patients, a standardised frailty assessment tool will be used to identify patients. This will be employed from the point of assessment with procedures in place to improve patient management through the hospital.
12. The Escalation Plan for the South Sector has been completely revised. It defines levels of ‘business as usual’ and clear, accountable actions associated with surges in activity. There is a clear documented process to ensure the safety of patients in the ED and IAU when demand for services outstrips capacity. The escalation plan provides a framework to proactively prevent crowding in these areas, its enables areas to establish their own clear escalation plans to allow patients to be seen in the right place at the right time, reducing boarding and disruption to elective schedules.
13. Staffing arrangements for the Festive period have now been finalised to ensure core staffing requirements are in place. This includes a Senior Manager on-site during the day at weekends in January . A manager is also on site until 20.00 Monday to Thursday

## **Additional Resources for Winter Period**

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The sector has a number of proposals for use of additional resources for the winter period, these include, which are subject to further discussion.

### **Inpatient Bed Capacity**

The Sector opened an additional 48 beds as part of the 15/16 plan which were not withdrawn at the end of the Winter. Dermatology will cease admitting elective patients over the winter period to provide additional capacity.

### **Supporting patient flow**

To support patient flow a range of staffing enhancements are proposed to target specific concerns:

- Additional staff to review medical patients admitted outwith medicine
- Additional AHP staff for DME to maintain discharge
- Additional support workers to free up medical staff time
- Additional cardiac physiology service at weekend to reduce ALOS
- Additional weekend AHP services
- Additional bank staff on three month contracts

### **Managing peaks**

Similarly, additional staff will be directed to avoid overcrowding in ED at known pressure points.

### **Recovering elective cases**

To maintain the elective programme, an additional all day Saturday list would be provided at the ACH from January through to March.

### **Additional support for other services**

Additional support will be required from diagnostic and pharmacy services including staffing as much as is possible for business as usual on the second of the 2 Public Holidays.

Additional ambulances will be required – both pre the 2 week peak holiday period and then throughout the winter period

## APPENDIX 2

### North Sector

#### 2016/17 Winter Plan

##### Introduction

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1. The North Sector winter planning process for 2016-17 builds on the lessons learnt from the 2015-16 process. The same multidisciplinary team approach has been adopted with the various elements and teams responsible for the delivery of scheduled and unscheduled care given the opportunity to contribute.
2. The first step was to review the performance through the winter of 2015-16 with a view to identifying the key metrics which contributed to the level of performance. A detailed analysis of 16 different metrics over a period of 19 weeks was conducted. This analysis showed that unscheduled care performance was not linked directly to any one metric but was a complex system in which a number of metrics played a significant role.
3. The next step was to review with the multidisciplinary team, the value that had been added by each funded winter proposal in 2015-16 with a view to prioritising financial spend on those actions which were agreed to have the most positive impact on performance. Also any action not seen as effective was removed from the 2016-17 plan at that point.

##### Activity and Demand Assumptions

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###### GRI A&E TARGET

4. Performance against the 4hour A&E target at GRI has been showing more sustained improvement over recent weeks. At the end of October GRI had achieved a performance above 90% in 9 out of the last 12 weeks and sits above 91% performance for the last 6 weeks. Significant improvement work is underway to sustain and improve on this level of performance.

Glasgow Royal Infirmary	7/8/16	14/8/16	21/8/16	28/8/16	4/9/16	11/9/16	18/9/16	25/9/16	2/10/16	9/10/16	16/10/16	23/10/16
4hr A&E Target Compliance	91%	91%	92%	90%	88%	84%	89%	93%	91%	91%	90%	92%

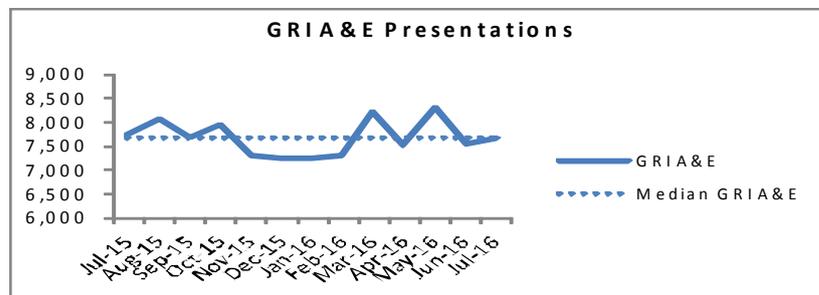
5. The main reasons for patients breaching the 4 hour target at GRI consistently fall into 4 categories:
  - Wait for first assessment
  - Wait for bed
  - Wait for clinical reasons, and
  - Wait for Diagnostics

6. In previous months GRI ED has had particular challenges with longer waits for first assessment than other sites across NMSGC. However a new system of Triage+ is being piloted and early indications are this is beginning to have a positive impact on the time for first assessment.

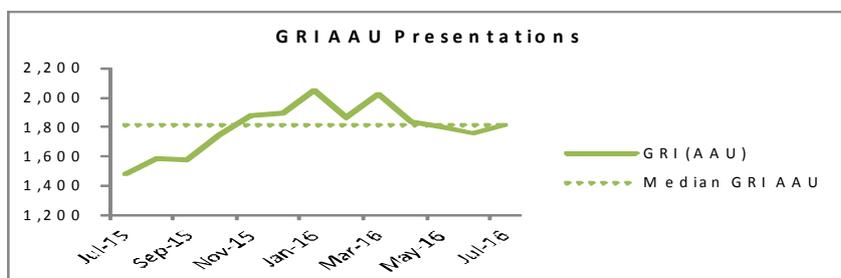
GRI ED 4Hr Breach Reason	09/10/2016	16/10/2016	23/10/2016	30/10/2016
1st Assessment	30%	22%	9%	39%
Bed	26%	35%	45%	29%
Clinical Reasons	12%	17%	23%	13%
Daignostics	11%	8%	11%	7%

### GRI EMERGENCY PRESENTATIONS – ED AND AAU

7. Similar to other sites across NMSGC over the last 12 months GRI Emergency Department has seen higher numbers of patients presenting during the summer months. A similar pattern of presentations is expected during winter 2016/7.



8. When looking at GRI AAU presentations there is an opposing trend, with greater numbers of patients presenting during the winter months. Again a similar presentation is expected this winter.
9. The net effect of combined ED and AAU presentation patterns means there is a fairly consistent volume of unscheduled care presentations to GRI throughout the year however the discharge rate from ED is over 75% whereas the discharge rate from AAU is 40% thus this shift to AAU presentations generates a greater admission flow.
10. Of particular importance for winter 2016/17 is the fact that there has been a steady increase in presentations to GRI AAU seen over the last 12 months. This rise is shown in the graph below. The 3 months July-Sept 2016 saw a 20% increase in AAU presentations when compared with the same 3 months in 2015.

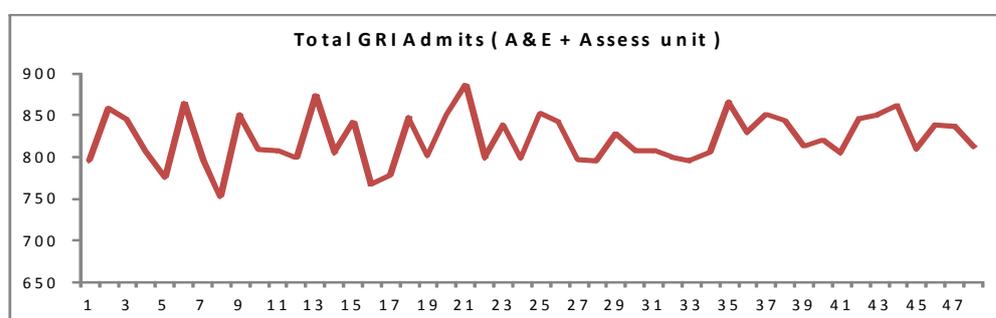


11. This significant increase in presentations to GRI AAU means the site will plan for up to 400 additional AAU presentations during the busiest months of winter.

12. In recognition of the rising number of presentations within GRI AAU, the unscheduled care improvement programme is currently piloting a new approach to offer a number of semi scheduled, next day appointments thereby reducing some unscheduled patient presentations. The pilot will continue into the winter months.
13. The North Sector winter plan identifies a number of proposals to improve the support of patient management in ED and AAU and improve patient flow through the units. This includes additional staffing within medical staff, nursing and porters.

### GRI ADMISSIONS

14. Looking back over the last 48 weeks from November 2015 to September 2016 shows an average weekly admission rate of 822 patient admissions to GRI. Weekly admission rates remain fairly consistent over this 48 week period, with lowest levels at 752 patients and highest levels at 886 patients.



15. The underlying rise in AAU presentations and admission rate from AAU would predict a higher level of admissions in the winter of 2016-17.

### Capacity and Operational Contingencies

16. Bed Capacity at GRI has remained static over the last year. There are 837 permanent beds at GRI (excluding beds for Obstetrics, Gynaecology and Plastics).

Specialty	GRI	S'hill	L'burn
Medicine	389	0	0
Surgical	272	12	0
Older People	176	48	56
Total	837	60	56

17. There are 11 temporary beds currently open for Older People in Ward 18/19. These beds have been open consistently for several years and although these do not have permanent funding are clinically considered part of the permanent bed base.
18. As part of the winter proposals an additional 21 beds have identified across the site which could potentially be opened as surge capacity for times of extreme demand. The full cost for opening these beds has been included within the North Sector winter plan.
19. There are beds at Stobhill Hospital and Lightburn Hospital for short stay surgery and stroke and geriatric rehabilitation. These off site beds are not considered suitable for very acutely unwell patients but their use will be maximised during the winter months. Despite the relatively good

performance in terms of breaching for a bed wait, many of the challenges in meeting the demand for unscheduled care revolve around the availability of inpatient beds when demand is high.

20. In recognition of this there is a strong focus within the North sector on improving patient flow throughout receiving and downstream wards. This work includes reducing length of stay in hospital, increasing use of the Discharge Lounge and increasing pre-noon discharges. The winter plan includes a significant number of proposals to support improvements in patient flow including additional consultant capacity, AHP and nursing roles to speed up discharge, diagnostic, pharmacy and portering support.

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### **Additional Resources for Winter Period**

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#### **Bed Capacity Proposals**

21. The review of current bed capacity has underpinned a range of interlocking proposals that will impact on the ability to manage demand through change of use and increase of capacity during the Winter months. Up to 36<sup>2</sup> additional beds over and above core bed capacity may be brought into play.
22. Staffing to be enhanced to protect and maximise bed utilisation across Critical Care, Additional nurse staffing for level 3 critical care pts (Oct - Mar), Wards 66 and 62 and SCN cover for GRI and QEB.
23. Opening hours of the Surgical Admissions Unit will be extended at weekends. Capacity utilisation will be further enhanced by introducing a Maxillo Facial transfer area, increasing the Castle St Discharge Lounge and establishing a new surgical Discharge Lounge in QEB.
24. This additional capacity will incur Facilities costs with extra portering across site, costs associated with specialist consumables for management of Winter Flu Cases and portering to transfer ED/XRay traffic.

#### **Front Door SDM and Flow Proposals**

25. Arrangements targeted at the Front Door will include enhanced staffing for all professional groups: Consultant backshift for AAU; Additional nursing in ED and AAU; Diagnostics; Pharmacy; Portering and Clerical.
26. Additional capacity will be created in Endoscopy and to support the management of demand in 'hot clinics' for medical and surgical workload.
27. Co-ordination of patient flow will be enhanced by ensuring sufficient ring fenced capacity in the 'Bed Buster' team and extension of hours of Trauma Co-ordinator and AMRU transfer Nurses. Similar measures will be applied in Theatres.

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<sup>2</sup> 9 beds in Ward 14; 4 beds in Ward 70 (Urology); Continuation of 11 beds in Wards 18/19; 8 beds are in Ward 47 (Plastics); 4 beds in Ward 56A/B (PRM)

## **Reducing ALOS and Enabling Discharge Proposals**

28. Learning from previous years underpins proposals to:

- Boarding team – Consultant/SHO/FY1 for medical pts in AAU and non medical wards
- Weekend provision for consultant wards rounds, AHPS, Pharmacy, Ward Clerks
- Discharge processes including the 'Home Today' nurse and ECAN resource in Orthopaedics and more generally.

## **Elective Programme**

29. To mitigate any impact on the elective programme, the Sector intends to:

- Run 'super weekends' at the Stobhill ACH: 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
- Protect elective flow at ACHs and Day case throughout the period, transferring IP sessions from capacity that may be required for Trauma
- Establish additional HDU beds by reconfiguration of critical care and general surgical services. Option for "pop" up arrangement – extension of 2 beds in recovery to take HDU patients overnight
- Utilise Private Sector

## APPENDIX 3

### Clyde Sector

#### 2016/17 Winter Plan

##### Introduction

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1. The Winter Plan for 2016/17 builds on the work developed in previous years, together with the work developed through the Emergency Department Capacity Plan and the wider Unscheduled Care Programme and the Outcomes and Indicators set out in Scottish Government Guidance: *Preparing for Winter 2016/17*. Significant analysis of the information available is used to on a daily basis to manage, and plan the unscheduled care system. A copy of the updated reports for the Essential Actions and the Unscheduled Care Task & Finish Groups which have informed winter planning are available for reference.
2. It is recognised there are a number of issues and pressures across Clyde, many connected with the existing estate. For the RAH site capital funding was secured to support redesign of inpatient facilities. This work, together with the extension of the MAU in autumn 2016 has led to noticeable benefits for patients from the front door, right through the system. While service improvements are already evident the full benefits of this work will not be realised until 2017/18.
3. The winter plan should be read in conjunction with other Sector and GG&C plans and policies – including Escalation Policy, Major Incident Plan and Pandemic Flu Plan.
4. The Sector will work closely with colleagues in the HSCPs in planning for winter: notably in areas such as Safe and Effective Admission and Discharge- including admission avoidance and strategies for additional winter beds and surge capacity across the whole system. Assuming local GP Practices will be closed for the 2 x 4 days over the Festive period it is anticipated this will lead to an increase in ED presentations of a clinically minor nature. There has been good engagement with Scottish Ambulance Service and its role in supporting the Sector through winter.
5. The activity at EDs/MIUs across the three sites in Clyde saw a reduction of 2% full year 2015/16 compared with 2014/15: activity for the first 6 months of 2016/17 is up 4.26% on same period in 2015/16: this will be closely monitored over the next couple of months to see if the trend continues heading into winter. Emergency admissions of acute conditions are generally higher in winter, due in part to weather and other external factors.
6. The period of winter for planning purposes is considered to be November 2016 – March 2017. Christmas and New Year's Day both fall on Sundays so the Bank Holiday focus will be on the 4 day weekends during this period. In preparing for winter it is assumed that services which help manage the demand at the front door of the hospitals – notably NHS 24 and GP Out of Hour Services will be available to provide similar level of service as in previous years. However, early indications are that due to the challenges recruiting doctors to the service, notably over the

Festive Period, there is a risk that it may not be possible to retain the OOH service at Inverclyde and Paisley as in previous years.

7. There are significant pressures on resources in the NHS and in social care. To date there is no confirmation of non-recurring funding to open surge beds and recruit additional staff for key areas. This is critical to supporting patient flow right through the acute system when an increase in acute admissions is anticipated.

## Activity and Demand Assumptions

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### Analysis of Demand Inpatient Services

	RAH	IRH	VoL	Total
Medicine for the Elderly	160	97	41	298
Medical Specialties	203	127	39	369
Surgical Specialties	202	93	-	305
<b>Total</b>	<b>565</b>	<b>317</b>	<b>80</b>	<b>962</b>

Table 1; Clyde In Patient Bed Numbers Based on SMG submission

	Average	85th percentile	95th percentile
<b>CLYDE</b>	<b>828</b>	<b>893</b>	<b>919</b>
Royal Alexandra Hospital	491	530	548
Inverclyde Royal Hospital	266	290	296
Vale of Leven Hospital	71	80	86

Table 2: Beds occupied by hospital over winter 2015/16

8. Comparing last year's activity with the bed model the average beds used on a daily basis across the Sector was 828 and at the 85<sup>th</sup> percentile this was 893 which is equivalent to 93% occupancy. For flow to be effective, occupancy should be around 80-85%. Table 1 above shows the bed complement as 962: increased temporary capacity available in previous years has helped to manage the demand on the system at both Royal Alexandra Hospital and Inverclyde Royal Hospital. The average length of stay remained constant throughout the year, with the additional services in place over winter supporting discharge. The expansion of the MAU at RAH also supported the system, with 50-60% of patients being assessed treated and discharge, without requiring a downstream bed. The rate of emergency re-admissions at 7 days and 28 days for 2015/16 showed no increase over the winter period.

## Review of Ed Presentations

Site	Year to March 2014	Year to March 2015	Year to March 2016	% variation from 2014/15 to 2015/16
RAH	68,299	68,980	67,746	-1.79%
IRH	31,635	32,633	31,816	-2.50%
Vale of Leven	15,073	15,834	15,546	-1.82%
<b>Total</b>	<b>115,007</b>	<b>117,447</b>	<b>115,108</b>	<b>-1.99%</b>

Table 3: ED/MUI attendances for full year

9. The activity for the year to March 2015 was the highest year of three recent years. With ED activity traditionally higher in summer than winter the demand over the next few months will be monitored to see if the increase seen during the first 6 months of this year continues.

Site	6 months to Sept 20 15	6 months to Sept 2016	%Variation
RAH	34,380	35,591	3.52%
IRH	16,064	16,538	2.95%
VoL	8,092	8,899	9.97%
<b>Total</b>	<b>58,536</b>	<b>61,028</b>	<b>4.26%</b>

10. Attendances across all sites vary through the week so too the conversion of attendances into admissions. Using the activity data available Clyde Acute Sector will work with the Health & Social Care Partnerships and local GPs on variation across Practices in relation to rates of attendances at ED, both during the in-hours and out of hours periods. In Renfrewshire the pilot work scheduling unscheduled referrals from GPs has received positive feedback from GPs. This work will be built on over winter with the aim of managing the pressures on ED and MAU. There had been significant learning from the experiences of previous winter periods : as a result, despite the variation in demand on the system over the 7 day period compliance with the 4 hour wait standard remained constant over the winter period: benefitting from staff managing the demand and the resources in place.

## Capacity and Operational Contingencies

11. The Winter Plan for 2016/17 builds on the work developed in previous years – most notable 2015/16 , together with the work developed through the Emergency Department Capacity Plan and the wider Unscheduled Care Programme .

Objective	Detail	Expected Benefits
RAH		
Increased/rationalised assessment capacity: increasing capacity at front door supporting ED and downstream wards work efficiently	<p>MAU:Open 7 days 8am-10pm providing initial assessment of GP referred patients with ANPs pulling patients with potential for same day discharges from AMU. The Unit is embedded in the service and is working well.</p> <p>Contingency plan has been developed: in the event of extreme pressure on the system beds would be flexed to provide additional capacity overnight.</p> <p>The SAU is embedded into the service, aim is to extend SAU opening to midnight</p>	<p>Pathways developed will support patients requiring investigation who could be transferred to the Ambulatory care area and treated on OP basis with access to rapid assess return clinic.</p> <p>:Reduces pressure on ED</p> <p>:Reduces admissions to downstream wards for zero and 1-3 day LoS</p> <p>:Improves 4 hour wait performance</p> <p>Improved patient flow: free Receiving Team</p> <p>Support patients waiting for surgical assessment from ED</p>
	<p>Older Adult Assessment Unit</p> <p>is dedicated resource for GP referred patients or those ‘pulled’ from ED based on criteria of frailty. 4assessment beds and 8 short stay beds with max: stay 72 hours . Aim to assess and safely discharge patients home.</p>	<p>Established pathway from ED</p> <p>Shorter length of stay for patients who are transferred to unit</p> <p>Quicker access to specialty consultant staff</p> <p>Minimise boarding of elderly patients across hospital – beds</p>

Objective	Detail	Expected Benefits
		<p>free for medical patients</p> <p>Improved liaison with RES team</p>
<p>Increase capacity to address demand surges to support patient flow</p>	<p>Key pressures are in Medicine and to lesser extent Medicine for the Elderly:</p> <p>Proposal</p> <p>6 beds : Ward 11</p> <p>7 day 'delegated discharge unit' in Ward 29</p>	<p>Supporting pre-noon discharges and anticipated peaks in demand. Reduces boarding: allowing the hospital to cohort patients with EDD within 48 hours.</p>
<p>Improve patient flow and discharge planning: facilitating efficient system</p>	<p>The seniority of the Medical Receiving Team overnight is variable with Receiving Team responsible for AMU and all medical emergencies on site. Surgical Team are covering similar responsibilities and the number of patients requiring input is significant. Aim is to increase Registrar and FY2 cover overnight 7 days.</p> <p>Aim is also to increase ED consultant cover between 11pm and early AM.</p>	<p>Improve flow on site and reduce the number of 1<sup>st</sup> assessment and wait for specialist delays; increase senior decision making on site and improve the patient experience.</p>
	<p>There will also be increase in portering staff to support MAU and ED in patient transfers including diagnostics OOH.</p> <p>Increase trauma liaison cover</p>	<p>Reduce delays in movement of patients to all wards and departments –enabling Diagnostics to operative efficiently and patients</p> <p>Improve patient flow from ED to ward or home</p>
<p>Increase Discharge Lounge Activity to support early discharges</p>	<p>The discharge/transport hub is now embedded into the service and working well. The transport hub is the central point for all transport requests focussing on same day discharge. The hub's model is working well and will be</p>	<p>The further development of the satellite pharmacy within the unit will facilitate an increase in AM; free up beds earlier in the</p>

Objective	Detail	Expected Benefits
	<p>enhanced by the current capital works and a satellite pharmacy dispensary service over the winter period. The Hub supports each of the sites in Clyde in patient movement.</p> <p>A contingency plan has been developed to access private ambulances in extremis ( all sites)</p>	<p>day.</p> <p>To support discharges, freeing capacity on site</p>
Ensure EDD entered on TRAK: visibility will assist across the system in capacity planning	CSMs/Lead Nurses to ensure EDD entered onto TAK timeously on admission/transfer for all patients.	Will support bed managers identify potential capacity: facilitate early discharge and reduce pressure on front door where admission appropriate
Improve AHP support at weekends to support system over 7 days	Increased establishment within OT and Physiotherapy to enable teams to work 5/7	Supports patient flow through system over 7 days. Posts will also be responsible supporting patient flow, reducing LoS: supporting discharge. Improve liaison between hospital and community teams .
Senior leadership presence on site through winter: supporting escalation of critical issues	Senior management rota developed 24/7: with site presence up to 8 PM week days and weekends. Based at RAH the cover will be for each of the sites in Clyde Sector.	Early decision making will support system work efficiently
IRH		
Increase capacity to address anticipated demand surges.	Medical – open winter ward L south : 20 beds 12 Medicine for the Elderly beds in Larkfield	<p>L South supports early discharge: unit operated very effectively in winter 2015/16 where patients with EDD within 48 hours were cohorted</p> <p>Reduces number of patients boarding.</p>

Objective	Detail	Expected Benefits
		Supports anticipated demand in admissions
Improve AHP support at weekends to support system over 7 days	Additional capacity required in Physiotherapy and O/T to enable rota cover: enable staff to work 5/7 with services to provide	Supports patient flow through system over 7 days. As at RAH where service working well, posts will also be responsible supporting patient flow, reducing LoS: supporting discharge. Improve liaison between hospital and community teams
Ensure EDD entered on TRAK: visibility will assist across the system in capacity planning	CSMs/Lead Nurses to ensure EDD entered onto TRAK timeously on admission/	Will support bed managers identify potential capacity: reduce pressure on front door where admission appropriate: facilitate early discharges
<b>Vale of Leven</b>		
Increase capacity to address anticipated increase in demand	Open Ward 6	Increase capacity will help manage increase in demand on site and facilitate transfers back from RAH timeously
Ensure EDD entered on TRAK: visibility will assist across the system in capacity planning	CSMs/Lead Nurses to ensure EDD entered onto TRAK timeously on admission/transfer for all patients	Will support bed managers identify potential capacity: reduce pressure on front door where admission appropriate: facilitate early discharges

#### **Additional Resources for Winter Period**

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12. The Winter Plan includes actions derived from the lessons learned from a review of last year's plan including the benefits achieved from the focussed actions. The table below details the

proposals. Funding was secured earlier in 2016 from NHS GG&C for the capital costs associated with the expansion of the Medical Assessment Unit at Royal Alexandra Hospital. As there is not physical space on site to increase the A&E Department this expansion alleviated some of the pressure which was building, all through the year, at the front door of the hospital.

13. Other developments and areas of redesign which are being supported across the Sector through the 6 Essential Actions work and the Task & Finish Groups leading on the priorities identified by NHS GG&C Unscheduled Care Group will support the system through the winter period. However, based on past trends increased admissions are to be anticipated over the winter period, with subsequent increases in re-admissions. These factors together with the impact on service delivery across the health and social care system before during and after the Festive Period suggest that additional short term funding is required to sustain a safe and efficient service.
14. The Sector's priorities are identified in above. The current financial pressures are recognised and the Sector will only progress to implementation once funding has been confirmed.

APPENDIX 4

Women & Childrens Services

27 October 2016

Winter Plan

Introduction

1. This paper presents an overview of the Directorate’s Winter Plan. The Royal Hospital for Children has consistently achieved the 4 hour A&E target and accommodated unscheduled admissions throughout the last 12 months.
2. The paper presents an overview of the demand for service, the core capacity required to meet this and the additionality planned to address seasonal changes in case mix.
3. The Directorate also contributes to the Acute Division’s Winter Plan with the provision of the Early Pregnancy Assessment Services.

Activity and Demand Assumptions

4. Demand for A&E services have increased over the last 3 years but experienced a sustained step increase of demand following the move to the new Royal Children’s Hospital. From September 2015 onwards, the monthly attendances were on average 30% greater than September 2013.
5. Despite this demand, monthly performance against the 4 hour target continues to be over 99%.

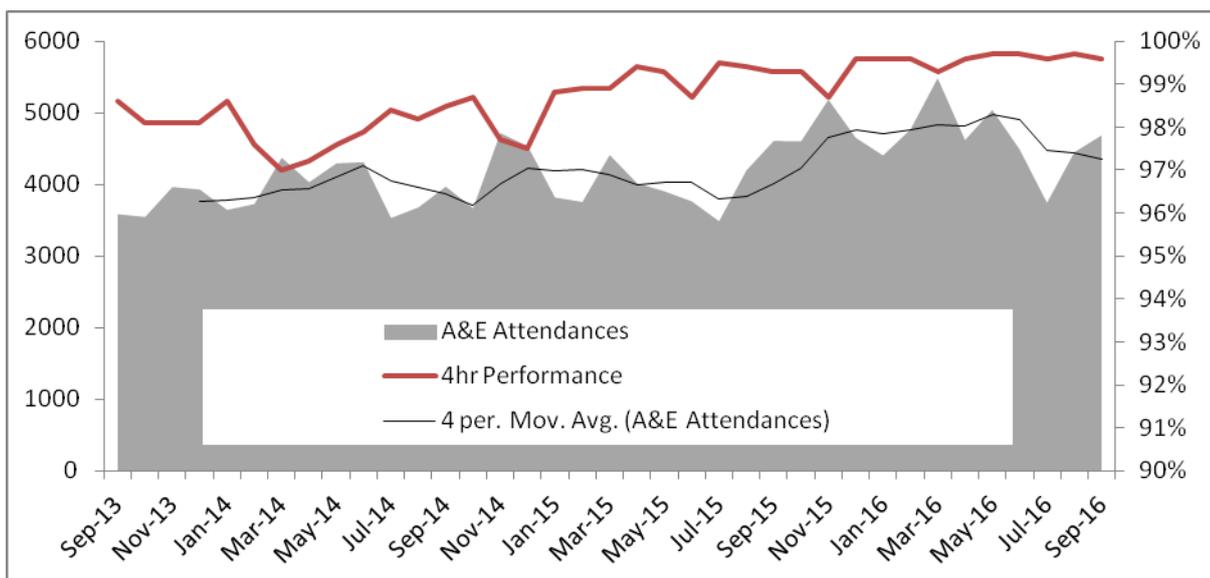
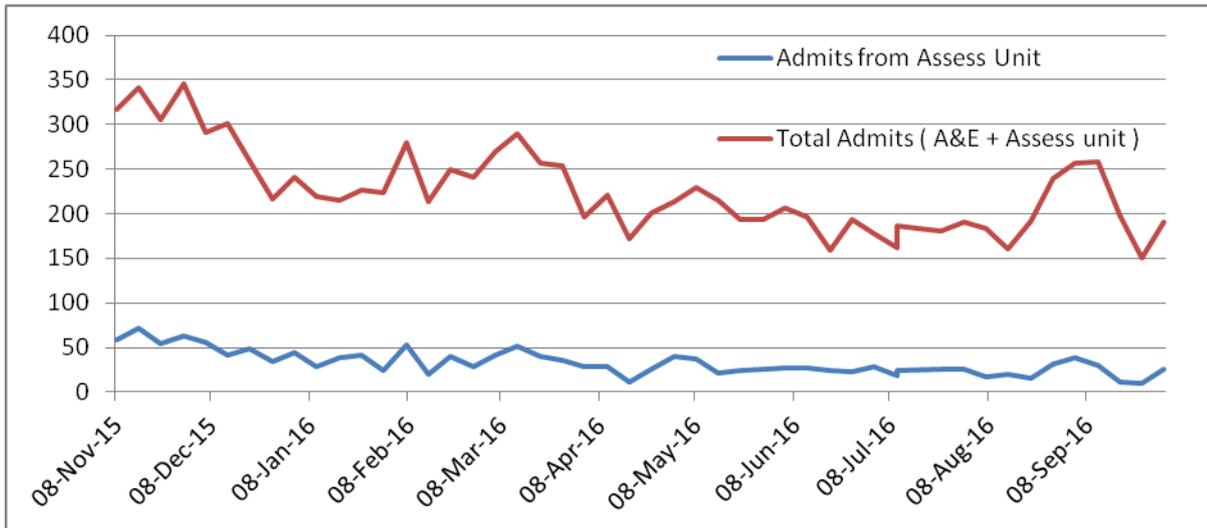


Fig 1: Monthly A&E Attendances and Performance Sept 2013 – Sept 2016

6. Analysis of the weekly non-elective admissions over the last year indicates an average of 227 admissions per week but with periods of much higher admissions.



7. The average length of stay for admitted patients has been 2.5 days. 37% of patients admitted will be discharged without an overnight stay, a further 47% will stay between 1 and 3 nights. For the 15% of patients who stay longer, the average length of stay is 11.5 nights.

### Capacity and Operational Contingencies

8. Current bed capacity in the RHC is:
- 32 Acute Receiving beds
  - 15 bed CDU in RHC
  - 20 ITU and 2 HDU beds
9. The RAH service will experience a change in case mix but this can be absorbed within existing resource.
10. Women’s services provide on each of the main hospital sites (QEUH, PRM) the midwifery led Early Pregnancy Assessment Service designed to provide appropriate and responsive care for women who might otherwise present at A&E.

### Additional Resources for Winter Period

11. The service plans for enhanced capacity during the winter period are:

<b>Assessment Capacity</b>	<ul style="list-style-type: none"> <li>- Open further 8 beds in ARU and 5 beds in CDU</li> <li>- Introduce 7 day service for Early Pregnancy Assessment Service (QEUH and PRM)</li> </ul>
<b>Flow Management</b>	<ul style="list-style-type: none"> <li>- Extend Bed Management Arrangements to provide 7 day cover.</li> </ul>
<b>Optimise Capacity</b>	<ul style="list-style-type: none"> <li>- Diversion protocol established to manage access between RHC and RAH, Ward 15</li> </ul>

	<ul style="list-style-type: none"><li>- Extend PICU to full 22 bed ITU capacity (uplift of 2 HDU beds)</li></ul>
<b>Admission Avoidance/Discharge</b>	<ul style="list-style-type: none"><li>- Establish RSV/Bronchiolitis nurse led discharge pathway</li></ul>



# **Glasgow City Health & Social Care Partnership**

## **Draft Winter Plan**

**2016/17**

**October 2016**

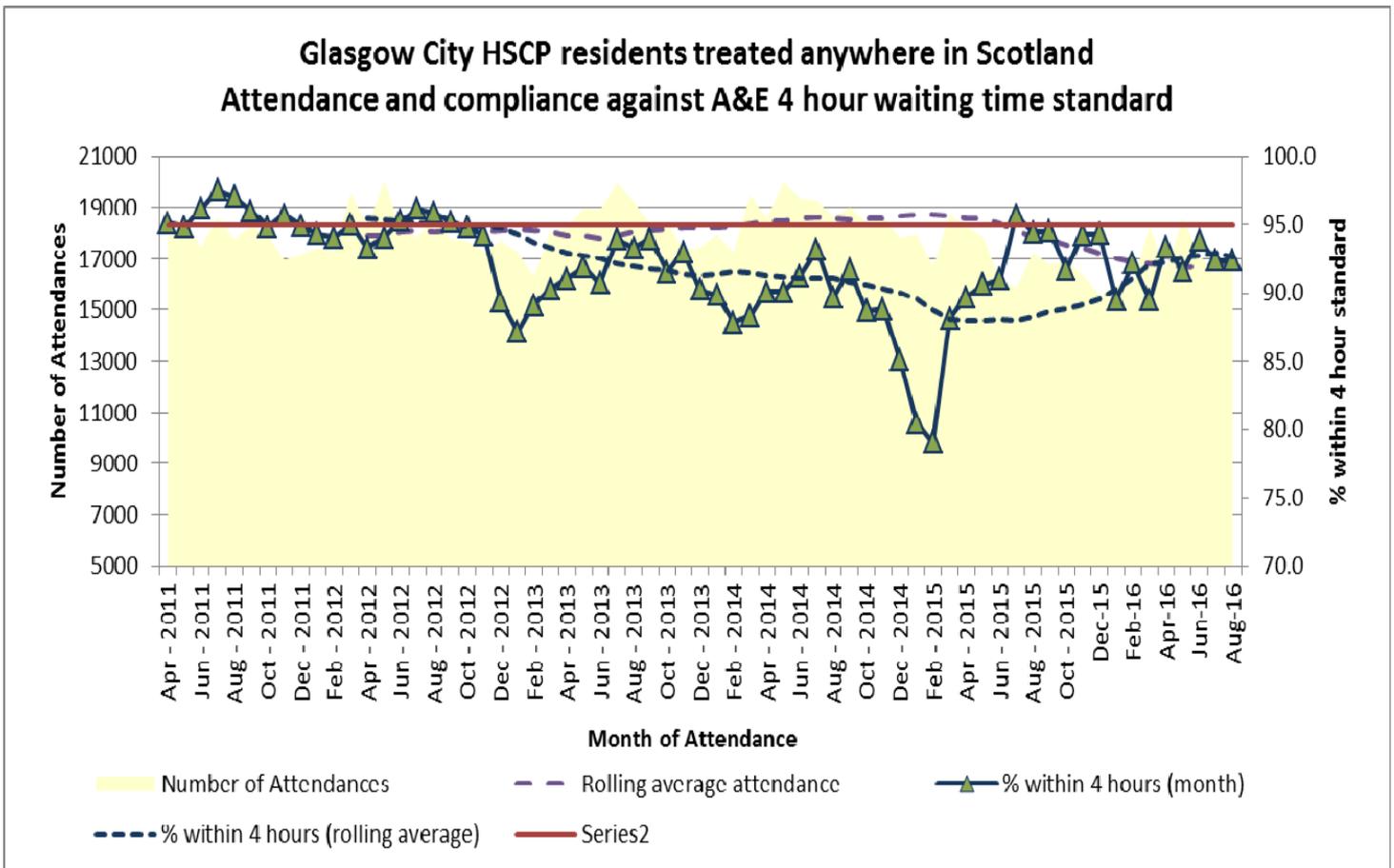
## 1. INTRODUCTION

- 1.1 This draft plan outlines Glasgow City Health & Social Care Partnership’s (HSCP) preparations for winter 2016/17 in order to minimise any potential disruption to the provision of health and social care services to patients, service users and carers.
- 1.2 The plan has been prepared in the context of national guidance from the Scottish Government on preparing for winter 2016/17 [DL (2016) 18]. The plan also forms part of the HSCP’s broader approach to unscheduled care.

## 2. UNSCHEDULED CARE CONTEXT

- 2.1 The health and social care system in Glasgow has faced considerable pressures in recent years. In particular there has been considerable pressure in delivering the national target to delivery care to 95% of accident and emergency attendees within four hours. The recent trends for Glasgow City residents are shown in figure 1 below.

**Figure 1 – Accident & Emergency Attendees – 4 hour target – Glasgow City residents April 2011-October 2015 to July 2016**



- 2.2 Further analysis of Glasgow City A&E attendances shows that since April 2012, with the exception of seasonal variations, there has been an overall gradual downward trend in attendances (see figure 2). The significant reduction around June 2015 is in line with the introduction of Acute Assessment Units in both GRI and QEUH. Glasgow City attendances at A&E have slightly increased since June 2015. 2015/16 saw the lowest level of emergency admissions rate per 1,000 head of population for people aged over 65 and 75 (see figures 3 and 4). This has increased slightly in 2016/17. There is a pattern of increased admissions for 75 years plus since May 2015, with the rate per 1000 population almost back to the 2014/15 level.

Figure 2 – Glasgow City A&E Attendances 2013/14 – 2016/17

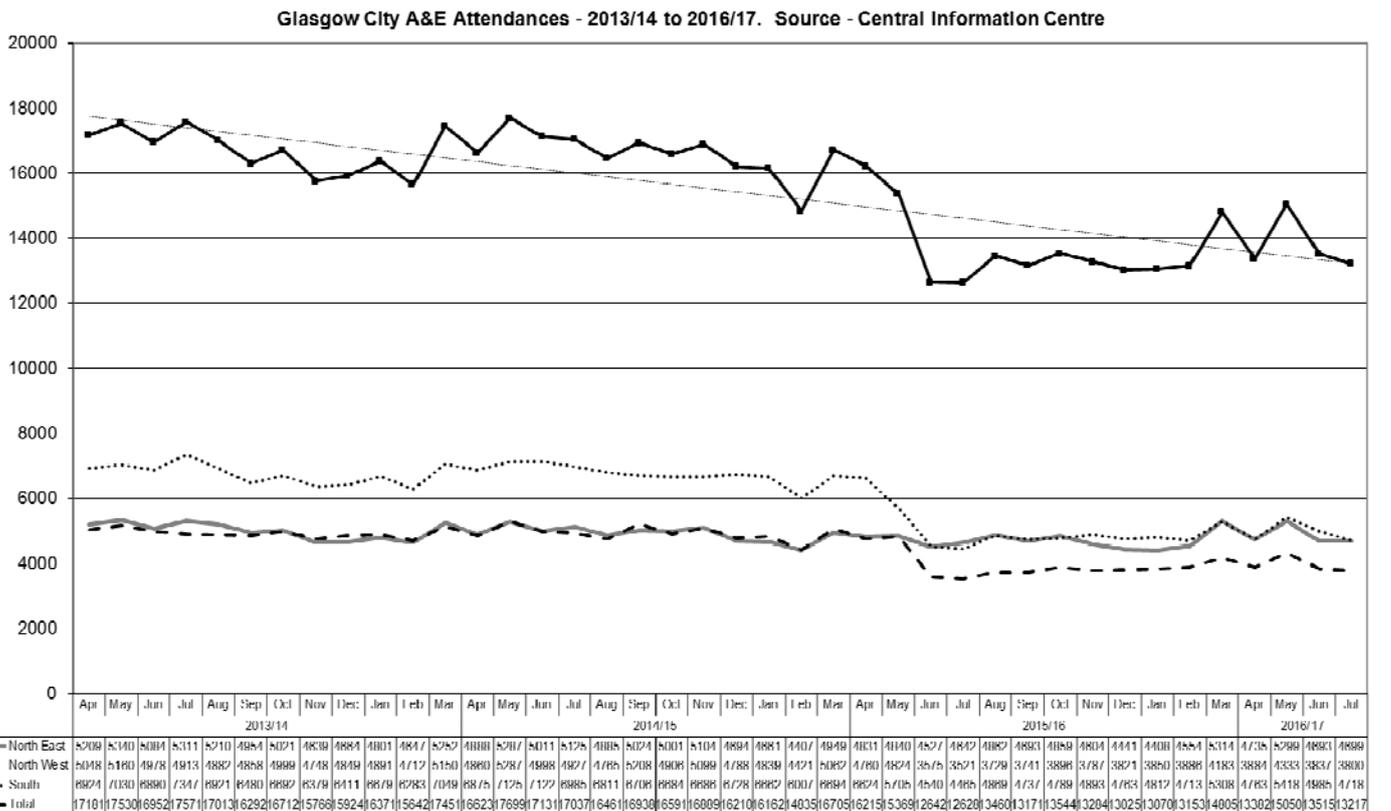
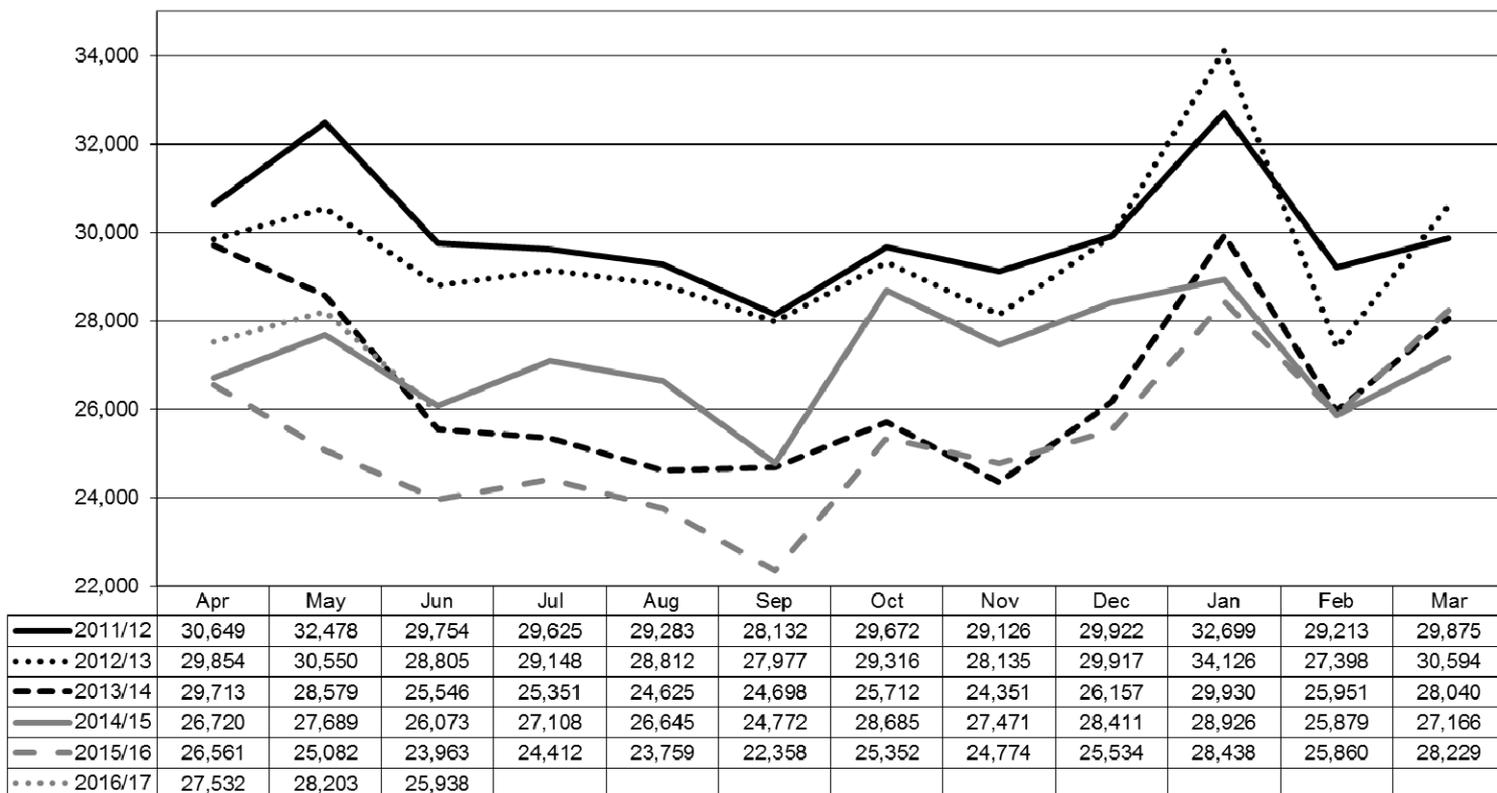


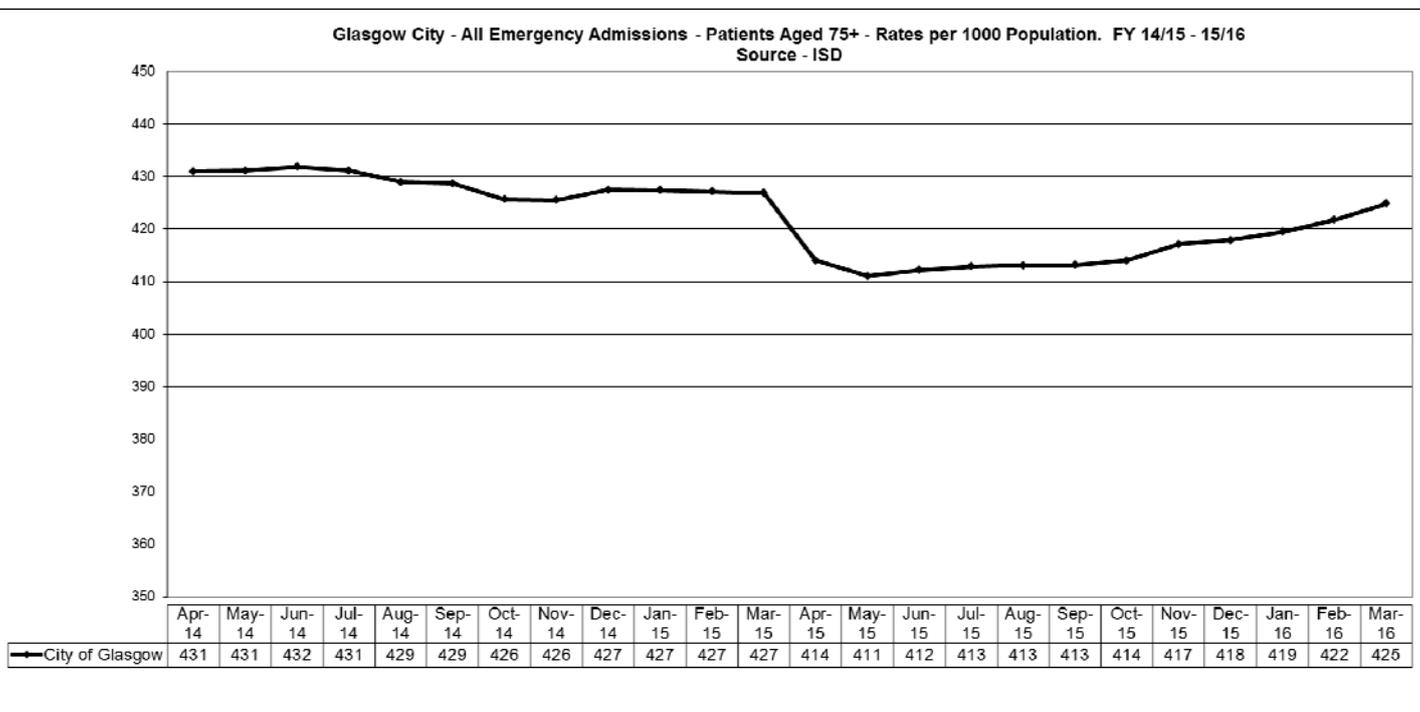
Figure 3 – Glasgow City Emergency Admissions Rate per 1,000 Population 65+

2011/12 – 2016/17

Unplanned Acute Bed Days - Over 65 years - Comparison 2011/12, 2012/13, 2013/14, 2014/15, 2015/16 and 2016/17. Glasgow City.

Source - Change Fund Report



**Figure 4 – Glasgow City emergency admissions rate per 1,000 of population 75+ - 2014/15**

- 2.3 Further analysis shows that these attendances are influenced by deprivation with a greater rate of attendance from SIMD 1 areas as shown in table 1.

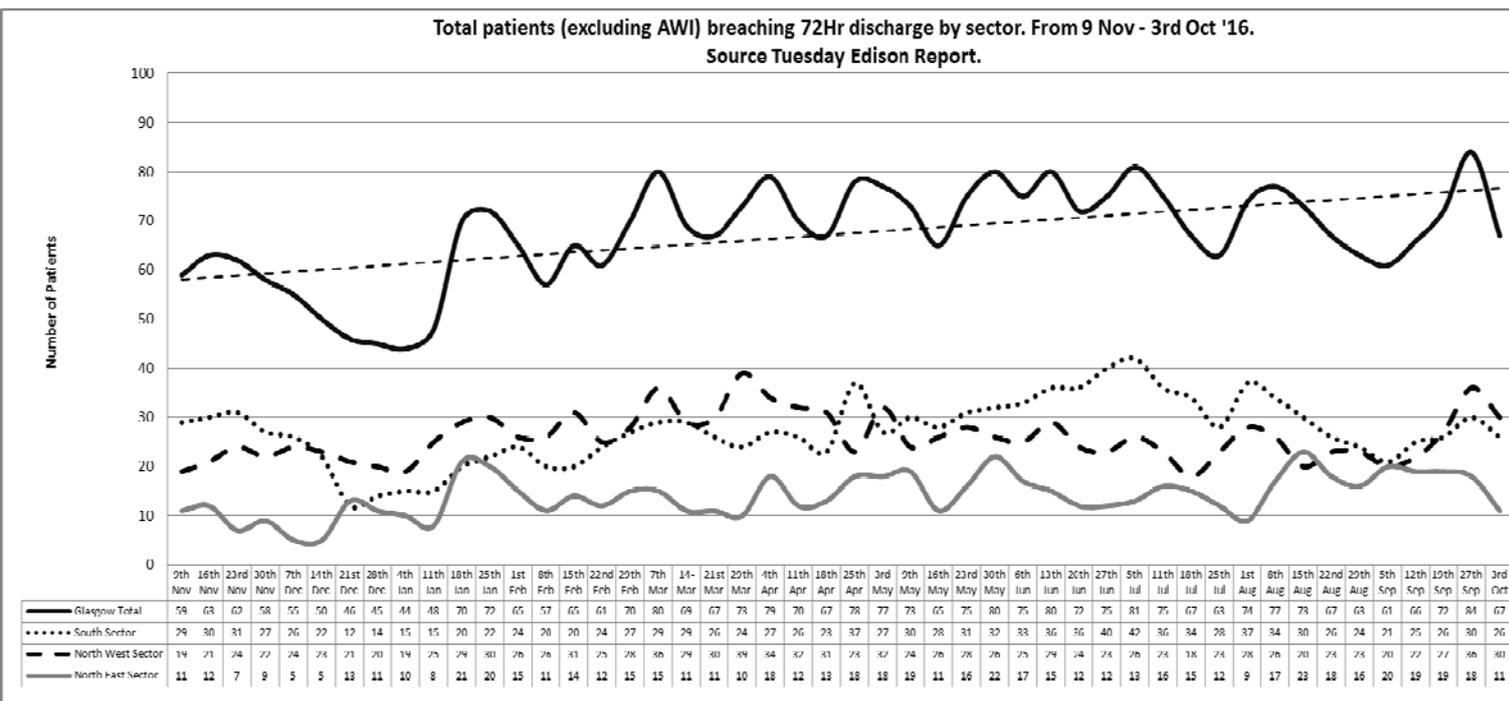
**Table 1 – Glasgow City unplanned admissions by SIMD 2011/12-2016/17**

	2009/10	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (to June)
<b>Quintile 1</b>	9,771	8,607	8,871	8,808	9,252	10,020	2,444
<b>Quintile 2</b>	7,292	8,439	8,228	7,757	7,096	7,363	2,049
<b>Quintile 3</b>	4,742	5,341	5,438	4,912	4,844	5,134	1,336
<b>Quintile 4</b>	2,954	3,494	3,637	3,459	3,345	3,670	955
<b>Quintile 5</b>	1,443	1,440	1,466	1,366	1,700	1,704	476

- 2.4 There are a number of actions in our plan outlined below designed to prevent avoidable admissions to hospital. The trends in A&E attendance and emergency admissions will be closely monitored over the winter period to ensure we continue to deliver safe and effective patient care. In addition to work to mitigate avoidable attendances and admissions, the HSCP has a programme in place to continually improve discharge (outlined below). Delayed discharges have traditionally been a pressure and although significant reductions have been made – particularly in the over 65 age group - there has been a plateau in these overall numbers since January 2016. The HSCP is committed to maintaining a focus on this during the winter period (see figure 6).

**Figure 6 – Glasgow City delayed discharges – number of patients breaching 72 hour target November '15 – Current**

**3. PREPARATIONS FOR WINTER 2016/17**



- 3.1 This plan focuses on the HSCP’s actions to manage the potential additional pressures in the health and social care system, including adult mental health services that may arise over the winter period. As part of this process the HSCP will be working with partner agencies, including housing and the third sector to maximise their contribution over the winter period.
- 3.2 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 (outlined below) in the Scottish Government’s winter planning guidance DL (2016) 18, including measures to avoid admissions and manage delayed discharges.
- 3.3 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 weekly and report to the Operations Executive Group, and the IJB.

**4. CRITICAL AREAS – KEY ACTIONS**

- 4.1 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 DL (2016) 18. 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*; the Scottish Government’s national programme to improve unscheduled care.

4.2 We are currently working on an integrated HSCP business continuity plan. The current business continuity arrangements for each service area will remain in place until the new plan is implemented.

4.3 Primary care practitioners are also encouraged to have business continuity plans.

### **Escalation plans tested with partners**

4.4 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:

- routine monitoring of delayed discharges;
- regular meetings of the winter planning group to ensure implementation of this plan;
- reports on winter planning performance to the weekly HSCP Executive Team;
- regular review of locality performance at Locality Management Team meetings; and,
- a rota of senior management cover over the winter period to ensure an appropriate management response when required.

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

4.5 This winter plan has 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:

#### ***Anticipatory Care Planning***

- all GP completed anticipatory care plans uploaded onto the electronic information system, eKIS;
- all patients with palliative and end of life care needs will be invited to work with clinicians to develop an advanced care plan which contributes to an electronic palliative care summary being completed within eKIS;
- the continued roll out of the Glasgow Community Respiratory Service to support patients with COPD, and develop self-management strategies and Anticipatory Care Plans.
- completion of the roll out of anticipatory care plans for people in Intermediate Care beds; and,
- continued development of our wider programme to extend anticipatory care plans in collaboration with HSCP staff, the independent sector, housing, Cordia and others.

#### ***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 housebound patients with nursing needs and those with palliative care needs. Those at greatest risk on the DN caseload are subject to frequent clinical monitoring and case review to ensure all measures are in place to avoid admission to hospital. If District Nurses identify additional needs, they will check if other services are attending and if necessary will the 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; 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.

### ***Expediting Discharge from Hospital***

4.6 The HSCP has established a Hospital Discharge Operations Group (HDOG) charged with improving hospital discharge performance and consistency across the three localities in Glasgow. This group will meet on a regular 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 figure 6 and the indicators in annex A) over the winter period with a particular focus on the city's two A&E departments.

4.7 The work programme includes the following actions:

- develop models of Intermediate Care to reduce delays in hospital for patients who are under 65s including patients with complex physical health care needs, mental health and homelessness;
- 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:
  - aligned dedicated Social Work resource and practice into acute hospital Teams;
  - move to improved early referral of patients who are unable to return home from hospital;
- develop model of Intermediate Care ( complex/palliative ) hospital discharge pathway in North Glasgow
- implement an accommodation-based strategy that seeks to divert demand away from acute care at both admission and discharge ends of the system; 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

4.8 Other actions to expedite acute hospital discharge include:

- the Glasgow Fast Track service, delivered in partnership with Marie Curie, supports people with palliative care needs to get out of hospital as quickly as possible. 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;
- EquipU out of hours service for urgent referrals to avoid potential delays as a result of equipment issues;
- GPs will ensure that people are reminded to order and collect their medications, including repeat prescriptions, in advance of the festive period; and,
- 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.

### **Strategies for additional winter beds and surge capacity**

4.9 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.

4.10 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.

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

- 4.11 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.

### **Effective analysis to plan for and monitor winter capacity, activity, pressures and performance**

- 4.12 The HSCP will put in place a robust performance management system to underpin 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.

- 4.13 Attached at annex A is a set of metrics to be used as part of our performance regime which will be further developed and refined.

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

- 4.14 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.
- 4.15 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.

### **Discharges at weekend & bank holiday**

- 4.16 The HSCP will put in place a skeleton integrated response team, with access to home care, over the Monday and Tuesday 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.

- 4.17 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.
- 4.18 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.
- 4.19 Community rehabilitation teams will work every day other than Christmas Day and New Year's Day, and will support A&E admission avoidance and Intermediate care.
- 4.20 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.

#### **The risk of patients being delayed on their pathway is minimised**

- 4.21 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.

#### **Communication to Staff & Primary Care Colleagues**

- 4.22 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, acute 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;
  - other arrangements to provide simple access to services include Social Care Direct for all GCC enquiries and service specific access points for NHS provision; 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.

#### **Preparing effectively for norovirus**

4.23 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.

### **Delivering Seasonal Flu Vaccination to Public and Staff**

4.24 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 housebound patients on their current caseloads, and who give consent to receiving the flu vaccination.

4.25 Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided across the city.

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

## **5. CONCLUSION**

5.1 This draft plan outlines the actions the HSCP is taking in preparation for winter 2016/17 in line with national guidance. 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. An action plan has also been developed identifying key leads for each action, reporting arrangements and key performance indicators. Regular reports and updates will be made to the Integration Joint Board.

East Dunbartonshire  
Health & Social Care Partnership

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**East Dunbartonshire  
Health & Social Care Partnership**

**Winter Plan**

**2016/17**

## 1 Introduction

Health and Social Care Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHSGG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period. These plans will cover:

- The community service aspects of the 6 essential actions
- Delayed discharge
- Measures to reduce admissions and attendances
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care
- Continuity and resilience
- Developing an agreed set of indicators to monitor performance
- Planning with GPs for the two long bank holidays

This Winter Plan identifies and addresses the local issues across the primary care and community services for which East Dunbartonshire Health and Social Care Partnership is responsible, to support the NHSGG&C whole system planning as detailed above.

## 2 Winter Planning Arrangements

Winter Planning arrangements have been established through the fortnightly Operational Managers' Group, with Winter Planning being a standing agenda item throughout the winter period. This ensures that all HSCP service leads are represented in discussing the delivery of the Winter Plan and identifying 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.

## 3 Key Themes

The Scottish Government guidance *Preparing for Winter 2016/17* (DL (2016) 18) has identified twelve key critical areas, outcomes and indicators which are considered key to effective winter planning and the bedrock on which winter plans are built. The indicators underpin the processes to achieving the outcomes described.

The HSCP local planning arrangements are set out under the headings of the 12 critical areas identified. 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*

### ***i. Business continuity plans tested with partners.***

Business Continuity Plans (BCP) for both Health and Social Care Services have been harmonised into a single BCP and will be tested during the winter season. Each service has completed a Departmental Service Plan and these were tested in February 2016. Service leads have been asked to update and review their individual Departmental BCP service plans by November 2016.

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. The HSCP met with Practice Managers in September 2016 and asked that they reaffirm their arrangements.

**ii. 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 Hospital Discharge team will provide a reduced staff rota during the week between the public holidays, with a minimum of two staff 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 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.

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

**(a) 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 a *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.

## **(b) 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 NHS GG&C winter website link.

## **(c) 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 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 to assist early identification of admissions known to social care services;
- 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 for the development of an intermediate care facility which will allow for the further assessment of an individual’s needs, including resolution of financial barriers, following a hospital admission and also provide rehabilitative support in a controlled environment which will facilitate recovery to enable people to return to their own home.

#### **iv. Strategies for additional surge capacity across Health & Social Care services**

The HSCP will respond where possible to support Acute services in managing surge capacity. The GP practices will be informed of any acute pressures to assist in considering possible alternatives to admission, where appropriate. This will be supported by the Rapid Assessment link Team, and 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.

#### **v. Whole system activity plans for winter: post-festive surge / respiratory pathway**

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

Links will be maintained 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.

**vi. *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)

**vii. *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 through the Operational Management Group in October.

**viii. *Discharges at weekend & bank holidays.***

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.

**ix. *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.

**x. *Communication Plans***

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.

***xi. Preparing effectively for norovirus.***

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

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

**4 Governance**

A detailed rolling action log will be maintained and updated at the Operational Management Group, and a report analysing the activity, performance and pressures will be provided at the end of the winter planning period.



**West Dunbartonshire  
Health & Social Care Partnership  
Winter Plan  
2016/17**

## Introduction

Health and Social Care Partnerships (HSCPs) have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHS GG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period. These plans will cover:

- The community service aspects of the six essential actions (Appendix 1).
- Delayed discharge.
- Measures to reduce admissions and attendances.
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care.
- Continuity and resilience.
- Developing an agreed set of indicators to monitor performance.
- Planning with GPs for the two long bank holidays.

This Winter Plan identifies and addresses the local issues across the primary care and community services for which the West Dunbartonshire Health and Social Care Partnership (WDHSCP) is responsible, to support the NHS GG&C whole system planning as detailed above.

## Winter Planning Arrangements

A Winter Planning Group has been established and meetings are taking place regularly and report to the WDHSCP 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. The detailed plan is attached.

CORE TASKS	ACTIONS
<p><b>1. Safe &amp; effective admission / discharge continue in the lead-up to and over the festive period and also into January.</b></p>	<p><b>1 Admission Avoidance</b></p> <ul style="list-style-type: none"> <li>☐ Our Community Nursing teams use <i>Patient Status at a Glance</i> 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.</li> <li>☐ 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.</li> <li>☐ 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.</li> <li>☐ 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.</li> <li>☐ 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.</li> <li>☐ 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</li> <li>☐ Contracts with independent providers of Homecare services include monitoring their capacity for delivering services as commissioned.</li> <li>☐ Locality Groups will continue to work in partnership with GPs, Acute Services, Independent</li> </ul>

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**

- 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). 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. These include additional homecare, respite, nurse led beds in local care homes and step up/down placements.
- 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 Services and the Scottish Ambulance Service. Our extended Palliative Care Team (Nursing, Homecare and Pharmacy) provide additional support.
- Our community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period.
- Additional equipment and supplies are ordered and available for clinical staff.
- Our 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 a 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 NHS health care 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 occupational therapy, physiotherapy, nursing, social work, homecare 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 mental health officer (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 Services for patients delayed whilst awaiting legal powers and these will be active when resident medical officer (RMO) cover is advised by Acute Services.

<p><b>2. Workforce capacity plans &amp; rotas for winter / festive period agreed by October.</b></p>	<p>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 following the four day holiday periods.</p>
<p><b>3. Whole system activity plans for winter: post-festive surge.</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> The HSCP will contribute to the NHSGG&amp;C whole system activity planning and ensure representation at winter planning groups.</li> <li><input type="checkbox"/> The HSCP Chief Officer links with NHSGG&amp;C Acute Division and other Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.</li> <li><input type="checkbox"/> Situation reports (SITREPs) will be shared between the Community and Acute Services to inform escalation pressures.</li> </ul>
<p><b>4. Strategies for additional winter beds and surge capacity.</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> The HSCP will respond where possible to support Acute Services in managing surge capacity.</li> <li><input type="checkbox"/> Our Hospital Discharge Team will provide services between the public holidays to support surge activity.</li> <li><input type="checkbox"/> Additional capacity to respond to particular increases in service demand can be resourced from the wider local teams if required.</li> <li><input type="checkbox"/> Additional care at home respite and nurse-led beds will be available over the period.</li> </ul>
<p><b>5. The risk of patients being delayed on their pathway is minimised.</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Our single point of access (SPOA) will be fully resourced to accept referrals.</li> <li><input type="checkbox"/> All referrals are assessed and allocated daily.</li> <li><input type="checkbox"/> Patients identified by our early assessor team will have care packages in place timeously.</li> <li><input type="checkbox"/> Access to rehabilitation and nursing services will be available throughout the period.</li> <li><input type="checkbox"/> Our Homecare Services are managed alongside district nursing services and home based</li> </ul>

	pharmacy support to ensure continuity of care post discharge.
<b>6. Discharges at weekend &amp; bank holiday.</b>	<ul style="list-style-type: none"> <li>□ Our 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.</li> </ul>
<b>7. Escalation plans tested with partners.</b>	<ul style="list-style-type: none"> <li>□ Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues.</li> <li>□ 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 that put a strain on GP services.</li> <li>□ Our 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.</li> <li>□ Commissioned services have emergency arrangements 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.</li> </ul>
<b>8. Business continuity plans tested with partners.</b>	<ul style="list-style-type: none"> <li>□ Business Continuity Plans (BCPs) are in place across HSCP services and shared with locality representatives.</li> <li>□ Managers have been asked to review their individual BCP service plans by November 2016.</li> <li>□ 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.</li> <li>□ 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.</li> </ul>

<b>9. Preparing effectively for Norovirus</b>	<p>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.</p>
<b>10. Delivering Seasonal Flu Vaccination to Public and Staff</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> All health care and homecare staff have been offered vaccination.</li> <li><input type="checkbox"/> All health care 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.</li> <li><input type="checkbox"/> Our Community Nursing Service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination</li> <li><input type="checkbox"/> Health care staff are actively encouraged to be vaccinated, with local peer vaccination sessions will be provided in all Health Centres.</li> </ul>
<b>11. Communication to Staff &amp; Primary Care Colleagues</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> The HSCP will ensure information and key messages are available to staff through communication briefs, team meetings and electronic links.</li> <li><input type="checkbox"/> The HSCP will circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices.</li> <li><input type="checkbox"/> The HSCP will 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 NHS GG&amp;C.</li> <li><input type="checkbox"/> Information regarding GP availability throughout the festive period will be provided through the NHS GG&amp;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 HSCP Clinical Director will re-enforce these messages to GP Practices.</li> </ul>
<b>12. Effective analysis to plan for and monitor</b>	<p>The actions set out in this Winter Plan will be monitored and analysed to identify and potential</p>

<p><b>winter capacity, activity, pressures and performance</b></p>	<p>improvements to inform future predictive modelling and planning.</p> <p>Particular measures that will be monitored include:</p> <ul style="list-style-type: none"> <li>• Bed days lost to delayed discharge.</li> <li>• Bed days lost to delayed discharge for adults with incapacity (AWIs).</li> <li>• A&amp;E attendances.</li> <li>• Emergency admissions all ages.</li> <li>• Emergency Admission age 65yrs+.</li> <li>• Emergency admissions age 75yrs+.</li> <li>• Percentage uptake of flu vaccinations by staff.</li> <li>• Percentage uptake of flu vaccinations by GP population.</li> <li>• Referrals to Rapid Response and Rapid Assessment Link team.</li> <li>• Referrals to Hospital Discharge Team and time to assessment and provided care.</li> <li>• Demand and capacity on community services, including GP practices, and community health services.</li> </ul>
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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.

APPENDIX 8

AGENDA ITEM No. 6



<b>Meeting of East Renfrewshire Health and Social Care Partnership</b>	Integration Joint Board (IJB)
<b>Held on</b>	25 November 2015
<b>Agenda Item</b>	6
<b>Title</b>	Winter Plan

<b>Summary</b>  <p>Scottish Government has issued guidance to ensure that Boards are fully prepared for this winter in order to minimise any potential disruption to patients and carers. Each Health and Social Care Partnership within the NHS Greater Glasgow &amp; Clyde area has a critical role in the wider health care service system. This plan sets out local preparations for winter 2015/16. The report also informs the IJB about unscheduled care planning being undertaken by four task and finish 'Safe and Supported' work groups using improvement methodology, these include:</p> <ul style="list-style-type: none"><li>a) Prevention and Anticipatory Care</li><li>b) Point of Possible Admission</li><li>c) During Admission</li><li>d) Discharge from Hospital</li></ul>			
<b>Presented by</b>	Frank White, Head of Health and Community Care  Candy Millard, Head of Strategic Services		
<b>Action Required</b>  <p>The IJB is asked to note the unscheduled care planning arrangements in place to support the wider health system over the winter period.</p>			
<b>Implications checklist – check box if applicable and include detail in report</b>			
<input checked="" type="checkbox"/> Financial	<input checked="" type="checkbox"/> Policy	<input type="checkbox"/> Legal	<input type="checkbox"/> Equalities
<input type="checkbox"/> Efficient Government	<input checked="" type="checkbox"/> Staffing	<input type="checkbox"/> Property	<input type="checkbox"/> IT

**EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP**

**INTEGRATION JOINT BOARD**

**25 NOVEMBER 2015**

**Report by Julie Murray, Chief Officer**

**WINTER PLAN**

**PURPOSE OF REPORT**

1. To inform the Integration Joint Board (IJB) about unscheduled care planning and preparations for winter.

**RECOMMENDATION**

2. The IJB is asked to note the unscheduled care planning arrangements in place to support the wider health system over the winter period.

**BACKGROUND**

3. Scottish Government has issued guidance to ensure that Boards are fully prepared for this winter in order to minimise any potential disruption to patients and carers. Each Health and Social Care Partnership within the NHSGGC area has a critical role in the wider health care service system. It has been agreed through the NHSGGC whole system planning group that

each Partnership will produce a local unscheduled care plan with a particular focus on the winter period. These plans should cover:

- The community service aspects of the 6 essential actions (Appendix 1)
  - Delayed discharge
  - Measures to reduce admissions and attendances
  - Delivery of key service features including single point of access, Care Home support and Anticipatory Care
  - Continuity and resilience
  - Developing an agreed set of indicators to monitor performance
  - Planning with GPs for the two long bank holidays
  - Local Improvement
  - Local Communications
4. The following report sets out local planning arrangements and planned actions under the twelve key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20). The relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance* (Appendix1) are covered within the twelve themes.

## **REPORT**

### Planning Activity

5. 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.
6. In addition, planning for delayed discharge and unscheduled care had already been identified as a priority area by the Strategic Planning Group. It approved the establishment of four distinct task and finish 'Safe and Supported' work groups using improvement methodology. These include:
- a) Prevention and Anticipatory Care
  - b) Point of Possible Admission
  - c) During Admission
  - d) Discharge from Hospital
7. 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 task 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

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

### Admission Avoidance

8. 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 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 provide immediate access to preventative supports and care packages. This includes access to step up care home respite with rehabilitation support.

### Anticipatory Care Planning

9. 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.

#### Expediting Discharge from Hospital

10. 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.

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

11. 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.

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

12. 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.

13. 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***

14. 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.

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

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

***xviii. Discharges at weekend & bank holiday***

16. The Community Nursing service, Telecare responder 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***

17. 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.
18. 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.

***xx. Business continuity plans tested with partner***

***Draft winter plan – version 3 –14/10/16***

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

20. 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.

***xxi. Preparing effectively for norovirus***

21. Information for Care Homes will be shared by the Independent Sector Integration Lead and the established Care Home Providers Forum.

***xxii. Delivering Seasonal Flu Vaccination to Public and Staff***

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

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

***xxiii. Communication to Staff & Primary Care colleagues***

24. 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 NHS GG&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***

25. 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)

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

## **FINANCE AND EFFICIENCY**

27. The HSCP has received £537,000 to support winter and delayed discharge planning. Expenditure to date has been on additional inreach and stepdown capacity. The Safe and Supported programme of work will prioritise additional areas for investment.

## **CONSULTATION**

28. The work has built on considerable consultation and engagement through the 'Better by Design' with people who have recent experience of discharge. 'Safe and Supported' workstreams will report back to a stakeholder event on 10 December, where improvement and investment proposals will be prioritised.

## **PARTNERSHIP WORKING**

29. The 'Safe and Supported' workstreams include partnership representation from planning partners, working together to improve unscheduled care.
- People who use services and unpaid carers;
  - Third and independent sector providers,
  - Acute hospital clinicians and discharge professionals
  - Social work and home care;
  - Nurses, AHPs and other professional groups;
  - GP locality links and CHCP RES locality managers

## **IMPLICATIONS OF THE PROPOSALS**

### Policy

30. This report sets out the local response to Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20). The relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance* (Appendix1).

### Staffing

31. The requirement to ensure adequate home care cover for the festive period and sufficient post festival assessment capacity will impact on the capacity of certain service areas to grant leave. Managers will work with staff to ensure duty rotas are effectively and fairly managed.

## **CONCLUSIONS**

32. East Renfrewshire Health and Social Care Partnership has prepared this plan in response to Scottish Government guidance to ensure that Boards are fully prepared for this winter in order to minimise any potential disruption to patients and carers. The plan sets out local preparations for winter 2015/16, building on CHCP experience of previous winters. Additional unscheduled care planning is underway with four partnership task and finish 'Safe and Supported' groups using improvement methodology:
- a) Prevention and Anticipatory Care
  - b) Point of Possible Admission
  - c) During Admission
  - d) Discharge from Hospital

## **RECOMMENDATIONS**

33. The IJB is asked to note the unscheduled care planning arrangements in place to support the wider health system over the winter period.

## **REPORT AUTHOR AND PERSON TO CONTACT**

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October 2015

**BACKGROUND PAPERS**

[National Unscheduled Care Programme: Preparing for Winter 2015/16 \(DL \(2015\) 20.](#)  
[Scottish Government 6 Essential Actions to Improving Unscheduled Care Performance](#)

**KEY WORDS**

Winter plan; delayed discharge; unscheduled care; hospital discharge; improvement

A report to inform the Integration Joint Board about unscheduled care planning and preparations for winter 2015/16.

## *Renfrewshire HSCP - Winter Plan 2016/17*

### APPENDIX 9

#### 1. Introduction

Health and Social Care Partnerships (HSCPs) have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHS Greater Glasgow and Clyde (GGC) whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period. These plans will cover:

- The community service aspects of the 6 essential actions (Appendix 1)
- Delayed discharge
- Measures to reduce admissions and attendances
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care
- Continuity and resilience
- Developing an agreed set of indicators to monitor performance
- Planning with GPs for the two long bank holidays

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 Royal Alexandra Hospital (RAH). It will be reviewed and monitored on an ongoing basis by the HSCP Senior Management Team.

## 3. Renfrewshire Actions Against the Scottish Government Key Themes

Scottish Government Key Themes	Renfrewshire Actions
Safe and Effective Admission and Discharge	<p><u>Avoiding Admission</u></p> <p>Three RDP projects will continue throughout the winter period. In particular, the older adults' assessment unit supported by the in reach Community Out of Hours (OOH) Service and the chest pain assessment unit will be supported to prevent unnecessary admissions. There is an ongoing funding challenge as no additional resources have been put in to support these initiatives.</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>We will review the data to 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 liaison nurses, community Rehabilitation and Enablement Services (RES) and our older adults liaison nurse to target those care homes.</p> <p><u>Safe and Effective Admission and Discharge</u></p> <p>We will use TQA data from ISD and PAR reports to support practices and clusters to reduce performance outliers.</p> <p>We will explore the possibility of supporting residential homes which now accommodate more unwell residents with our liaison nurses.</p> <p>We carried out a pilot of referrals to RES from four Scottish Ambulance crew members for non-conveyed fallers which has just been extended to 8-10 SAS crews. The pilot has been extended but results are not significant.</p> <p>We will continue to remind GPs about the need to update the Key Information Summary (KIS), and to ensure their Anticipatory Care Plans are completed and clearly signposted.</p> <p>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.</p> <p>Our district nurses (DNs) will support the national campaigns offering advice to patients</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>with chronic conditions.</p> <p>We will share information about community pharmacy services and times with Homecare staff and with the local Accident and Emergency (A&amp;E) department.</p> <p><u>Safe Discharge</u></p> <p>We will continue our existing good practice re discharge planning and avoiding lost bed days supported by a comprehensive social and health care response.</p> <p>The RAH target is to increase throughput in the Discharge Lounge to 400 patients per month; with referrals from all specialties on the site being encouraged. The lounge is available 5 days per week from 8am –8pm. The Lounge will have capacity for patients on trolleys which will help patients getting home quicker. The satellite dispensary facilities will mean patients can go to the lounge earlier in the day and the pharmacy will have access to pharmacy packs and controlled drugs, as appropriate. These enhanced facilities will help to free beds earlier in the day and mean that a wider range of patients can make use of the facilities. If funding becomes available the RAH would look to open the Lounge on Sunday over winter.</p> <p>We will use Darnley Court as a step-down facility for AWI patients, freeing up capacity in acute inpatient beds.</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>We will continue to participate in the daily huddle meetings at the RAH and have extended this participation to include mental health and addictions. We will formalise and share the key messages/outputs of these meetings appropriately to promote whole system working. Any communication to GPs will be agreed at these meetings.</p> <p>The RAH target for the Transport Hub is for throughput of 400 patients per month. The transport is provided by Red Cross and SAS and there is a range of vehicles available to the team. The transport service is available 7 days per week from 7am – 7pm, with call handlers supporting the service 5 days and Bed Manager covering transport decisions at weekends to support weekend discharges. Referral to the Transport Hub is from inpatient areas and ED: the latter reducing the ED patients waiting for transport. We will also look to support Inreach Service if they require assistance with transport.</p> <p><u>Mental Health Inpatients ( Adult)</u></p> <p>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. Noro virus, influenza etc. Annual leave will be managed across the winter and festive period to ensure sufficient staffing to manage demand. The pattern of</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>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.</p> <p><u>Community Mental Health Service</u></p> <p>Intensive Home Treatment Team will provide 24 hour 7 day week provision for emergency Mental health assessment and treatment to both community and the Emergency Department within the RAH. These services will be in place over the festive period. The Intensive Home Treatment Team will provide public holiday cover during the festive period.</p> <p>Community Mental health teams will operate throughout the festive period with skeleton staff during public holidays to facilitate discharge and prevent admission</p> <p>The services above receive referrals from Primary Care, Liaison Psychiatry and secondary Acute services.</p> <p><u>Out of Hours Arrangements</u></p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>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.</p> <p><u>Acute Hospital Liaison</u></p> <p>Liaison Psychiatry Services are provided 5 days a week to Royal Alexandra Hospital by Psychiatric Liaison Nurse services. Intensive Home Treatment Team provide mental health assessment of patients for deliberate self-harm over weekends and public holidays.</p>
Workforce Capacity Plans and Rotas	<p>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.</p> <p>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</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>allocate annual leave on a weekly basis as demand and capacity are reviewed.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p><u>Severe Weather/Transport</u></p> <p>Within Mental Health Services, there is now access to some vehicles which will be fitted with winter tyres. Should it be required Adverse Weather policy will be used re staffing contingency arrangements. The Adverse Weather policies (NHS and Council) will be re-circulated to staff.</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p><u>Senior Staff Arrangements – Psychiatry</u></p> <p>Arrangements to ensure that senior staff are on-call and available over the festive period are in place. The on-call information will be held at each hospital and the centralised telephone service.</p>
<p>Whole System Activity Plans – post Festive surge</p>	<p>A joint meeting of the acute and community service managers is planned for the end of October.</p> <p>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.</p>
<p>Strategies for Additional Winter Beds and Surge Capacity</p>	<p>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, Allied Health Professionals (AHP) and medical cover (both money and people) within available resources.</p>
<p>Risk of Patients being delayed on their Pathway is Minimised</p>	<p>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.</p>

Scottish Government Key Themes	Renfrewshire Actions
Discharges at Weekends and Bank Holidays	<p>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).</p> <p>We have identified the need for the Adult Services Referral Team (ASeRT) service to be available for the extra Social Work bank holiday. This will have a financial implication.</p> <p>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.</p>
Escalation Plans tested with Partners	<p>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.</p>
Business Continuity Plans tested with Partners	<p>We have reviewed and updated current business continuity plans in health and social care services. All services have a robust business continuity plan which will be tested in January 2017. Our Clinical Director will remind GPs about need to have robust business continuity plans, as he visits practices.</p>

Scottish Government Key Themes	Renfrewshire Actions
	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 and GGC wide Norovirus Escalation plan will be followed.
Delivering Seasons Flu Vaccination to Public and Staff	<p>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.</p> <p>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.</p>
Communication to Staff and Primary Care	<p>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 2016/17.</p> <p>We will use the planned meeting in November with the 29 Integration Liaison GPs and the GP Forum on 24<sup>th</sup> 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.</p> <p>We are exploring a system of using group text messaging to communicate simultaneously</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>with large staff groups.</p> <p>The availability and access to Mental Health Services is included in the Greater Glasgow &amp; Clyde Board's public communication information issued for the festive period.</p> <p>We will develop, with acute colleagues, a briefing for GPs to make clear the routes into and services available at the RAH. This will include the times services are available, and will remind GPs of the advantages of admission early in the day.</p>
<p>Effective Analysis to Plan for and Monitor Winter Capacity, Activity, Pressures and Performance</p>	<p>Key indicators:</p> <ul style="list-style-type: none"> <li>- Bed days lost due to delayed discharge</li> <li>- Bed days lost due to delayed discharge (AWI)</li> <li>- Emergency admissions 75+</li> <li>- Uptake of flu vaccinations (staff)</li> <li>- Uptake of flu vaccinations (GP population)</li> <li>- Referrals to services which prevent admission.</li> </ul> <p>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.</p> <p>In the event of exceptional circumstances such as a flu pandemic/ norovirus/extreme weather conditions then there would be additional costs associated with staff cover including overtime and other costs.</p>

<b>Scottish Government Key Themes</b>	<b>Renfrewshire Actions</b>

APPENDIX 10

Inverclyde HSCP

HSCP Winter Planning Work Plan 2016/17

Alan Brown, Service Manager

Updated 24/09/2016

Key Issues	Status & Issues	Task	Lead	Progress
Ensure community services are available when required	Clear Service Pathways are in Place Process of referral and response is timely	Established Direct Access Point for community Services in particular out of hours Out Of Hours pathway finalised	EC	Completed
	Ensure up to date information re access to service is available	Update information sheet with 2 main contact numbers <ul style="list-style-type: none"> <li>• Office Hours (ACM 01475 715010)</li> <li>• Out with Office Hours (DN OOH)</li> </ul> Information supplied to partners of community based services		5/10/2016  31/11/2016

Operational Discharge Meeting is attended by key operational individuals including community Leads who assist in planning discharge of complex cases	ODM to be arranged	AB	31/10/2016
	Report into WPDP (Winter Plan Data Pack) Include discussion of HC packages including restarts Agreed process require to update HC by Tue lunchtime Information around hospital admissions Need to check if home care info is being communicated to wards on		in place
Homecare has a fast flexible service to respond to referrals and discharge on a enablement model	Identify potential pressure on service	JA	completed
	Advise of HC service over Winter/Holidays Referral Process for discharge prior to Festive period		31/10/2016
The Community Nursing service and Homecare service provide a service 24 hours, 365 days per year inclusive of	These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.	A Best	In place

	bank public holidays.			
<b>Focussed recovery from periods of limited cover</b>	HSCP Rotas over winter period to be confirmed	Based on previous years CACM/ Duty cover IRH in terms of back up & support	AB	31/11/2016
		Arrange Annual Leave for period to ensure sufficient cover		
	CACM duty rota to cover peak holiday period and January 16 (Dec15 -Jan 16)	Home Care Reablement RES District Nurses Liaison Nurses	AB	
	Peer immunisation clinic	HSCP Staff are actively encouraged to be vaccinated and local peer vaccination sessions were organised	TB	31/10/2016 Passed to communication teams
Access to Joint Store	CIL Access Point in place Social Work Occupational Therapy is staffed week days 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.	JA	In place	

<b>Planning GPs cover for 2 bank holiday periods</b>	GP practices will put in contingency arrangements for winter period	AB to liaise with Pauline for arrangements by GP's over Dec/Jan	PA	<p>Raised with practice managers and GP forum by Oct 2015</p> <p>PA to link with Practice Managers to confirm BCP</p>
		practices to ensure their business continuity plans are up to date and that emergency contact details are accessible in the event of an incident		
		<p>GPs will implement suggested contingency arrangements over the festive period as per LMC guidance. In addition</p> <p>Practices will advise Patients of closure via SOLUS Screens and also prompt patients to order prescriptions in advance.</p>		
<b>Service Capacity</b>	Home Care capacity	Exception reporting agreed to be included in Winter Plan Data Pack	AB	In Place
	Care Home Capacity is monitored daily with pressures identified	Link with care home providers to maintain daily reports around pressure	AB	In place
	Equipment Stock Take	A predictive stock order of essential equipment will be submitted early November to ensure availability of supplies for the Community Home Care teams during	JA	31/10/2016

		the holiday period.		
		A predictive stock order of essential equipment from 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.	A Best	31/10/2016
	Care Homes have BCP in place	Identified at Governance Meetings  AB email Care Homes requesting confirmation of BCP in place	AB	31 October 2016
<b>Prioritising emergency patients</b>	Currently have early identification in IRH	Managed through weekly Operational Discharge Meeting early identification of potential discharge  Meeting attended by Acute and Comm Staff	AH	In place
		Increase access to read only SWIFT in wards  Plan to include A/E  In progress for Wards J and Lakefield Unit	AB	Review by 31/10/2016
		Identify discharge of New Home care packages	JA	In place

	<p>Early identification process of vulnerable people at risk of admission to IRH in community</p>	<p>Criteria for identification of most vulnerable adults at risk of admission</p> <p>Mental Wellbeing</p> <p>Il health/elderly carer</p> <p>Complex cases</p>	<p>AB</p>	<p>Review 31/10/2016</p>
		<p>Development of Friday Allocation Meetings to identify capacity issues complex cases</p>	<p>AB</p>	
		<p>The Community Nursing teams introduce <i>Patient Status at a Glance Team have daily meetings update</i>. details of vulnerable patients as well as patients with changing needs. To identify those at risk of admission. The nurses will link with GPs and HCC to identify patients who may potentially be vulnerable during the winter period</p>	<p>A Best</p>	<p>In Place</p>
		<p>The Home Care/ Social Work team maintain a note of vulnerable people known to them living in the community. Link with OPMHT to ensure list is updated Identification or flag on SWIFT</p>	<p>JA</p>	<p>31/10/2016</p>
		<p>Contacts with private providers of Homecare services include monitoring their capacity for delivering services as commissioned.</p>		<p>31/10/2016</p>

		<p>Team leaders Home Care/ACM?DN speaking to managers about identifying critical cases</p> <p>Note local up to date information is vital and require facility to add to WPDP</p>		
		<p>Review role of Fast Track Assessment service</p> <p>Identify use, capacity and effectiveness of fast track clinic.</p> <p>Develop strategic approach to development of service alongside gerontology role</p> <p>Gerontology nurse is now seeing increased numbers of patients in community working as part of RES</p>	EC	Review 31/10/2016
	Health Improvement	Link to GCC generic information and add local focus	AH	Review 31/10/2016
<b>Reducing Numbers</b>	Early identification of patients requiring supported discharge	<p>Home First Action Plan is moving towards achieving 72 hour target</p> <p>Recorded as part of performance</p>	AB	Review 31/10/2016
<b>Reduce Admissions</b>	Step Up Beds –	In place continue pilot over winter period	EC	Review at 31/10/2016
	Through the Night care teams in place and functioning	Link with OOH DN service	EC	
<b>Single Point of Access</b>	Discharge Team/CACM now have single point of access based at GHC	<p>Ensure contact information is circulated</p> <p>Generic email to be created for CACM</p>	AB	Review resource requirement 31/10/2016

		Ensure telephone contact is available		
<b>Care Home support</b>	HSCP Governance arrangements with Care Homes established.  Care Home Providers Forum in place  Enablement input to Nursing Homes	Liaison Nurses/ AHP peer group agreed to support work with care homes identification of residents at risk of admission  Explore fast track discharge for existing residents liaison between ward and home	TB	Review 31/10/2016
<b>Anticipatory Care</b>	ACP in place for residents in care homes	Access to ACP	A Best	Review 31/10/2016
<b>Capacity for AWI Patients</b>	MHO rota in place and increased capacity of MHO service	Monitor the impact of AWI on IRH	CG	Review 31/10/2016
	Early identification of AWI issues on wards with TL CMHT attending ODEM			Review 31/10/2016
<b>Equipment</b>	Fast Track in place for discharge  Joint Store single access in place	Access to equipment out with working hours.  A stock of equipment is left at several points across Inverclyde and there is the provision of a folding hoist and slings based within the community alarm team.  The district nursing service also holds moving and handling equipment, mattresses, commodes etc.  The main sites where equipment is stocked are within	DM	Review 31/10/2016

		<p>Greenock Health Centre and at Hillend House although there is also a stock at IRH OT department and the Larkfield Unit.</p> <p>This is a long standing arrangement between services. The Joint Equipment store staff ensures that equipment is always stocked at these venues.</p> <p>This allows for 24 hour access to equipment if required.</p> <p>The Occupational Therapy service has a Response team that respond to urgent requests for equipment within 24 hours Mon-Fri. This service often follows up where equipment is provided out with working hours to allow for a more comprehensive assessment of the home environment.</p>		
<b>In reach to Hospitals</b>	Home First Action Plan	A District Nurse and OT in reach have been appointed to facilitate communication between Acute and Community and assist assessment and support planning for quicker discharge home	AB	Review 31/10/2016
<b>Rehabilitation</b>	Home First Action Plan	<p>Establish the principle of assessment at home</p> <p>Use of OPDG to develop this</p> <p>Discharge Performance is good</p>		
		RES team specialist input around COPD	JA	Review 31/10/2016
		Falls pathway in place and linked to initial referral to HSCP to take preventative approach.		

<b>Develop agreed indicators to monitor performance</b>	keep current PI so to compare performance on DD bed days lost	Staffing numbers capacity	EC	Review 31/10/2016
		Outcomes for step up to be determined		
		Identify escalation point and triggers- agree when and how huddle information should be escalated		
		Contingency plan for weekly meeting over winter period to evaluate performance and risk management	AB	
		Develop Data Capture Tool	DP	
		Produce weekly data pack	RM	
		Link this date to IRH daily Huddle information	AB	
		Capacity of services reported weekly HSCP Team leaders will report every Friday with pressure on service, availability and absence	Service managers	
<b>Develop local communications plan</b>	<p>Communication to Staff &amp; Primary Care Colleagues</p> <p>To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;</p> <p>Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links</p>	<p>Winter Planning to be on agenda at HSCP communication group</p> <p>Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices</p> <p>Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP,</p>	AB	<p>HSCP communications group in place to coordinate communication</p> <p>Review 31/10/2016</p>

		<p>Primary Care colleagues and NHSGG&amp;C Board.</p> <p>Information regarding GP availability throughout the festive period will be provided through the NHSGG&amp;C Winter Booklet.</p> <p>Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices.</p> <p>The Clinical Director will re-enforce these messages to GP Practices.</p>		
	Advice to Patients with chronic conditions on source of help	<p>Public Health information to be circulated</p> <p>Local Contacts to be included</p> <p>Link to communication Plan</p> <p>Link to CR Plan on preparing for Winter Link to GCC generic information and add local</p>	AH	Review 31/10/2016
	Twice daily huddle established in IRH	Identify how HSCP can input to Huddle during this time as well ODM	AH	Discharge Team Lead attend Huddle daily
	Advice to Patients with chronic conditions on source of help	<p>Public Health information to be circulated</p> <p>Link to communication Plan</p> <p>Link to CR Plan on Preparing for Winter</p>	focus on winter issues	AB/AH Review 31/10/2016

		Local Contacts to be included		
		Comms plan to be refreshed		

