NHS Greater Glasgow & Clyde

NHS Board Meeting

Deputy Medical Director **15 August 2017** **Paper No: 17/39**

Unscheduled Care - Update, Governance and Programme Plan

Recommendation:-
It is recommended that the contents are noted by the board following agreement at the Unscheduled Care Collaborative Steering Group meeting on the 03/08/17.

Purpose of Paper:-
The following provides a summary of the UCC Governance structure effective from August 2017 onwards. It embodies the recommendations made by the NHS Scotland Director of Performance in the Scottish Government's *6-Essential Actions for Unscheduled Care* forward plan for 2017/2018 and reflects a system wide accountability to improve the boards unscheduled care performance.

The paper also contains the NHSGGC and HSCP unscheduled care high level programme plans that have been developed to drive forward the improvement activity to ensure the governance structures can effectively monitor the programme of work.

Key Issues to be considered:-

- Proposed approaches to improving unscheduled care performance
- Proposed delivery of unscheduled care change

Any Patient Safety /Patient Experience Issues:-
Yes

Any Financial Implications from this Paper:-
Yes

Any Staffing Implications from this Paper:-
Yes

Any Equality Implications from this Paper:-
No

Any Health Inequalities Implications from this Paper:-
No

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-
No

Board Official

Highlight the Corporate Plan priorities to which your paper relates:-
Improved Unscheduled Care Performance

Author – David Stewart
Tel No – 0141 201 0674
Date – 08/08/17

NHS GGC Unscheduled Care Governance Structure Summary – 2017/2018

As outlined in the Unscheduled Care Review Report presented to board 27/06/17, and in agreement with senior NHSGGC and HSCP representatives at the GGC UCC Steering Group meeting 03/08/17, NHSGGC is implementing a new structure to govern the UCC programme and direct all future UCC improvement activities.

The governance structure for the future of the unscheduled care programme, effective from August 2017 onwards, embodies the recommendations made by the NHS Scotland Director of Performance in the 6-EA forward plan for 2017/2018 and reflects a system wide accountability to improve the boards unscheduled care performance. It also reflects the development of more effective joint working relationships between health and social care partners with a greater emphasis on local governance arrangements.

It is anticipated that by revising the governance structure in this way, it will better enable NHSGCC to meet the key 2017/2018 board objectives of:

- Delivering the 4 hour target at 90% level across all sites and to agree and implement trajectories to move towards the 95% level
- Redesigning the service across hospital, care home and community settings to reduce inappropriate use of hospital services, with a view to reducing demand by 10% this year
- Delivering a 10% reduction in unscheduled bed days through the implementation of the Unscheduled are Programme to reduce admissions and to ensure the timely discharge of patients from hospital

NHSGGC and HSCP unscheduled care programme plans have been developed to drive forward the improvement activity and to ensure the governance structures can effectively monitor the programme of work. The cross system plans will allow the NHSGGC and HSCP partners to deliver on a consistent programme of work to achieve common improvement objectives as indicated in **figure 1**.

Figure 1 – Graphical representation of NHSGGC/HSCP cross system plans

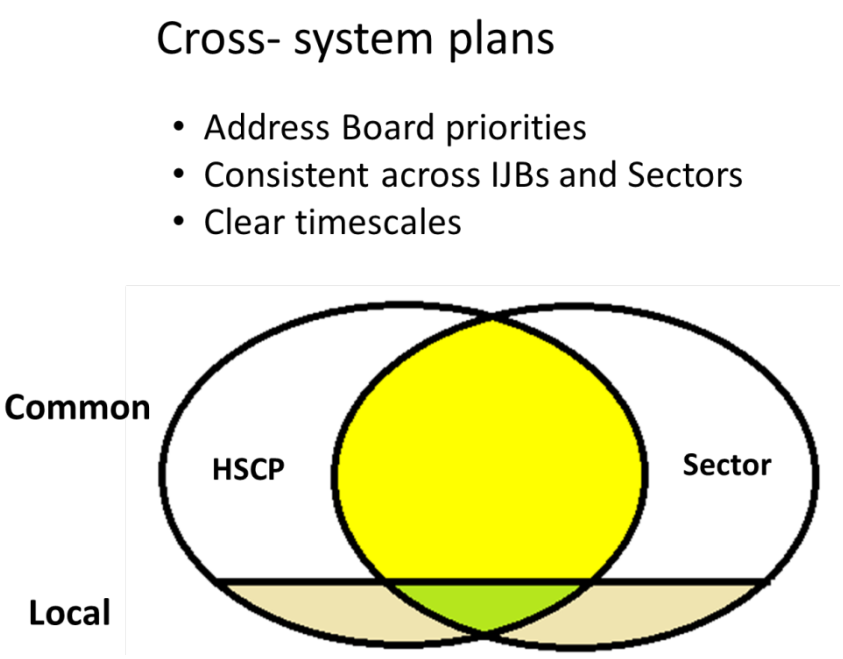
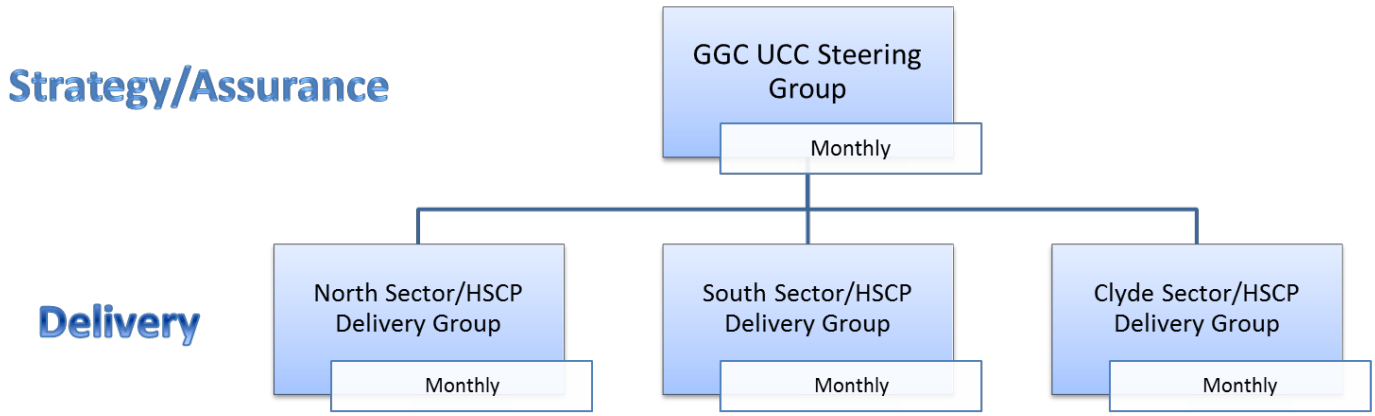


Figure 2 – Revised 2017/2018 UCC governance structure



While the high level structure and oversight hierarchy is outlined in **figure 2**, the role each group will play in the delivery of the UCC programme and their anticipated membership is detailed below.

UCC groups definition, membership and objectives

The revised governance structure will see NHSGGC and HSCPs jointly accountable for the strategic direction of the unscheduled care programme. This collaboration is reflected in the membership and objectives of the UCC Steering group, with its emphasis on delivering change to achieve the 95% national performance standard, improving the patient experience across all hospital sites and reduce demand.

UCC Steering Group (monthly)

Overall Purpose
High level strategic oversight and ownership of the board UCC programme.
Objectives
• High level strategic direction setting • Oversight, scrutiny and challenge • Senior programme sponsorship • Financial support and planning • Development of links between NHSGGC and HSCPs on areas of potential collaboration • Delivery of Winter plan
Membership
• Chief Executive (Chair) • Chief Operating Officer • IJB representation (x2/3) • Medical Director • Nursing Director • Deputy Medical Director (UCC Programme Director) • UCC Programme Manager

- Business Intelligence
- North Sector
- South Sector
- Clyde Sector
- *Additional attendees based on meeting relevance*
    - Public Health
    - Finance
    - Scottish Ambulance Service
    - NHS 24
    - IT services
    - Planning

***Scottish Government colleagues will be updated on the outcomes of meeting through a monthly briefing of UCC steering group meeting outcomes**

At sector level, local teams will fulfil the vision of the UCC steering group through their Sector/HSCP delivery groups. In addition, they will drive an element of local innovation and improvement work as appropriate to support the goals of the programme of work.

The recommended compositions of these groups are outlined below and again the joint NHSGGC-HSCP responsibility for the delivery of the local unscheduled care programmes is reflected.

UCC Sector/HSCP Delivery Group (monthly)

Overall Purpose
Sector level oversight and management of the delivery of local UCC programme.
Objectives
• Oversee the delivery of the UCC Programme within each sector • Supporting the development and delivery of sector projects • Identifying opportunities for future improvements • Capturing baseline data • Gap analysis and service/process review • Developing and review tests of change • Delivering planned improvements • Maintaining Sector/Project Plans • Local Innovation and Leadership
Membership

• Chief of Medicine
• Sector Director
• HSCP representation
• Senior sector Management
• Senior sector clinicians
• *Additional attendees based on meeting relevance*
  o UCC Support team
  o Scottish Ambulance Service
  o NHS24

NHS GGC Unscheduled Care Governance Structure Summary – 2017/2018

The above governance structure will also be supported in the delivery of the UCC programme by the UCC Board Programme Delivery Team. The team will be led by the Deputy Medical Director and continue to co-ordinate and support the boardwide unscheduled care agenda, as directed by the UCC Steering Group.

Additional resources will also be co-opted as required from Planning, Public Health, eHealth and Business Intelligence, Clinical eHealth, Practice Development, Clinical Governance and Organisational Development to support the delivery of the programme on a workstream by worksteam basis.

Theme of change	Aligned 6EA*	Project	HSCP Initiative Links	Lead	Expected Benefits	Timescale	Status Update
UCC Improvement timeline **Implementation of UCC Final Report Recommendations**							
Alternatives to admission	EA2 EA4 EA6	**Introduce Ambulatory Emergency Care pathways at all major acute sites to reduce avoidable admissions** **Phase 1 - Identification, development and introduction of high volume conditions** -Cellulitis -Chest Pain -COPD -Abdominal Pain -Frailty	•Potentially avoidable admissions •Frailty Review •Reduce admissions from care homes and directly provided residential homes •Alternatives to referral to GP Assessment Unit/ A&E •ALOS in Acute hospitals post-admission •Unscheduled care pathway •Reduction in bed days	**Overarching project lead** - David Stewart Site/condition specific leads determined locally	Reduction in potentially avoidable admissions in main acute sites. The Total AEC Combined ED and AU Opportunity across NHSGGC equates to over 8,000 patients per year broken down by site as follows: -QEUH 5,325 -GRI 844 -RAH 2,059 Top 19 conditions equates to 91% of the total opportunity presented via AEC pathways, allowing targeted pathway development in both the 1st and 2nd phase of the project. This also links to the board priorities of delivering a 10% reduction in UC beds and redesigning hospital services to reduce UC demand by 10% in 2017/18.	Jun - Sept 17	•Boardwide pathway development and introduction underway at QEUH, GRI and RAH sites.
		Introduce Ambulatory Emergency Care pathways at all major acute sites to reduce avoidable admissions **Phase 2 (Oct - Dec17) - Identification, development and introduction of low volume conditions.** Conditions to be determined based on local priorities from September onwards				Sept - Dec 17	
ED Processes	EA2 EA4 EA5 EA6	**Ringfencing minor patient pathways** **-Review of minors pathways and infrastructure** **-Implement changes to ensure minor pathway are protected**	•Potentially avoidable admissions •Alternatives to referral to GP Assessment Unit/ A&E •Redirection from A&E •Unscheduled care pathway	**Site Specific Lead -** L.Dunipace/J. Smart/R. Coulthard	Protecting minor patient pathways will enable a protected flow 1 even on busy days, minimising breaches and ensuring patients are treated in a timely manner. This links with the board priority of delivering the 4 hour target at 90% level across all sites	Jun - Sept 17	•Minor patient pathway pathways ringfencing underway
		Implementation of Triage+ at acute site front door		**Site Specific Lead -** L.Dunipace/ A.Ireland/A. Corfield	Triage plus implementation allows enhanced streaming of patients attending ED, ensuring patients get the most appropriate care earlier and unnecessary admissions where appropriate. This links with the board priority of delivering the 4 hour target at 90% level across all sites, delivering a 10% reduction in UC beds and redesigning hospital services to reduce UC demand by 10% in 2017/18.	July - Oct 17	•Review of Triage+ complete •Phased site implementation of Triage+ concept underway
Management of current inpatient capacity	EA2 EA3 EA4 EA5	**Exemplar Wards**	•Delayed Discharges •Older people system of care •Improving discharge process •Transport •ALOS in Acute hospitals post-admission •Reduction in bed days	**Site Specific Lead -** P.McInnes/ G.Mooney /C. Clark	Reducing the LOS of admitted patients and facilitating their transfer out of hospital to home, or an alternative community service. Increasing pre-noon Discharge to over 40%. Increase weekend discharges This links with the board policy of delivering a 10% reduction in UC beds.	Feb - Sept 17	•EQ concept introduced at QEUH and GRI sites. Pilot of EW-like concept ongoing at RAH
		Criteria Led Discharge		**Site Specific Lead -** P.McInnes/ G.Mooney /C. Clark		Feb - Oct 17	•Introduced in QEUH stack, other wards to follow •GRI and RAH introduction of CLD as test of change, full site implementation to follow.
		Hub Concept		**Site Specific Lead -** M.Carr/ J.Stuart /C. Clark	Improved management of inpatient capacity to help facilitate discharges. This links with the board policy of delivering a 10% reduction in UC beds.	Mar - Aug 17	•Discharge hub introduced at RAH •Flow/discharge hub concept review/development underway at QEUH and GRI.

		Day of Care Survey		**Site Specific Lead -** P.McInnes/ G.Mooney /C. Clark	Inform acute sites of key inpatient metrics to promote increased discharges from acute sites, and aligns with board priorities of delivering a 10% reduction in UC beds and redesigning hospital services to reduce UC demand by 10% in 2017/18.	Apr - Sept 17	•GRI and QEUH DoC strategy planned •RAH evaluation of DoC benefits ongoing
Reduction in Demand	EA6	**Redesign the service across hospital, care home and community settings**	• Reduce inappropriate use of hospital services	**HSCP's**	target to reducing demand by 10% this year.	Aug - Mar 17	•HSCP's currently reviewing demand profile and work commencing
Escalation	**EA1**	**Sector Level Escalation Protocol**	**•Alternatives to referral to GP Assessment Unit/ A&E •Redirection from A&E •Performance management •Unscheduled care pathway**	**Site Specific Lead -** A. Harkness/J.Stuart/M. Farrell	**Escalation protocol provides a framework to aid in managing capacity and patient throughput in times of reduced patient flow, as well as a clearly communicated message of current status to partner services e.g. SAS.**	Apr - July 17	•Sector level escalation policy's developed
		Boardwide Escalation Protocol		J. Best/D. Stewart	**This links with the board priority of delivering the 4 hour target at 90% level across all sites.**	Aug - Sept 17	•Boardwide policy in development
eHealth	**EA2** **EA4** EA6	**NHSGGC performance metrics dashboard**	•Potentially avoidable admissions •Reduce admissions from care homes and directly provided residential homes •Delayed Discharges •Improving discharge process •Alternatives to referral to GP Assessment Unit/ A&E •ALOS in Acute hospitals post-admission •Performance management •Reduction in bed days •Unscheduled care pathway •Evaluation framework	A. Noonan	All eHealth projects have been commissioned to support better ways of working for clinical and non clinical staff in acute and non acute settings. They all contribute to the board priorities of delivering the 4 hour target at 90% level across all sites, delivering a 10% reduction in UC beds and redesigning hospital services to reduce UC demand by 10% in 2017/18.	May - Jun 17	•Complete
		ED Trak model in AUs		M. Rodgers		Aug 16 -Apr 17	•Complete
		AU Microstrategy Dashboard		S. Hatrick		Mar - May 17	•Complete
		Trak Supporting Icons		/		Jun - Sept 17	•Development underway by eHealth dept.
		NEWS and GAPS autoc capture and display		M. Rodgers		Jun - Sept 17	•Development underway by eHealth dept.
		Develop ED flow algorithm		A. Noonan		May - Jun 17	•Development underway by eHealth dept.
		Live Bed State - 'hub concept (QEUH only)		M. Carr		Jul - Sept 17	•Draft concept prepared. eHealth options included in concept paper.
Governance	**EA1**	**Unscheduled care programme governance**	•Primary / Secondary care clinical interface •Unscheduled care programme governance •Evaluation framework	D. Stewart	Robust programme management arrangements to ensure delivery of expected programme benefits	May -Aug 17	•Draft governance arrangements produced and discussed •HSCP method of involvement in GGC UC programme to be confirmed
Future/Other developments	**NA**	**Royal College visits**	NA	J. Best	Supply external appraisal of sector level unscheduled care programmes to informal service improvement	Jun -Aug 17	•QEUH visit complete •GRI and RAH visits to be confirmed

***Scottish Government's 6 Essential Actions to improve unscheduled care**	
EA1	Each major site will have a management team made up of a hospital manager and a senior doctor and senior nurse with the autonomy to manage all patient workload – elective and emergency. This is to ensure that each patient is seen by the right person at the right time in the right environment. This team will be expected to manage the internal and external clinical relationships and work with the new Integrated Joint Boards to improve patient care links.
EA2	Each hospital will develop a balanced elective and emergency patient capacity management plan. That will be used to manage patient flow 365 days of the year. This should include whole system capacity, including community resources
EA3	Patient rather than bed management – empowering and enabling specialty teams to get the right balance between patients arriving and being discharged each day, including weekends
EA4	Improving patient flow between emergency departments and acute medical and surgical units and downstream specialty wards
EA5	Focus on primary and secondary care seven day services that maintain people in their own home and promote early appropriate discharge
EA6	Realign existing services across primary and secondary care to safely maintain patients in their own home