

NHS Board Meeting

Medical Director/  
Interim Chief Operating Officer for  
Acute

17 October 2017

Paper No: 17/53

**Winter Plan 2017/2018**

**Recommendation:-**

The Board is asked to note the significant work undertaken across the Acute Division and HSCPs in preparation for the winter period and approve the Winter Plan – 2017/18.

**Purpose of Paper:-**

The Board is required to provide assurance on preparations for the forthcoming winter period. The Scottish Government issued 'Preparing for Winter 2017/18 [DL (2017)19] in August providing clear guidance for the format and content.

Winter plans should provide safe and effective care for people using services and should ensure effective levels of capacity and funding are in place to meet expected activity levels. Underpinning the guidance is the importance of a collaborative approach to planning across local systems, building Out Of Hours capacity, improving delayed discharge and the Six Essential Actions Improvement Programme

This paper sets out the arrangements made to prepare for the Winter 2017/18 and provide the necessary assurance for the Board and Scottish Government.

**Key Issues to be considered:-**

The paper sets out NHSGGC cross system planning to address winter pressures.

The six Health and Social Care Partnerships have reviewed and developed their Winter Plans for sign off by their respective Integrated Joint Boards. The Acute Division has developed its Winter Plan within the Sector Management Structures

The Co-Chaired Sector Delivery groups, supported by pre-existing Acute/HSCP locality arrangements, have provided the forum to ensure collaboration, provide assurance and sign off arrangements within the broader governance of the Unscheduled Care Steering Group.

**Any Patient Safety /Patient Experience Issues:-**

Yes. This paper is focussed on the delivery of safe and effective care for patients.

**Any Financial Implications from this Paper:-**

Yes. Proposals for additional surge capacity will be subject to available funding over the winter period. Elements of the communications plan will require funding.

**Any Staffing Implications from this Paper:-**

Yes. There is a need for staffing plans (to be complete by end of October 2017) to confirm effective rota and minimise avoidable dependence on bank/agency staff.

**Any Equality Implications from this Paper:-**

None specified.

**Any Health Inequalities Implications from this Paper:-**

None specified.

**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-**

Risk assessment is an integral part of this planning process.

**Highlight the Corporate Plan priorities to which your paper relates:-**

Improving quality, efficiency and effectiveness.

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**Date:** 12<sup>th</sup> October 2017

# **Winter Plan 2017/18**

**NHS Greater Glasgow & Clyde**

**October 2017**

## **Introduction**

1. The Board is required to provide assurance on preparations for the forthcoming winter period. The Scottish Government issued 'Preparing for Winter 2017/18 [DL (2017)19] in August providing clear guidance for the format and content.
2. Winter plans should provide safe and effective care for people using services and should ensure effective levels of capacity and funding are in place to meet expected activity levels. Underpinning the guidance is the importance of a collaborative approach to planning across local systems, building Out Of Hours capacity, improving delayed discharge and the Six Essential Actions Improvement Programme.
3. Plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Plans should also have senior joint sign-off reflecting local governance arrangements and should be published online.
4. This paper sets out the arrangements made to prepare for the Winter 2017/18 and provide the necessary assurance for the Board and Scottish Government. A core principal underpinning these arrangements is that management of unscheduled care is core business. The winter period tests resilience with periods of heightened challenge where contingency for additional service is necessary. Core delivery is dependent on effective operation of process, structure and resource that is in place all year round.

## **Context & Governance**

5. NHS GG&C has set itself key objectives for 2017/2018 of:
  - Delivering the 4 hour target at 92% 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 Care Programme to reduce admissions and to ensure the timely discharge of patients from hospital
6. NHS GG&C has delivered against the 4 hour Emergency Access Standard an average monthly performance of 92.2% (September 2015 to August 2017). This has been variable across sites and a continued focus is necessary to deliver sustainable improvement towards the 95% target.

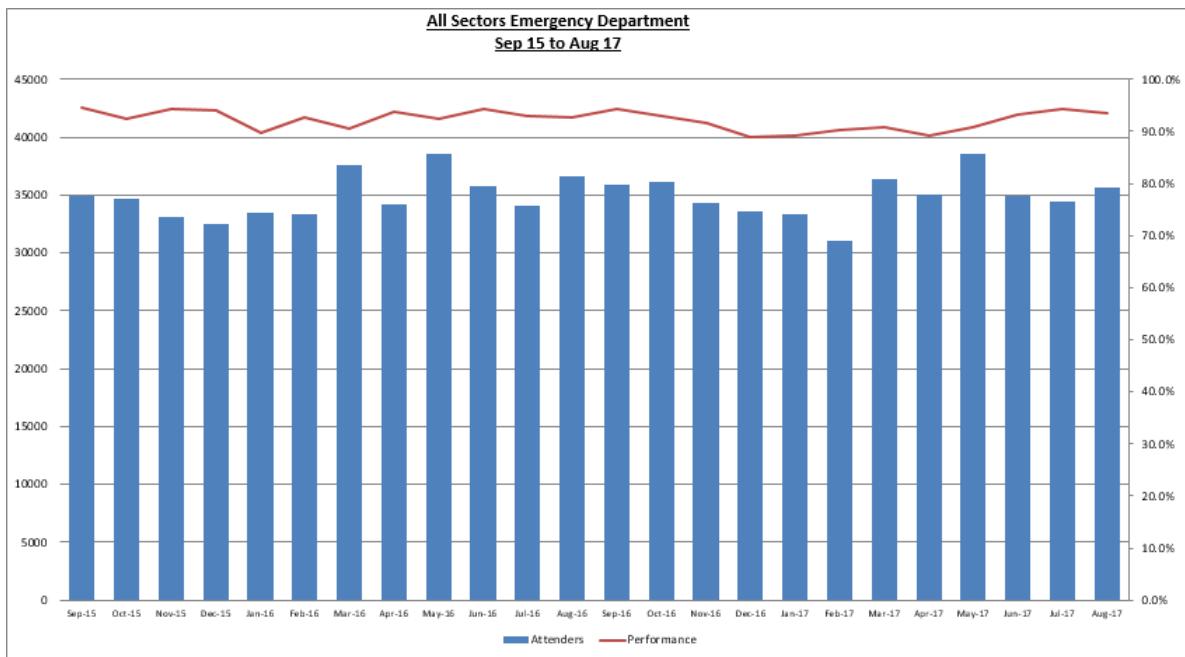


Figure 1: NHS GG&C Performance against 4hr A&E Standard [incl. RHC].

7. Last year, the Board established new governance arrangements for Unscheduled Care led by the Chief Executive. The aim was to deliver a systematic review of Unscheduled Care across NHS GG&C. In May 2017, the review formally presented its recommendations to the NHS GG&C Board.
8. The initial focus of work undertaken by the Unscheduled Care Programme centered on patient flow within the acute hospital setting, embedding the principles of the Six Essential Actions. As our performance against the 4hr A&E standard indicates, this is still the priority. The focus has also been extended further to address demand for acute care by strengthening ambulatory pathways and support out of the hospital setting in the community. Critical to this is collaborative work across health and social care, with revised structures of governance.
9. The revised governance arrangements now ensure integrated working at a strategic and operational level between the Acute Division of the Board and its HSCP partners. At Sector level, the Delivery groups will now be co-chaired by Acute and HSCP Directors strengthening integrated working on a geographic basis.
10. The Co-Chaired Sector Delivery groups will focus primarily on driving forward the improvement plans on patient flow and pathway redesign. [Appendix 1: Unscheduled Care Board-wide Programme attached].

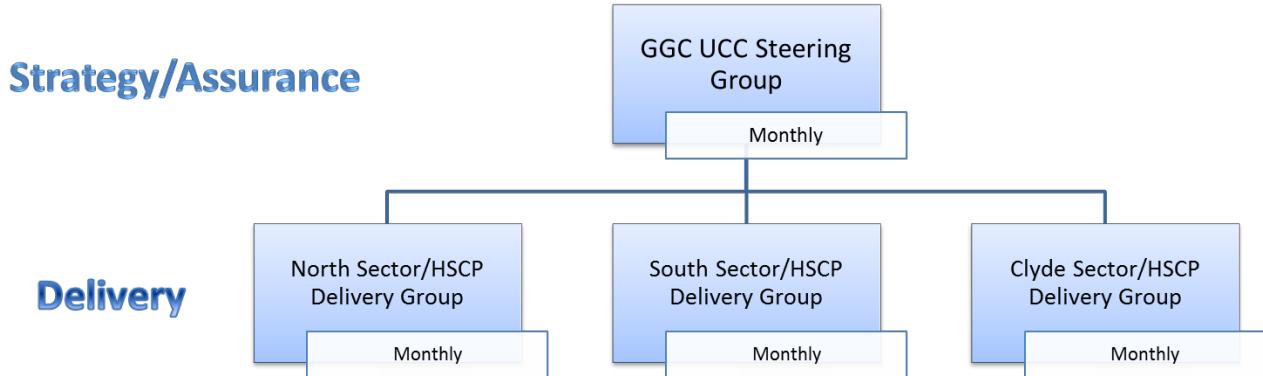


Figure 2: Revised 2017/18 UCC Governance Structure

11. The six Health and Social Care Partnerships (HSCPs) have reviewed and developed their Winter Plans for sign off by their respective Integrated Joint Boards. The Acute Division has developed its Winter Plan within the Sector Management Structures.
12. The Co-Chaired Sector Delivery groups, supported by pre-existing acute/HSCP locality arrangements, have provided the forum to ensure collaboration, provide assurance and sign off arrangements within the broader governance of the Unscheduled Care Steering Group.

### **Critical Areas, Outcomes and Indicators**

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

13. Across NHSGGC and the HSCPs business continuity plans have been reviewed during the summer months following the Manchester bombing and the temporary move to critical alert.
14. Flu Pandemic plans have been revised and updated in preparation for the winter. Working with the Civil Contingencies and Public Health department, HSCPs and the Acute Division built on learning from the national Silver Swan exercise, recognising that the response to a pandemic is multi-agency. All multi-agency plans work within Local Resilience Partnerships.

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

15. Acute Sector level Escalations plans have been developed and are being finalised. Remaining work is focused on sensitising the trigger points informed by indicators of patient flow and pressures with critical actions required at each stage. There are existing communication processes to escalate with partners across the system.
16. In the Acute Division, from November management teams will step up to enhanced winter cover arrangements. Each Sector has empowered and clinically engaged local site management with a duty manager of the day focused on managing and coordinating services across the hospital system focused on delivering safe high quality care. There is on site management at weekends and Public Holidays; a senior manager on call overnight and weekends with enhanced nursing also in place in evenings and weekends. These arrangements link in with the HSCP locality management structures to ensure systems for dialogue and escalation across the whole system.

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

17. Over the summer months, the concept of a 'Flow Hub' has been developed with the aim of establishing a 'control centre' for decision making. Making full use of Trakcare and live digital reporting, this approach will facilitate direction and co-ordination of operational services – a key component of the Six Essential Actions priority of managing the 'in/out balance'. This is now in place at the Queen Elizabeth University Hospital (QEUh), Glasgow Royal Infirmary (GRI), and Royal Alexandria Hospital (RAH) and will be in place at the Inverclyde Royal Hospital (IRH) by the end of this month.
18. The Sector Delivery groups continue to focus on the improvement work which includes embedding the exemplar Ward concept to improve patient flow and provide structure to the day to-day ward routine.
19. The Board's approach to Criteria led discharge (CLD) has received national commendation and is in place across the majority of medical and surgical wards and all Acute Receiving Units. Extension to Elderly Medicine is underway, with consideration of how this will interplay with the frailty service. A learnpro module on CLD to provide additional support to staff will be fully implemented imminently, embedding best practice in management of patient flow and effective discharge.
20. Pathways to better manage the care and early supported discharge of frail elderly patients have been established at QEUh, GRI and RAH. Glasgow HSCP has agreed to augment the pathways at QEUh and GRI by providing additional AHP, Social Work and Homecare support staff to work with the established teams. This is designed to improve the effectiveness and quality of discharge planning, avoiding unnecessary admissions and shortening length of stay. Although provided by Glasgow HSCP, this service will be available to all appropriate patients regardless of postcode. This initiative will start by the end of October.
21. All HSCPs arrangements recognise that pressures are no longer confined to the Winter Period but experienced throughout the year. HSCP plans reflect the integrated 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. Key elements of these are Anticipatory Care Planning, Admission Avoidance (including Medicines Management) and Expediting Hospital Discharge.
22. All HSCPs have driven forward anticipatory care planning, including engaging with GPs so that completed anticipatory care plans are uploaded onto the electronic information system, (eKIS) so can be utilized by Acute colleagues. Scottish Ambulance Service is also engaged with HSCPs to ensure that their staff making use of the information that eKIS provides in support of this.
23. HSCP District Nursing teams support an early alert system that enables 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.
24. HSCPs have taken forward work to improve access to services to people with Frailty and improve the experience and outcomes for people identified as frail following assessment and/or review.

25. The core business of HSCP services is focused on responding to urgent and unscheduled events. All areas have reviewed readiness and resilience in order to step up to the Winter challenges:

- All Mental Health Services across Greater Glasgow and Clyde provide Out of Hours services with referrals from the GP Out of Hour service, Emergency Departments and NHS 24. These services have reviewed readiness in preparation for the winter period.
- HSCP Prescribing Teams are working to support patients and care staff – in their own homes or in care homes – to manage their medicines and improve compliance, as part of enabling self-care and to reduce hospital admissions for avoidable medication related issues.
- HSCPs have developed their District and Community Nursing teams alongside their social care teams (e.g. homecare, telecare and telehealth) to 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 - supported safe and effective hospital discharges during weekends and holidays. In addition, HSCP hospital discharge staff work to identify residents on admission to hospital and proactively plan for their discharge (including prior to and over festive holiday periods).

26. HSCPs continue to balance developing and delivering service arrangements that are appropriate to their local areas alongside operating as an effective and important element of the overall NHSGGC system. New ways of working (such as the Liaison Psychiatry example below) and responding to these pressures with the Acute division and local partners are being tested in each of the six HSCP areas. These are reported to their respective Integration Joint Boards; and details can be provided if required for different areas.

*Liaison Psychiatry Services are provided 7 days a week to Acute Hospitals by HSCP Psychiatric Liaison Nurse services, including health assessment of patients for deliberate self-harm over weekends and public holidays within the acute medical wards. As part of the Mental Health Unscheduled Care review, from November a pilot programme within GRI and QEUH will address existing gaps in liaison services to the Emergency Departments.*

### **Strategies for additional surge capacity across Health & Social Care Services**

27. Our winter escalation process builds contingency for a daily Director level conference call between the Acute Division and the HSCPs. This will be enacted in the event of surges in pressure developing in any part of the broader system to ensure all parties are sighted and respond without delay. This sits across the Winter Management arrangements described earlier in this document.

28. Over the last two years, the volume of Unscheduled Admissions has increased at a rate of 2% across NHS GG&C. Fluctuations month by month show considerable variation but a rolling 3 month average enables some observable patterns to emerge (figure 2):

- The increase is pronounced during the Winter periods
- Noticeable increase between 2016 Winter period and 2017 Winter period
- In 2016, there were two surges in demand: during the Festive period and later in March/April

- In 2016, demand increased steadily in the run up to the Festive periods, followed by a fall in January then peak in February 2017.
- Fall in demand during summer months (May to Sep), particularly this year

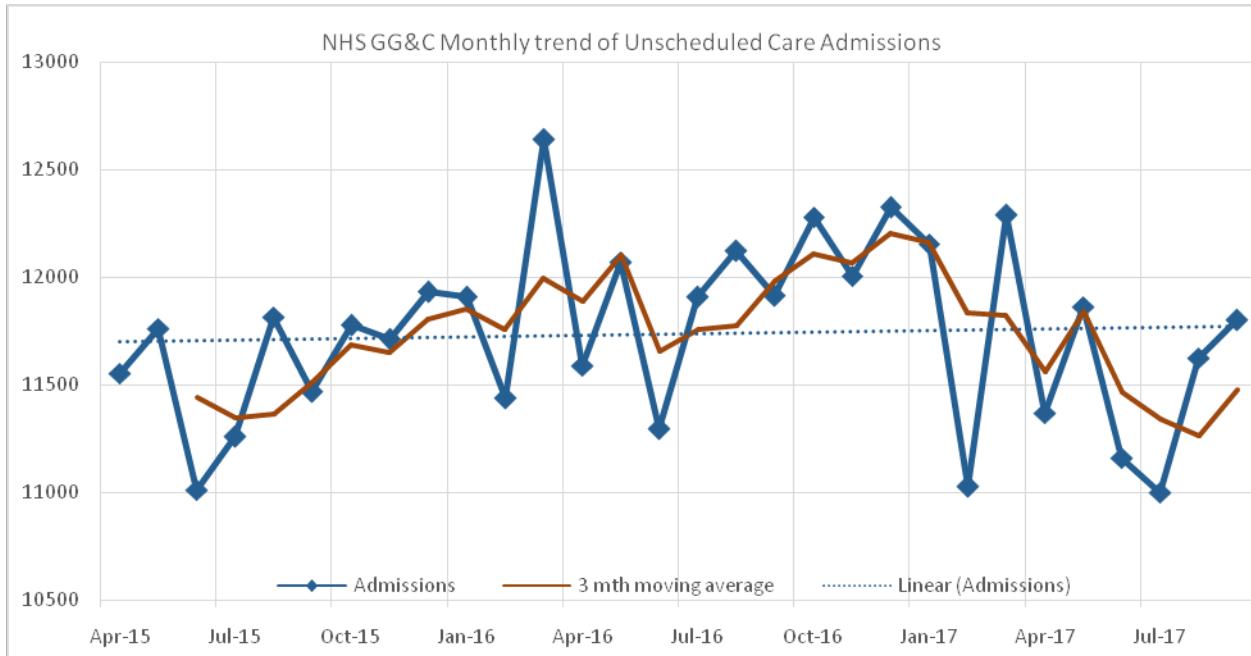


Figure 2: Monthly trend of Unscheduled Care Admissions

29. However when similar analysis is conducted at site level there are local differences from these Board-wide observations requiring more nuanced sector responses, for example

- The QEUH has experienced a sustained trajectory of a 4% increase in admissions since it opened in June 2015 whereas the profiles for the GRI and RAH follow a more expected seasonal pattern.

30. This local variation demonstrates the importance of sector/locality level plans but also the need for integrated Board level working to enable cross sector support. It is also clear from a 2 year 'look back' that trends are an insufficient guide to confidently model contingencies hence sectors have considered scenarios with different ranges of demand (eg. 2% - 6% increases).

31. Informed by the analysis described above and from experience of what worked in previous years, each Sector has plans in place to extend capability to respond to expected surges in demand. A winter fund of approximately £1.5m will be invested in key measures to strengthen resilience and capacity. The detail of how this allocation is distributed is still being finalised but will cover the themes described below.

Assessment Capacity
Extending medical staffing in A&E and Assessment Units
Strengthening the seniority of Clinical Co-ordination and Flow Management
Enhancing Nursing Cover across all 'front doors'
Flow Management

Additional Nursing to support 'huddle' management & discharge out of hours
AHP capacity to expedite assessment, treatment and discharge planning
Boarding teams
Optimise Capacity
Additional Bed Capacity
Enhanced Medical HDU cover
Support Staff to ensure rapid turnover of beds
Admission Avoidance/Discharge
Nurse Bank Pool
AHP target teams
Discharge Lounge
Extended Pharmacy cover
Additional Ambulance Transport

32. Within HSCPs, services 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.
33. As befits their integrated nature, HSCPs have budgeted for additional demands for care home and care at home places over the winter period. HSCPs have worked with local external providers of social care to ensure there is sufficient capacity over winter, with potential to spot purchase additional intermediate care placements to relieve any surge in appropriate referrals from the acute system.
34. HSCPs are working with Red Cross transport – supporting admission avoidance from A&E from the main acute hospital sites over the winter period– to widen the scope of their support to improve on admission avoidance or to support discharge planning.

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

35. Pathway Development – we have established a number of pathway projects sponsored by HSCP Chief Officers to deliver improved system wide pathways for Frailty, COPD, Abdominal Pain and Mental Health. The collaboration between HSCP's, Community, Acute and Partner services will ensure we develop enhanced, integrated pathways that provide the most appropriate emergency/urgent care for our patients by the right team, in the right place at the right time.
36. Assessment of the new Frailty Service at the QEUH showed that compared to all reference periods, there a reduction in Length of Stay (LOS) across Medicine for the Elderly and the Receiving Unit.
37. HSCPs have taken forward developments to support more holistic and co-ordinated palliative care, including working with local hospices and training activity with care homes.

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

38. The analysis referred to above informs planning for elective capacity over the winter period. Arrangements are in place to protect elective flow. During the festive period and its immediate aftermath, Elective activity will be:

	Date	
Festive Period	Fri 22 Dec	Trauma & Emergency, elective cancer, urgent & long waiting patients
	Sat 23 Dec	Trauma & Emergency
	Sun 24 Dec	Trauma & Emergency
	Mon 25 Dec	Trauma & Emergency
	Tue 26 Dec	Trauma & Emergency
	Wed 27 Dec	Trauma & Emergency, elective cancer, urgent & long waiting patients
	Thu 28 Dec	Trauma & Emergency, elective cancer, urgent & long waiting patients
	Fri 29 Dec	Trauma & Emergency, elective cancer, urgent & long waiting patients
	Sat 30 Dec	Trauma & Emergency
	Sun 31 Dec	Trauma & Emergency
	Mon 01 Jan	Trauma & Emergency
	Tue 02 Jan	Trauma & Emergency
<b>January</b>		Trauma & Emergency, elective cancer, urgent & long waiting patients (with a focus on short stay surgery in the early weeks of January)

Table 2: Elective Plans for Festive Period

39. The Acute Division and HSCPs have effective processes for monitoring demand, patient flow and performance. Reporting systems have been reviewed and a dashboard agreed through the Unscheduled Care Steering Group.

40. Regular 'Day of care' audits are now established across all major acute sites to provide baseline information on bed utilisation and inform the development of both in and out of hospital solutions to minimise in-patient delays. The most recent audit (10<sup>th</sup> October) indicated 14% of patients did not meet Day of Care criteria with the main reasons for delay in discharge identified being:

- Waiting social work allocation/assessment
- Waiting for AHP assessment/treatment
- Waiting MDT decision

Actions are being taken to address these issues.

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

41. Staffing plans will be completed by the end of October, confirming effective rota and minimizing avoidable dependence on bank/agency staff.

## **Discharges at weekends & bank holidays**

42. Sector Delivery groups continue to focus on improvement work, embedding the appropriate aspects of the 6 EA Programme. This includes ensuring Estimated Discharge Dates (EDDs) for all patients, continual push on discharge earlier in the day, expediting Immediate Discharge Letters (IDLs) and supporting pharmacy to reduce delays in discharge prescriptions.

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

43. Sector Delivery groups continue to focus on improvement work, embedding the appropriate aspects of the 6 EA Programme. Examples of pathway development include:

- Focus on high volume pathways to reduce short stay (Zero/1 Day) Inpatient episodes by providing alternatives to admission.
- Introduce a dedicated emergency pathway for frail elderly patients utilising early Frailty Screening, Comprehensive Geriatric Assessment and appropriate resources to achieve early discharge
- Develop ambulatory care pathways that begin in the community for high volume conditions initially targeting Acute Abdominal Pain, Chest Pain, Cellulitis, Self-Harm, Falls and Seizure & COPD

44. Emergency Department Processes are now targeting achievement of 100% compliance for Minor Injury patient flows on every site as routine performance. We will continue to monitor demand from West Glasgow and be in readiness to respond to pressures should they arise over the Winter Period.

45. Early senior clinical input and diagnostic screening to support decision making and improve the effectiveness of patient streaming ('Triage Plus') has been put in place at the Emergency Department 'front door'.

46. Early bed requesting – was tested and implemented in July, it is now in place across all Sectors for acute admissions.

## **Communication plans**

47. All year round, NHSGGC promotes "Know Who To Turn To" messages on our corporate social media platforms. 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:

- Winter special edition of Health News, our digital magazine, will be published in November to 20,000 subscribers with key messages about winter health and self-care, accessing services over the holiday period and flu vaccination messages. This will be

promoted also via Facebook and twitter (combined direct audience of a further 20,000 followers).

- Winter booklet on accessing services over the holiday season will be produced in print and online. 80,000 copies are distributed to GP surgeries, dentists, pharmacies and opticians and the online version is published on our website and via social media. The online version is also shared with our health and social care partnerships and NHS 24 to promote on their websites. The publication of the booklet will be accompanied by a media release.
- We will support the national flu campaign with local press releases and case studies. We will work with the Board's Immunisation Programme Manager on a staff campaign to increase uptake of the flu vaccination programme amongst healthcare workers. This was launched in October 2017.
- A proactive media statement will be issued to all media before the holiday period signaling that we expect to be busy and asking people only to attend Emergency Department (ED) if it is an emergency. This worked well last year and created a better opportunity to set the media tone rather than reactive statements responding to variation in performance.
- Our communications escalation plan will allow us to respond to service pressures and support colleagues in managing demand; we can issue urgent messages to the public, to GPs, to staff to respond to situations as they emerge if necessary.
- We will deliver an on-air and online radio campaign on KWTTT, urging patients only to attend ED if it's an emergency. This campaign runs for a two week period and achieved a significant reach last year.

### **Preparing effectively for Norovirus**

48. The NHSGG&C norovirus policy has been updated this year to include the management of norovirus within single room accommodation. The Standard Operating Procedure (SOP) is fully compliant with recommendations contained within the National Infection Prevention and Control Manual (NIPCM).
49. Trends continue to be monitored daily with reporting to Directors, Chiefs of Nursing, Chiefs of Medicine and the Nurse Director for Partnerships. Outbreaks are reported as required within chapter 3 of the NIPCM.
50. Access to IPCT advice during incidents and outbreaks is available on the desktop of all PCs. Season start memo with links to guidance and education is issued for both norovirus and influenza.

### **Delivering seasonal flu vaccination to public and staff.**

51. We aim to achieve the 50% target vaccination rate for staff. The flu vaccine will be offered to all staff working within high risk areas either by peer immunisation delivered within their department or by attending one of the mass clinics within their hospital site. Clinical managers have been asked to encourage staff to attend for their vaccine.

52. In line with recommendations in Chief Medical Officer (CMO) Letter (2017) clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. Clinics are delivered on all main hospital sites and within the larger health centres in central locations during normal working hours. Peer immunisation is being encouraged for clinical staff to receive the vaccination at a convenient time and location.
53. In the event of a surge of flu activity the subsequent increase in vaccination requirements will be accommodated by additional clinics and increased access to clinical areas. Flu plans are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods.

### **Conclusion & Recommendation**

54. The Board is requested to note and take assurance from the significant work done across the Acute Division and HSCPs to prepare for the Winter Period and approve the Winter Plan - 2017/18.
55. This work has been co-ordinated within the new governance arrangements of the Unscheduled Care Steering Group, facilitating joint working at locality levels between HSCPs and the Acute Sectors. These arrangements will continue through the Winter Period, strengthening partnership working at all levels.

Theme of change	Aligned 6EA*	Project	HSCP Initiative Links	Expected Benefits	Timescale	Status Update
UCC Improvement timeline						
Implementation of UCC Final Report Recommendations						
Alternatives to admission	EA2 EA4 EA6	<p>Introduce Ambulatory Emergency Care pathways at all major acute sites to reduce avoidable admissions</p> <p>Phase 1 - Identification, development and introduction of high volume conditions</p> <ul style="list-style-type: none"> <li>-Cellulitis</li> <li>-Chest Pain</li> <li>-COPD</li> <li>-Abdominal Pain</li> <li>-Frailty</li> </ul> <p>Introduce Ambulatory Emergency Care pathways at all major acute sites to reduce avoidable admissions</p> <p>Phase 2 (Oct - Dec17) - Identification, development and introduction of low volume conditions.</p> <p>Conditions to be determined based on local priorities from September onwards</p>	<ul style="list-style-type: none"> <li>Potentially avoidable admissions</li> <li>•Frailty Review</li> <li>•Reduce admissions from care homes and directly provided residential homes</li> <li>•Alternatives to referral to GP Assessment Unit/ A&amp;E</li> <li>•ALOS in Acute hospitals post-admission</li> <li>•Unscheduled care pathway</li> <li>•Reduction in bed days</li> </ul>	<p>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:</p> <ul style="list-style-type: none"> <li>-QEUH 5,325</li> <li>-GRI 844</li> <li>-RAH 2,059</li> </ul> <p>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.</p> <p>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.</p>	Jun - Sept 17  Sept - Dec 17	Phase 1 complete Phase 2 - Boardwide pathway development and introduction underway at QEUH, GRI and RAH sites.
ED Processes	EA2 EA4 EA5 EA6	<p>Ringfencing minor patient pathways</p> <ul style="list-style-type: none"> <li>-Review of minors pathways and infrastructure</li> <li>-Implement changes to ensure minor pathway are protected</li> </ul> <p>Implementation of Triage+ at acute site front door</p>	<ul style="list-style-type: none"> <li>Potentially avoidable admissions</li> <li>•Alternatives to referral to GP Assessment Unit/ A&amp;E</li> <li>•Redirection from A&amp;E</li> <li>•Unscheduled care pathway</li> </ul>	<p>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.</p> <p>This links with the board priority of delivering the 4 hour target at 90% level across all sites</p> <p>Triage plus implementation allows enhanced streaming of patients attending ED, ensuring patients get the most appropriate care earlier and unnecessary admissions where appropriate.</p> <p>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.</p>	Jun - Sept 17  July - Oct 17	<ul style="list-style-type: none"> <li>•Minor patient pathway pathways ringfencing underway</li> </ul> <ul style="list-style-type: none"> <li>•Review of Triage+ complete</li> <li>•Phased site implementation of Triage+ concept underway</li> </ul>
Management of current inpatient capacity	EA2 EA3 EA4 EA5	Exemplar Wards	<ul style="list-style-type: none"> <li>•Delayed Discharges</li> <li>•Older people system of care</li> <li>•Improving discharge process</li> <li>•Transport</li> <li>•ALOS in Acute hospitals post-admission</li> <li>•Reduction in bed days</li> </ul>	<p>Reducing the LOS of admitted patients and facilitating their transfer out of hospital to home, or an alternative community service.</p> <p>Increasing pre-noon Discharge to over 40%.</p>	Feb - Sept 17	<ul style="list-style-type: none"> <li>•EQ concept introduced at QEUH and GRI sites. Pilot of EW-like concept ongoing at RAH</li> </ul>
		Criteria Led Discharge		<p>Increase weekend discharges</p> <p>This links with the board policy of delivering a 10% reduction in UC beds.</p>	Feb - Oct 17	<ul style="list-style-type: none"> <li>•Introduced in QEUH stack, other wards to follow</li> <li>•GRI and RAH introduction of CLD as test of change, full site implementation to follow.</li> </ul>
		Hub Concept		<p>Improved management of inpatient capacity to help facilitate discharges.</p> <p>This links with the board policy of delivering a 10% reduction in UC beds.</p>	Mar - Aug 17	<ul style="list-style-type: none"> <li>•Discharge hub introduced at RAH</li> <li>•Flow/discharge hub concept review/development underway at QEUH and GRI.</li> </ul>

		Day of Care Survey		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	target to reducing demand by 10% this year.	Aug - Mar 17	Complete
Escalation	EA1	Sector Level Escalation Protocol	<ul style="list-style-type: none"> <li>•Alternatives to referral to GP Assessment Unit/ A&amp;E</li> <li>•Redirection from A&amp;E</li> <li>•Performance management</li> <li>•Unscheduled care pathway</li> </ul>	<p>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.</p> <p>This links with the board priority of delivering the 4 hour target at 90% level across all sites.</p>	Apr - July 17	Sector level escalation policy's developed
		Boardwide Escalation Protocol			Aug - Sept 17	Boardwide policy developed.
eHealth	EA2 EA4 EA6	NHSGGC performance metrics dashboard	<ul style="list-style-type: none"> <li>•Potentially avoidable admissions</li> <li>•Reduce admissions from care homes and directly provided residential homes</li> <li>•Delayed Discharges</li> <li>•Improving discharge process</li> <li>•Alternatives to referral to GP Assessment Unit/ A&amp;E</li> <li>•ALOS in Acute hospitals post-admission</li> <li>•Performance management</li> <li>•Reduction in bed days</li> <li>•Unscheduled care pathway</li> <li>•Evaluation framework</li> </ul>	<p>All eHealth projects have been commissioned to support better ways of working for clinical and non clinical staff in acute and non acute settings.</p> <p>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.</p>	May - Jun 17	•Complete
		ED Trak model in AUs			Aug 16 - Apr 17	•Complete
		AU Microstrategy Dashboard			Mar - May 17	•Complete
		Trak Supporting Icons			Jun - Nov 17	•Development underway by eHealth dept.
		NEWS and GAPS autoc capture and display			Jun - Nov 17	•Development underway by eHealth dept.
		Develop ED flow algorithm			Jun - Nov 17	•Development underway by eHealth dept.
		Live Bed State - 'hub concept (QEUH only)			Jun - Nov 17	•Draft concept prepared. eHealth options included in concept paper.
Governance	EA1	Unscheduled care programme governance	<ul style="list-style-type: none"> <li>•Primary / Secondary care clinical interface</li> <li>•Unscheduled care programme governance</li> <li>•Evaluation framework</li> </ul>	Robust programme management arrangements to ensure delivery of expected programme benefits	May - Aug 17	•Draft governance arrangements produced •HSCP method of involvement in GGC UC programme to be confirmed
Future/Other developments	NA	Royal College visits	NA	Supply external appraisal of sector level unscheduled care programmes to inform service improvement	Jun - Aug 17	•QEUH visit complete •GRI and RAH visits waiting confirmation from Colleges.

\*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