



NHS Greater Glasgow and Clyde Winter Plan 2018/19



Renfrewshire
Health & Social Care
Partnership



West Dunbartonshire
Health & Social Care Partnership

NHS Greater Glasgow and Clyde

Winter Plan 2018/19

Executive Summary

Preparation for winter is captured in the Board's Winter Plan. This document is designed to provide assurance to the NHS Board and the Scottish Government that effective arrangements are in place to respond to the projected level of demand over the winter months.

The Cabinet Secretary wrote to NHS Boards and Integrated Joint Boards on the 31st August 2018 seeking submissions of approved Winter Plans by the 31st of October 2018.

This year's preparations have drawn on lessons learnt from last winter with a continued focus on Unscheduled Care, the Board's corporate objectives to deliver the Emergency Care A&E standard and to achieve a 10% reduction in emergency admissions through a whole system programme of improvement. There has also been a focus on improving discharge rates earlier in the day and at weekends.

This plan recognises that additional acute bed capacity and measures in community and primary care will be required to deliver care during the winter period. Effective delivery of Unscheduled Care within the established performance parameters will require robust governance, effective processes and integrated responses from across primary, community and acute services.

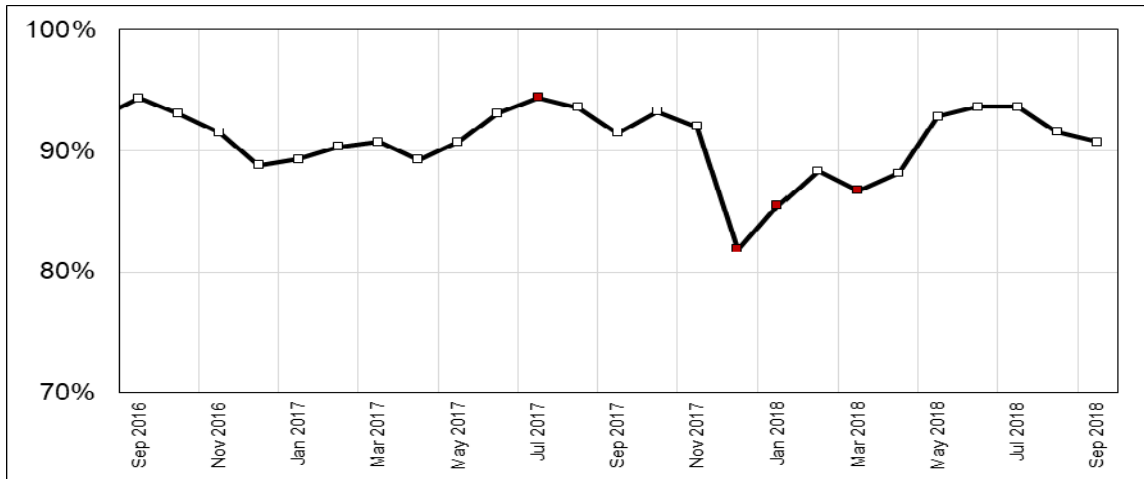
Our plan takes cognisance of the recommendations from the Sir Lewis Ritchie review and has incorporated the key findings into our approach.

Key actions which the Board has taken and will progress through the winter period are:

- Senior cross-system leadership at Chief Operating Officer/Chief Officer level with daily calls to ensure responsive and effective communication and coordination.
- Agreement of cross-system escalation plans.
- Contingency planning for additional bed capacity of between 115 to 150 beds.
- Additional Intermediate Care Beds (15 identified by Glasgow City Health and Social Care Partnership).
- Enhancement of senior medical and other clinical staffing at critical pressure periods across Acute, Community, Mental Health and Social Care services.
- Additional Ambulance Transport arrangements.

1. Projected Demand and Performance

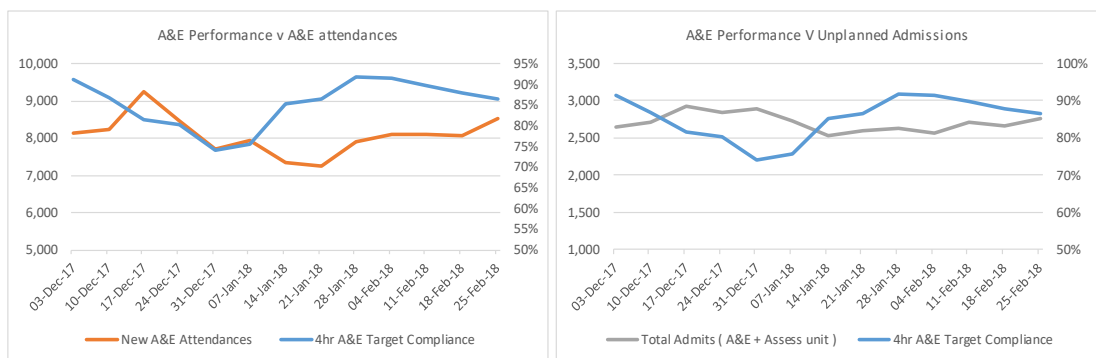
1.1 Unscheduled care activity has not abated since last winter. Experience this summer has seen sustained peaks in A&E attendances of 8% over a monthly mean of 21,600. Weekly performance against the 4 hour target has been sustained at 90% or more. Performance on different sites has been more variable, particularly on a day to day basis.



A&E Performance against the 4 hour target

1.2 Demand at the 'Front Door', through A&E and our Assessment Units, translates into a mean of 10,103 admissions per month. Our analysis of previous winters indicate that we should anticipate a seasonal increase during the December and January period of a further 4% in unplanned admissions per month.

1.3 Analysis of weekly trends from last winter indicates the extent to which the resilience of our 'System' is supported by the winter short term step up in capacity. The 2017/18 plan provided for the step up to be enacted from January. Our experience was of an early surge in December. A&E Performance started to dip as attendances increased reaching a peak of 16% above the mean for the period (Week ending 17 December). At the same time, admissions surged to 9% above the mean.



2017/2018 A&E Performance tracked with (i) A&E attendances and (ii) Unplanned Admissions

- 1.4 During the 2017/18 winter months, an additional 124 acute beds over the base capacity were funded across the North, South and Clyde sectors. This was based on modelling work which considered monthly trend analysis with projections based on 2%, 5% and 8% increases with the additional capacity provided broadly meeting the 5% increase. This was not always sufficient to deal with the demand last year.
- 1.5 Employing a similar methodology but building in the learning from last winter indicates our plans need additional beds within a range of 115 to 150 beds. Our aim is to better utilise intermediate care beds and out of hospital capacity to offset pressure within the acute system. The final configuration of additional capacity is still to be confirmed and will reflect a combination of acute and intermediate care beds.
- 1.6 System Watch is recognised as a key additional tool to monitor demand and anticipate pressure. The demand predictor is embedded into the information that supports the daily demand predictions. As part of the 6EA programme, ISD were recently asked to develop enhanced information to support capacity and demand processes. The new functionality is being reviewed and will be incorporated into the suite of reports to support decision making on patient flow, demand and capacity, as well as at cross-system forum.

2. Preparedness for Surge Demand and Additionality

- 2.1 Additional winter bed surge capacity will be required this winter and this capacity will be phased in from December. It is recognised that building the resilience to address demand will require a coordinated approach across primary, community and acute services. Throughout this year and based on analysis of demand and lessons from last winter, a cross system programme of work has been developed. The aim was to address variation in process and pathways across NHS Greater Glasgow and Clyde and develop common approaches to managing demand before and after hospital admission.
- 2.2 These actions build on the range of quantifiable actions that we know will strengthen our preparedness

Key Quantifiable Actions	Impact
Extending medical and nurse staffing in A&E and Assessment Units	Ensure sufficient senior clinical decision makers are available at critical times during early evenings and weekends.
Strengthened Clinical Co-ordination and Flow Management	Ensure appropriate clinical experience shapes prioritisation of patient flow throughout the hospital, with the authority to expedite obstacles and place patients in the most appropriate locations.
AHP capacity to expedite assessment, treatment and discharge planning	Reduce avoidable delays in the patient journey ensuring appropriate care and discharge planning; facilitate 7 day discharge.
Boarding teams	Strengthen continuity of care and senior decision-making for patients who at times of peak pressure cannot be accommodated in a specialty ward appropriate to their condition.
Additional Bed Capacity	115 to 150 beds

Enhanced Medical HDU cover	Increase the capacity of Medical HDU at critical periods enabling more effective patient flow and step down.
Support Staff to ensure rapid turnover of beds	Reduce the delays in making beds available following discharge of patients.
Extended Pharmacy cover	Enable provision of Pharmacy support outside of regular working hours to facilitate early discharge.
Additional SAS Transport	Increase flexibility and responsiveness of ambulance transport for transfers between hospitals.
Point of Care Flu Testing	Enable rapid identification and appropriate cohorting of patients from point of admission.
Intermediate Care Beds	Additional Surge Capacity commissioned on block and spot purchasing basis (15 beds within Glasgow City HSCP)
Red Cross Ambulance Transport	HSCP commissioned to support additional discharges
Community Respiratory Team extension	Deliver 7 day service
Community nursing & Home Care Services	Enhanced cover over holiday periods with contingencies for periods of peak activity.
Mental Health Services	Adult, Community Mental Health Teams, Out of Hours and Acute Hospital Liaison Support in place for anticipated levels of demand.

2.3 The above actions have been costed at circa £6m. However, due to the current allocation of £2.1m, we continue to refine the actions in order to prioritise against available funds.

We continue to work with our partners to identify any additional internal funds, and to discuss the potential for additional finds with the Scottish Government.

2.4 Further work is underway following a cross system Winter Planning workshop on the 20th September 2018. Facilitated by the Health Improvement Scotland Improvement Hub, this focused on identifying actions which reduce demand to the Acute Assessment Units. A follow up event in November will confirm how these will be operationalised by early winter. The key themes emerging from this workshop were:

- Stratification of demand utilising the principles of *Realistic Medicine* to avoid over treatment and unnecessary admission
- Improvement in utilisation of alternatives to admission
- 7 day service provision – strengthening supporting infrastructure in key areas
- Improved communication between GP and hospital based consultants
- The right care at the right level at time of presentation
- Development of 72 hour supported community care “Supported Time Out” for people who don’t need acute care
- A ‘How are you service?’ targeted at patients at risk of admission

3. Resilience Preparedness

- 3.1** Business continuity plans take account of the critical activities of NHS Greater Glasgow and Clyde and Health and Social Care Partnerships. They include analysis of the effects of disruption and the actual risks of disruption, and are based on risk assessed worst case scenarios. Plans prioritise activities, assess the risks and identify how they will be supported and maintained during service disruption. Business Impact analysis has been completed for each critical service to identify minimum staffing levels to maintain service delivery.
- 3.2** The Health and Social Care Partnership and Acute Business Continuity Plan framework has been developed to ensure coordination and consistency across sectors. Each plan has an escalation process, with roles and responsibilities identified through relevant action cards. The plans focus on recovery time objectives set for a return to normal operation. GP Practices and Pharmacy continuity plans include a 'buddy system' should there be any failure in their ability to deliver essential services.
- 3.3** Plans have been tested in recent months with the severe weather and updated from lessons learned. Internal exercises to validate plans are run by individual services to ensure fitness for purpose.
- 3.4** Business continuity arrangements within NHS Greater Glasgow and Clyde are networked effectively with Local and Regional Resilience Partnerships and will contribute to the West of Scotland Regional Resilience Mass Fatalities Group work plan.
- 3.5** NHS Greater Glasgow and Clyde leads met with Local Authority and Funeral Director representatives in October 2018. Actions agreed were the development of an Escalation Plan and consideration of options for additional capacity at times of greater need. The meeting confirmed key points of communication between appropriate officers.
- 3.6** Following last years' experience, a key learning point was the importance of gritting and other weather related priorities to minimise the adverse impact on services. Arrangements have been confirmed with Local Authorities to ensure appropriate contact points to assist with escalation in the event of adverse weather.

Staffing

- 3.7** Annual leave is actively managed all year including over the winter period, with leave in key services managed according to the demand projections and clinical priorities. For the Festive Public Holidays, rotas are now agreed. This includes additional staff for weekends to promote discharges and ward rounds. There is an absence management process in place and this is applied as business as usual.
- 3.8** The Staff Banks and Recruitment service provide both pro-active and reactive activity to help mitigate risks as a result of winter demands and pressures across NHS Greater Glasgow and Clyde. The Board has successfully recruited over 450 newly qualified nurses many of whom are now in post and are registered with the Bank at time of starting. Band 2 Healthcare Support Worker recruitment is underway with the aim to recruit approximately 150 - 200 individuals. Closer working with the Universities has led to a change of process, signing student nurses to the Bank prior to the winter period, enabling more responsive support at key periods. Retirees have also been targeted during August and September to promote Bank opportunities.

- 3.9** A key pressure area is in the Clyde Sector. Owing to the level of demand and an increased number of vacancies, a targeted recruitment campaign has taken place for substantive and Bank staff, this included action from the NHS Greater Glasgow and Clyde Employability team and local engagement with job centres and workforce employability programmes for Healthcare Support Worker posts.
- 3.10** Fill rates will be reported on a daily basis to support shift monitoring, with staffing levels discussed at the 'Hospital Huddle' reports each morning. Dedicated resource and actions for fill priorities will be confirmed with each sector.
- 3.11** The national review of the Adverse Weather Policy is underway. A partnership group has been commissioned by the Scottish Government Workforce Directorate to develop a "Once for Scotland" policy. The policy will be approved in November, allowing NHS Boards to incorporate within local policies. NHS Greater Glasgow and Clyde have reviewed and updated the local policy which will be used pending the National agreement.
- 3.12** Our corporate website "HR Connect" is updated regularly throughout winter for both bank workers and services. In extreme weather and other high demand situations this will include instructions and guidance for Bank staff. Bank workers will be alerted to updates on the website through email and text.

4. Unscheduled Care/Elective Care Preparedness

Clinically Focussed and Empowered Management

- 4.1** 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 are management cover arrangements 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 are mirrored in each Health and Social Care Partnership with locality management structures to ensure systems for dialogue and escalation across the whole system.
- 4.2** System wide Director level communication and coordination with daily Chief Operating Officer calls between Acute and Integrated Joint Board Chief Officers is an established process linked to Escalation procedures. It is triggered by the Chief Officer on a daily basis and in line with the hospital huddles to ensure there is optimum visibility of the current position.
- 4.3** A focus over the summer months within the hospital management structures has been to review and revise arrangements for the Consultant in Charge, Flow Hubs and Escalation Policies. We have created a model of the Daily Demand and Capacity Cycle to illustrate the various stages and coordination of processes that currently enable us to establish the status of the hospital and estimate the anticipated demand and capacity requirements. In addition we have developed our local escalation policies to ensure that they reflect the required levels of decision making and associated actions to maintain and improve patient flow. During the winter months there will be a focus on increased ward rounds and earlier clinically appropriate discharge from hospital

4.4 The NHS Greater Glasgow and Clyde 6 Essential Actions Programme reflects the following programme of work for Unscheduled Care in collaboration with Acute and Health and Social Care Partnerships:

- High volume Admissions – we have identified the highest volume patient conditions resulting in attendance and admission within each HSCP. Subgroups have been formed to focus on a specific condition with the intention to reduce attendance, admission and hasten discharges.
- Frequent attendance - HSCPs are undertaking a review of frequent attendees to Accident and Emergency Departments. This data has been shared with GP Practices and Cluster Quality Leads (CQLs) to initiate action and additional meetings have been held between the Greater Glasgow and Clyde UCC Programme Manager and Glasgow City HSCP manager to ensure there is planned action to reduce these frequent attendees. Additionally the HSCPs are promoting the “know who to turn to” campaign, to divert patients away from ED.
- Daily Dynamic Discharge – All Sectors have established DDD working groups to ensure compliance with DDD which are aligned to the Exemplar Ward processes. We have undertaken a number of IT improvements to help the ward teams, creating Electronic weekend handover which is targeted to safely track patient tasks and expedite discharges over the weekend and during the out of hours period. We are also promoting the uptake of Criteria Lead Discharges, Discharge Lounge utilisation and overall compliance with Estimated Dates of Discharge to improve the end to end process.
- Day of Care Survey (DoCS) – NHS Greater Glasgow and Clyde completed the National Day of Care Survey in April this year. All sites incorporated the reported recommendations into their 6EA action plans and work has continued to be progressed across individual areas with specific focus on weekend discharge rates and the process for reviewing patients with a LoS of >10 days. In September 2018, the Queen Elizabeth University Hospital conducted an additional mini DoCS to analyse differences between weekend and weekday inpatients to understand and measure patient discharge status and the impact this might have on Monday flow and ED performance, with learning being incorporated into action plans. The Board participated in the National DoC audit on the 25th October, the findings will be inform further action planning.
- Improving Ambulance Turnaround Times – At a system level, we have an established forum with the Scottish Ambulance Service to resolve issues such as delayed turnarounds and address other priorities. All hospitals have conducted process audits and established a more detailed understanding of delays in the handover process. At a sector level work is ongoing jointly between Scottish Ambulance Service and hospital teams to improve performance, an example being the “safe to sit” programme being piloted at the Royal Alexandra Hospital.

Optimising Patient Flow

4.5 The proposed uplift in winter surge bed capacity will be complemented by additional measures by the Acute Sector and Health and Social Care Partnerships to:

- Reduce the length of stay and expedite discharge and improve time of day of discharge
- Maximise the turnover of HSCP intermediate care beds
- Reduce admissions into hospital
- Provide alternatives to hospital admission
- Increase pharmacy support focussed on discharge planning

4.6 Reducing length of stay and expediting discharge will be enabled by the actions described above in the sections relating to Clinically Focused and Empowered Management (Consultant in Charge, Flow Hubs and Escalation Policies) as well as the continued focus on the principles of the 'Six Essential Actions' and Daily Dynamic Discharge activities.

4.7 Our plan envisages a trajectory to improve discharge rates as follows:

	Weekly average	Improvement	Target	By When
Discharge Pre Noon	18.3%	5%	23%	December
Weekend Discharge	16.7%	5%	24%	December
Delayed Discharge	160	Winter 17/18 levels	89	December

Current Position – week ending 29th October, all discharges (excl. Obstetrics)

4.8 Throughout this year, the Health and Social Care Partnerships have worked together to develop a joint action plan reflecting agreed actions common across all 6 Partnerships. The objective is to reduce activity by 10% for Attendances, Admissions and Occupied Bed Days. The plan is complemented by individual Health and Social Care Partnership plans which focus on local needs with initiatives to address them.

The plan is made up of a combination of detailed activity in relation to particular clinical conditions as well as a range of enabling activity, designed to impact across a number of clinical pathways. Work on these streams will continue throughout the winter and add value on a phased basis.

The following sections describe the areas of work that can be expected to have impact over this winter.

- **COPD Pathway** – One of several high volume pathways, COPD has been targeted for attention in recognition of a lower proportion of patients being discharged within 24 hours across NHS Greater Glasgow and Clyde than other Boards. The COPD24 pathway will introduce a Multi-Disciplinary Team approach to managing patients within the first 24 hours of presentation. The pathway is supported by a digital dashboard enabling identification of COPD patients and information to be shared digitally across care providers. Care bundles for Admission and Discharge are being finalised for use across all sites and services.
- **Reducing admissions from Care Homes** – Health and Social Care Partnerships have been working closely with care homes, GPs and others to

improve clinical support to residents and reduce admissions to hospital, to date a 15% reduction has been achieved. The next phase is the introduction of the Red Bag scheme with wide scale adoption across NHS Greater Glasgow and Clyde by late November. The red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with the resident. This is a simple process for supporting communication and information sharing across care homes and acute services at times of unscheduled care. Evaluation will be facilitated with the Care Home's dashboard tool introduced earlier this year which identifies and enables monitoring of admissions to hospital from Care Homes.

- **Frailty** – Health and Social Care Partnerships have agreed a single approach to identify people with frailty in the community and review current service delivery to develop new pathways and ways of working to support people with a frailty diagnosis to live at home or homely setting as independently as they can. Permission has been granted to adopt the Rockwood et al Dalhousie University Clinical Frailty Scale and West Dunbartonshire Health and Social Care Partnership is an early adopter of this tool. The tool itself is easy to apply and provides a common language across services in describing and understanding the person's level of frailty. The Frailty score will determine the requirement for engagement in Anticipatory Care Planning and population of the Key Information Summary. Implementation is underway and will continue through the winter.
- **Anticipatory Care Plans (ACP)** – Health and Social Care Partnerships have confirmed a standardised approach should be implemented with robust monitoring to track improvement. A well-completed Key Information Summary covers enough useful information to achieve the goals of an ACP. Health and Social Care Partnerships are encouraging full use of KIS functionality within EMIS as a practical proxy for an ACP, acknowledging the function of the ACP as a patient held record but noting the 32 pages can be difficult to ensure widespread use. The approach is to target those patients with the most fragile health needs and therefore most likely end up being seen by Out of Hours or admitted to hospital. This includes, but is not limited to:
 - Housebound patients
 - Dementia patients
 - Nursing home patients
 - Patients with frailty and significant conditions such as severe COPD, bronchiectasis, CF, MND and MS
- **Delayed Discharge** – This issue continues to be a priority for Health and Social Care Partnerships with processes to systematically review and expedite delays. Anticipatory structures aim to ensure that potential areas of need, particularly in respect of the adults with incapacity (AWI) are best met and delays minimised. Identification and targeting of homecare clients who lack capacity and promotion of Powers of Attorney is part of this process. Access to TrakCare allows early identification of patients known to Social Services. Learning has been pooled across Health and Social Care Partnerships to identify best practice which includes:

- Access to digitised AHP record/ assessment through Clinical Portal/TrakCare/EMIS
- Access to dashboards re inpatients.
- Electronic referrals - reducing time between referral sent to and received by hospital team.
- Accurate reports that provide managers with statistical data to support core tasks such as allocation and managing staff resources.
- Improvements in care pathways with SAS to increase number of patients not conveyed to hospital
- Engagement with OOH services to identify better pathways that manage risk, including NHS24 and SAS
- Better anticipatory care planning & eKIS – more robust use of escalation plans with GP involvement
- Making sure care at home prioritise hospital discharge. Investment in this service and focus on recruitment and retention to sustain performance
- Availability of beds for under 65s with complex needs – with a view to explore joint commissioning
- Dedicated MHO (define) input re delayed discharges
- Additional resources to manage increased demand such as District Nursing, rehabilitation equipment and aids and adaptations

4.9 Elective Services and Scheduled Care – We will continue to seek to maximise the overall elective programme during the winter period with specific emphasis on maintaining the Orthopaedic Programme. During the festive period and the initial two weeks of January we will focus on prioritising cancer and urgent patients as well as utilising fully Day Case and 23 hour stay capacity. This will include maximum use of theatres and bed capacity on sites which are not the main acute receiving sites.

5. Out of Hours Preparedness

5.1 The Out of Hours Winter Preparations have been developed having incorporated the lessons learned from the review of last year.

5.2 There has been considerable work done on a Board wide review of Health and Social Care Out of Hours Services which takes into account local lessons and the recommendations of the Ritchie Report. The Primary Care Emergency Centres (GPOOHs) already host the Community Psychiatric Nurses who provide telephone support. From this year, Out of Hours services will also include pharmacists.

5.3 Capacity requirements across the interface between NHS24 and GP Out of Hours over the Festive Period Public Holidays has been assessed to determine the rostering of Out of Hour's services. High Risk shifts are highlighted with additional staff identified. All rosters are reviewed at regular intervals to manage any additional issues. During the winter months, these reviews will be conducted more frequently to enable mitigation of risks and ensure resilience.

5.4 Work is also progressing on processes to manage demand more effectively with a cross system work stream focused on 'Redirection', utilising resources such as System Watch which has informed winter capacity planning. Following a cross-system workshop involving Primary, Secondary care, Pharmacy, Mental Health and Out of Hours Services, a programme of work is underway differentiating between

urgent and emergency care. This will inform the public holiday information campaigns to establish a new narrative on the use of services. The Acute Division has reviewed and relaunched the Redirection Policy for use in Emergency Departments.

6. Preparation for and Implementation of Norovirus Outbreak Control Measures

- 6.1** The Board's standard operating procedure is available via the Infection Prevention & Control Team icon on all PCs. This includes an 'Outbreak' procedure with resources/guidance and the escalation plan for acute care. There is close working with local Infection Prevention and Control staff (LIPC) and all receiving units to ensure policy and procedure are up to date.
- 6.2** Communication processes within our hospitals are in place with daily position of bed closures including external issues such as nursing home closures. Board Directors receive a daily email which is cascaded through appropriate forum such as the daily 'huddles'. The Press office is included in this communication and attend any outbreak control meeting where it is decided if information requires to be given to the wider public. The Health Protection Team are also represented at this meeting and can issue information to GPs and nursing homes.
- 6.3** The IPCT undertake awareness training on the appropriate precautions to reduce the spread of Norovirus as part of their winter preparations. Staff are reminded to isolate patients with D&V symptoms immediately on admission and to send appropriate specimens for diagnosis. Patients are isolated in single rooms initially but this can be escalated to cohort bed bays/wards to support bed pressures. IPCTs will visit wards weekly to reinforce appropriate precautions. An SOP and care checklist are accessible for staff to ensure optimal patient placement to reduce the risk of transmission. The IPC Data team and PHPU liaise daily on care home closures. This information is entered into a norovirus report that is circulated to all directors, associate directors, Chiefs of medicine and nursing daily and will include daily ward closures throughout NHS Greater Glasgow and Clyde. Similar activity is undertaken for influenza.
- 6.4** Cover over the Public Holidays will be in place with on call microbiology and LIPC nurses to review closed wards over weekends and festive periods to facilitate prompt opening of closed wards.

7. Seasonal Flu, Staff Protection and Outbreak Resourcing

- 7.1** Last year, 15,500 staff received the flu vaccine equating to a rate of roughly 40%. The ambition for 2018/19 is to achieve a rate of 60%.
- 7.2** Led by the Occupational Health team with close support from the Public Health Protection Unit, the 2018/19 campaign has been launched with communication media updated and a dedicated web page in place with all the relevant information for staff. Peer immunisation is recognised as being highly effective and will be a central feature of this year's campaign. To date we have a higher uptake of volunteers to support delivery and have active support by Clinical leads to encourage uptake. A programme of large onsite drop in clinics commenced from the beginning of October. The uptake is monitored daily and inform plans for further sessions to facilitate access where there is scope to reach more staff.
- 7.3** Outside of hospital, the Public Health Protection Unit will support Primary Care on diagnosis, anti-viral treatment and flu immunisation. Care homes are also supported to promote vaccination and encourage uptake in residents and staff. Routine surveillance, utilising the Health Protection Scotland weekly reports, is embedded into

daily practice. Local outbreaks in locations such as schools, prisons and care homes are actively managed to minimise the spread and potential impact on secondary care.

7.4 Last year, Point of Care Testing was introduced across sites contributing to the rapid identification of patients on admission, allowing appropriate management. Plans are being finalised to build on our experience targeting services where impact was most apparent.

7.5 The table below summarises the flu vaccine-uptake rates in NHS Greater Glasgow and Clyde last flu season (2017/18) a significant proportion of the vulnerable population in NHS Greater Glasgow and Clyde remained unprotected from the risks and complications of influenza last season. Those practices that achieved a good flu vaccine uptake are encouraged to continue the work this season.

Eligible Groups	Average Uptake Rate	Range	National Uptake Target
65 yrs and over	73.9%	55.3 - 89.1%	75%
< 65 yrs & 'at risk'	45.6%	24.2 – 68.5%	75%
Children 2 – 5 yrs	54.7%	10.2 – 93.1%	65%
Pregnant Women (not in another clinical risk group)	54.2%	14.29 – 100%	

8. Communications

All year round, NHS Greater Glasgow and Clyde 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:

- For the first time, a regional approach is being promoted to winter communications with a West of Scotland on air and online radio campaign planned for the January-February period across the NHS Greater Glasgow and Clyde, Forth Valley, Ayrshire and Arran and Lanarkshire areas. Each Board is making a contribution to the campaign which is also being supported financially by NHS 24. The key messages for the campaign will be to ‘Meet the Experts’ and encourage people to make use of the local ‘experts’ within minor injuries units, pharmacies and mental health for swift access.
- This radio campaign will be backed by a suite of ‘Meet the Experts’ videos to be published on NHS Greater Glasgow and Clyde’s social media channels which already have a proven record in promoting alternatives to ED. The videos cover minor injuries, mental health, pharmacies and self-care.
- A social media ‘Countdown to Christmas’ campaign will encourage people to be prepared for the holiday period. We will also support the NHS 24 ‘Be Health Wise’ campaign through our social media channels and website.
- A special winter edition of Health News, our digital magazine, will be published in November to 30,000 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 30,000 followers).

- A winter booklet on accessing services over the holiday season will be produced in print and online. Approximately 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. In October we launched the Board's staff campaign to increase uptake of the flu vaccination programme amongst healthcare workers. (We have shared our staff campaign across Scotland and have already had interest of other boards seeking to use our campaign with their staff).
- A proactive media statement will be issued to all media before the holiday period signalling that we expect to be busy and asking people only to attend ED if it is essential. 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 communication escalation plan will allow us to respond to service pressures and support colleagues in managing demand; our social media channels allow us to rapidly respond to emergency situations and we can issue urgent messages to the public, to GPs, to staff to respond to situations as they emerge if necessary.

9. Conclusions

- 9.1** This Winter Plan has been developed under the oversight of the Unscheduled Care Steering Group with cross system ownership from across the Acute Division, Health and Social Care Partnerships and the Corporate department.
- 9.2** This plan reflects the progressive improvement in governance, processes, and patient pathways across the Acute Division and Health and Social Care Partnerships. The aim is to deliver safe, effective care across all our services for patients requiring emergency healthcare, whilst maintaining planned care.

Appendix 1: Admission Avoidance Actions

<ul style="list-style-type: none">• High volume Admissions – we have identified the highest volume patient conditions resulting in attendance and admission within each HSCP. Subgroups have been formed to focus on a specific condition with the intention to reduce attendance, admission and hasten discharges.
<ul style="list-style-type: none">• Frequent attendance - HSCPs are undertaking a review of frequent attendees to Accident and Emergency Departments. This data has been shared with GP Practices and Cluster Quality Leads (CQLs) to initiate action and additional meetings have been held between the GGC UCC Programme Manager and Glasgow City HSCP manager to ensure there is planned action to reduce these frequent attendees. Additionally the HSCPs are promoting the “know who to turn to” campaign, to divert patients away from ED.
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<ul style="list-style-type: none">• Reducing admissions from Care Homes – HSCPs have been working closely with care homes, GPs and others to improve clinical support to residents and reduce admissions to hospital, to date a 15% reduction has been achieved. The next phase is the introduction of the Red Bag scheme with wide scale adoption across NHS GGC by late November. The red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with the resident. This is a simple process for supporting communication and information sharing across care homes and acute services at times of unscheduled care. Evaluation will be facilitated with the Care Home’s dashboard tool introduced earlier this year which identifies and enables monitoring of admissions to hospital from Care Homes.
<ul style="list-style-type: none">• Frailty – HSCPs have agreed a single approach to identify people with frailty in the community and review current service delivery to develop new pathways and ways of working to support people with a frailty diagnosis to live at home or homely setting as independently as they can. Permission has been granted to adopt the Rockwood et al Dalhousie University Clinical Frailty Scale and West Dunbartonshire HSCP is an early adopter of this tool. The tool itself is easy to apply and provides a common language across services in describing and understanding the person’s level of frailty. The Frailty score will determine the requirement for engagement in Anticipatory Care Planning and population of the Key Information Summary. Implementation is underway and will continue through the Winter.
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- Dementia patients
- Nursing home patients
- Patients with frailty and significant conditions such as severe COPD, bronchiectasis, CF, MND and MS

Appendix 2: Improving Discharge Actions

Trajectory for improving Discharge:

	Weekly average	Improvement	Target	By When
Discharge Pre Noon	18.3%	5%	23%	December
Weekend Discharge	16.7%	5%	24%	December
Delayed Discharge	160	Winter 17/18 levels	89	December

Current Position – week ending 29th October, All discharges (excl. Obstetrics)

Summary of actions

<ul style="list-style-type: none"> Daily Dynamic Discharge – All Sectors have established DDD working groups to ensure compliance with DDD which are aligned to the Exemplar Ward processes. We have undertaken a number of IT improvements to help the ward teams, creating Electronic weekend handover which is targeted to safely track patient tasks and expedite discharges over the weekend and during the out of hours period. We are also promoting the uptake of Criteria Lead Discharges, Discharge Lounge utilisation and overall compliance with Estimated Dates of Discharge to improve the end to end process.
<ul style="list-style-type: none"> AHP capacity to expedite assessment, treatment and discharge planning - Reduce avoidable delays in the patient journey ensuring appropriate care and discharge planning; facilitate 7 day discharge.
<ul style="list-style-type: none"> Boarding teams - Strengthen continuity of care and senior decision-making for patients who at times of peak pressure cannot be accommodated in a specialty ward appropriate to their condition.
<ul style="list-style-type: none"> Extended Pharmacy cover - Enable provision of Pharmacy support outside of regular working hours to facilitate early discharge.
<ul style="list-style-type: none"> Intermediate Care Beds - Additional Surge Capacity commissioned on block and spot purchasing basis (15 beds within Glasgow City HSCP)
<ul style="list-style-type: none"> Red Cross Ambulance Transport - HSCP commissioned to support additional discharges
<ul style="list-style-type: none"> Delayed Discharge – This issue continues to be a priority for HSCPs with processes to systematically review and expedite delays. Anticipatory structures aim to ensure that potential areas of need, particularly in respect of the adults with incapacity (AWI) are best met and delays minimised. Identification and targeting of homecare clients who lack capacity and promotion of Powers of Attorney is part of this process. Access to TrakCare allows early identification of patients known to Social Services. Learning has been pooled across HSCPs to identify best practice which includes: <ul style="list-style-type: none"> - Access to digitised AHP record/ assessment through Clinical Portal/TrakCare/EMIS - Access to dashboards re inpatients. - Electronic referrals - reducing time between referral sent to and received by hospital team. - Accurate reports that provide managers with statistical data to support core tasks

such as allocation and managing staff resources.

- Improvements in care pathways with SAS to increase number of patients not conveyed to hospital
- Engagement with OOH services to identify better pathways that manage risk, including NHS24 and SAS
- Better anticipatory care planning & eKIS – more robust use of escalation plans with GP involvement
- Making sure care at home prioritise hospital discharge. Investment in this service and focus on recruitment and retention to sustain performance
- Availability of beds for under 65s with complex needs – with a view to explore joint commissioning
- Dedicated MHO (define) input re delayed discharges
- Additional resources to manage increased demand such as District Nursing, rehabilitation equipment and aids and adaptations