Local Unscheduled Care Action Plan

NHS Ayrshire & Arran

June 2013
CONTENTS

1. OVERVIEW ................................................................................................................................... 2
2. ACTION PLAN .................................................................................................................................. 6
   2.1 Strategic theme 1 - Making the community the right place: developing community services and support for people with ongoing care needs .................................................. 6
      a) Analysis .................................................................................................................................. 6
      b) Interventions and redesigns ................................................................................................ 7
      c) Statement ................................................................................................................................ 8
   2.2 Strategic theme 2 - Getting urgent care needs met at the right time, in the right place: developing the primary care response .............................................................................. 9
      a) Analysis .................................................................................................................................. 9
      b) Interventions and redesigns .............................................................................................. 12
      c) Statement ............................................................................................................................ 17
   2.3 Strategic theme 3 – Getting emergency patients to the care they need at the right time: flow and the acute hospital .............................................................................................. 19
      a) Analysis ................................................................................................................................ 19
      b) Interventions and redesigns .............................................................................................. 21
      c) Statement ............................................................................................................................ 23
   2.4 Strategic theme 4 – Making sure patients get the right care across unscheduled care: promoting senior decision making along the pathway ................................................. 23
      a) Analysis ................................................................................................................................ 23
      b) Interventions and redesigns .............................................................................................. 24
      c) Statement ............................................................................................................................ 27
   2.5 Strategic theme 5 – The right care every time: assuring effective and safe care 24/7 at the hospital front door .............................................................................................................. 27
      a) Analysis ................................................................................................................................ 27
      b) Interventions and redesigns .............................................................................................. 28
      c) Statement ............................................................................................................................ 29
3  WINTER 2013 ............................................................................................................................. 30
4  FINANCIAL INVESTMENT PLAN ............................................................................................... 36
5  WORKFORCE .................................................................................................................................. 37
6  PERFORMANCE FRAMEWORK ...................................................................................................... 38
7  SUMMARY ...................................................................................................................................... 40

Appendix 1 – Local System Health Check
Appendix 2 – Performance Support Team Diagnostic Report (still to be received)
1. OVERVIEW

Unscheduled care in NHS Ayrshire and Arran has been experiencing challenges for the past 18 months, which became more significant over last winter (2012/13) and beyond, when the Board’s performance against the 4 hour quality standard deteriorated without recovering as expected.

Comparative unscheduled care activity information for hospitals across NHS Boards in Scotland demonstrates that in 2011/12, NHS Ayrshire and Arran had an Emergency Department (ED) attendance rate of 325.8 per 1000 population compared to a national average of 317.5, and whilst this local attendance rate may be seen to be in line with the national average, it is significantly higher than comparable population sized Boards such as NHS Fife and NHS Forth Valley who reported respective attendance rates of 250.5 and 256.6 per 1000 population. Further to this, while the percentage of patients presenting with minor injury / illness in Ayrshire and Arran is broadly in line with the Scottish average, 58.4% compared to 59.4%, there is a marked difference in the percentage of patients admitted, 37.7% compared to 22.7%. As with the ED attendance data, NHS Fife and NHS Forth Valley report much lower admission rates of 17.4% and 13.4% respectively. It therefore appears that NHS Ayrshire and Arran has significantly higher rates of ED attendance than comparable Boards, a broadly similar percentage of minor injury and illness but a much higher percentage of patients being admitted: a fact that places the unscheduled care system under some strain.

The signs of escalating pressure in the system were recognised in Winter 2011/12 and in response to not meeting the 4 hour standard, the Board established a quality improvement programme to improve performance. The Emergency Care Quality Improvement Programme (ECQIP) established in August 2012 sought to ensure that unscheduled care was safe, effective and person centred, with an improvement in performance in the 4 hour access standard as a key outcome measure. The programme initiated a number of evidence based test projects, supported by a dataset to inform its work. These test projects and subsequent changes to practice have resulted in improvements to safe and effective patient pathways.

The projects and improvements associated with ECQIP were carried out in conjunction with the Board’s Winter Plan, but in common with other similar Boards in Scotland, performance against the 4 hour standard worsened as a result of sustained pressure, characterised by surges in demand and increased admissions of older people. This ongoing situation prompted the Performance Support Diagnostic Team (PSDT) to review our unscheduled flow pathways (April 2013), and the findings and recommendations of this review will be incorporated into our Local Unscheduled Care Action Plan (LUCAP). Recent bed modelling work has also been undertaken to support our major capital investment programme and service change project - ‘Building for Better Care’ (BfBC). Taken together these present a clear focus on the main issues and challenges preventing consistent delivery of quality unscheduled care and direction on the improvement areas moving forwards.
Key issues

**Acute Services**

Change is required in the way in which patients are assessed in the acute phase of their journey, with a shift away from traditional methods of assessment and from the reliance on batch based “post take” ward round systems of medical assessment that, whilst once fit for purpose, now require to be redesigned. In addition, some unscheduled care services that do not span 7 days of the week are now obstacles to continuous patient flow.

Continuous review models of assessment over the full week are now considered best practice for many streams of patients and supplanting existing models of review with this type of arrangement would deliver significant gains. Further to this, discharges from hospital are unevenly spread over the 7 day period, extending lengths of stay and placing unnecessary demand on the acute hospitals at certain times of the week. This pattern is clearly seen in a range of medical services where access to senior medical opinion across 7 days would result in many more weekend discharges and shorter lengths of stay.

The shift from traditional models of assessment is the key component of the Board’s longer term BfBC Programme that sets out a new vision for Unscheduled Care that is based on these new models of acute assessment and pathway driven care alongside direct admission to assessment areas and access to early senior decision making.

The BfBC project has required detailed capacity forecasts to model present and future capacity requirements and the latest analysis, based on recent activity, demonstrates a shortfall in medical beds at the University Hospital Ayr (UHA) site, now and into the future, with the deficit increasing alongside forecast increases in activity.

The propensity of the UHA site to quickly slow down in terms of patient flow can be explained by this and the overall impact this has on Board performance is now thought best addressed, in the short term, by providing additional medical bed capacity.

**Community Services**

The four year change fund was established in 2011/12 to facilitate a whole system redesign of Older People’s Services, and Ayrshire partners have worked together to develop a 10 year Reshaping Care for Older People Vision, supported by separate three year action plans for each partnership.

The vision is that older people in Ayrshire and Arran enjoy full and positive lives within their own communities. Services are being planned on a model that supports community wellbeing and independence as the norm, providing community based rehabilitation and enablement when required and intensive support and hospital care
for those who need it. Services are person centred and outcome focused, supporting prevention and community resilience.

Key service changes include Integrated Care and Enablement Services based in the community but supporting assessment and discharge planning; community wards supporting a new, GP led, intensive community care service model; a wider range of care out of hours by district nurses including palliative care; development of tele-health projects; support for people with dementia; additional support for carers; development of new services with third and independent sectors including care homes; community pharmacy enhancements; and housing aids and adaptations.

Community hubs have been created with the aim of establishing a Single Point of Contact In Hours and Out of Hours to support service access and coordinated assessment and care. The impact of the Change Fund investment is currently being measured and reported through the Community Health Partnerships and the NHS Ayrshire and Arran Board, and whilst there is evidence of significant progress it is clear that the growing older population is placing community services under considerable strain meaning more focus and investment is likely to be required into the future.

**Major changes required to address the above**

The ECQIP test projects which have proven to have been effective now require to be scaled up and established - specifically the Acute Physician GP referral assessment service, the Consultant Geriatrician multi disciplinary assessment service and the shift to 7 day working specifically in Cardiology.

In relation to bed capacity, work is now underway to permanently establish 6 additional medical receiving beds at UHA, re-designating existing surgical beds that adjoin the hospital’s medical receiving unit and further to this, 6 additional medical winter contingency beds will remain open. The addition of these medical beds will immediately limit the boarding of patients to surgical areas which currently occurs later in the day. The establishment of a Clinical Decisions Unit (CDU) is also being considered.

In regard to hospital ED attendances and rates of admission, work will be carried out using the Access Toolkit to reduce variation between GP practices where it has been identified that only 70–80% of patient survey respondents reported that they could access the Primary Care Team within 48 hours. In addition, it is known that patients with mental health and/or addiction problems often make disproportionately high use of Accident and Emergency Services and via the Quality Outcome Framework - Quality and Productivity (QOF – OP) ED indicators, a Local Enhanced Service will be introduced to support GP practices in identifying this cohort of patients and to signpost them to the most appropriate service. Similarly, a number of local GP Practices offer Minor Injuries Enhanced Services to prevent their patients attending Accident and Emergency Departments and there is now the opportunity to expand this element of unscheduled care. These changes are expected to deliver improvement.

Anticipatory Care Planning (ACP) is seen as a key method to encourage and support preventative approaches, involving patients and their families as well as the
professional team. In this current year (2013/14) the Change Fund has invested in 6 community staff members to support the use of ACPs in patients’ homes and to work with GP Practices to develop ACPs as part of their QOF contract. This work extends to acute services through the availability of the Key Information Summary (KIS) which will enable IT links across the system for the first time.

Community and hospital staff are contributing to a review of discharge planning and use of Estimated Date of Discharge (EDD) from time of hospital admission to support seamless care and minimise time in hospital, again helping secure better access to quality unscheduled care.

Community hospitals are playing an increasing role in supporting effective community based care. Within Ayrshire, the four traditional Community Hospitals - Girvan, Arran War Memorial, Lady Margaret and East Ayrshire Community Hospital - are developing hospital plans as part of the National Community Hospitals refresh strategy. In addition, hospital plans are being refreshed for Ayrshire Central, Biggart and Kirklandsie Hospitals, to be ready by November 2013 in time for the 2013/14 Winter Plan and also to address the increased demand on community services.

NHS Ayrshire and Arran is also participating in European initiatives to support further development of tele-healthcare including an ambitious plan for spread, to support care of older people and people with long term conditions to manage their condition in their own homes.

The Change Fund is supporting a number of test projects to deliver whole system working across acute, community and primary care, notably in respiratory care, and it is believed that the success of these projects will encourage wider roll out and further reduce pressure on the Board’s acute hospitals. The necessary changes outlined will be further developed and delivered. The imperative is to embed these changes as soon as possible and to improve our performance against the 4 hour standard.

Developing the detailed LUCAp

The following sections expand on the above and are set out under 5 Strategic Unscheduled Care Themes, to support the delivery of interdependencies across the local system, thereby ensuring that all important elements are considered and included. The quality health check provides baseline information to support analysis of the system and identification of the various causes and pressures. The first section of each strategic theme builds on the analysis, setting out a prioritised matrix of intervention, re-design and solutions. The impact of each is quantified and an assessment of their collective impact presented.

The second section of each theme details our improvements and what will result for patients, particularly in relation to safe, effective and person centred care. These improvements will address the longer term demand whilst giving full consideration to the forthcoming winter and its known challenges, adopting a shift towards longer term structural changes whilst not losing sight of necessary arrangements and escalation plans to deal with short term surges in demand.

The interventions and redesign of services are accompanied by a financial plan that describes how Board and national funding will be applied, linking these to specified

30 June 2013
outcomes. In addition, the LUCAP describes the enhancements to workforce that are needed to secure the specified outcomes. Thereafter and in specific regard to what needs to be delivered and by when, a performance framework is set out for consideration.

The Local Unscheduled Care Action Plan (LUCAP) is timely and an ideal opportunity to further invigorate the developments already tested by ECQIP, taking forward also the recommendations from the diagnostic review. The LUCAP also fully supports the health system to move towards the principles and practice underpinning the Board’s BfBC programme that will place a new ED at University Hospital Ayr and a Combined Assessment Unit on each of our acute sites.

2. ACTION PLAN

The baseline information summarised in the Local System Health Check (Appendix 1), the recent observations of the Performance Support Diagnostic Team (Appendix 2 – still to be received), and the work of our local Emergency Care Quality Improvement Programme clearly identify areas for enhancement and improvement within the NHS Ayrshire and Arran unscheduled care system, across each of the 5 strategic themes. The detail is set out as follows:

2.1 Strategic theme 1 - Making the community the right place: developing community services and support for people with ongoing care needs.

a) Analysis

Ayrshire and Arran’s population of older people, in common with the rest of Scotland, is increasing fast. In addition, there is a continuing shift in the pattern of disease toward long term conditions, particularly a growing number of older people with multiple conditions and complex needs such as dementia.

Ayrshire’s 10 year vision for joint services, recently developed by NHSA&A, South, East and North Ayrshire Councils as well as third and independent sector organisations across Ayrshire, is that ‘Older People in Ayrshire and Arran enjoy full and positive lives within their own communities’. Partners are developing new models of care to support the shared vision focusing on:

- Community wellbeing
- Staying independent
- Rehabilitation and enablement
- Intensive community support

Key priorities are prevention of admission and early, effective discharge, partnership working, personalisation and performance improvement.

The Scottish government has allocated a 4 year Change Fund to support redesign of services in order to deliver transformational change and the three Community Health Partnerships have led the local programme of change and innovation. Each element of the Change Fund plans is subject to formal measurement, reporting and

30 June 2013
evaluation. However wider system change takes time and progress is often difficult to measure objectively. Individual patient and carer stories form an increasingly important part of service evaluation.

The Change Fund ends in March 2015 and it is essential that agreement is reached before that date on which service improvements have been most effective at delivering the required strategic objectives and how these will be sustained and funded.

More widely, NHSA&A community services are changing in response to the demographic pressures and the requirement to work differently to support prevention and early intervention. The integration of adult health and social care in Scotland from April 2015 and the transition to integrated Health and Social Care Partnerships in East, South and North Ayrshire, will offer further opportunities to improve quality of care for individual patients and reduce inequalities within local populations. Changes will include the development of locality planning to encourage GP involvement and effective community engagement and neighbourhood working. These organisational changes must support the integrated whole system acute/community approaches which are currently underway in Ayrshire.

b) Interventions and redesigns
Community services are working with acute services on three key levels: strategic, operational and individual patient and practitioner.

I. Community and primary care managers are represented on the Ayrshire and Arran Emergency Care Quality Improvement Board, contributing to development of strategic, integrated transformational approaches.

II. Managed Clinical Networks, including stroke, CHD, MS, diabetes and respiratory, are key to effective, clinically led, long term condition pathways across acute and community services.

III. An acute/community interface group, including GP representative, meets fortnightly to drive forward new integrated and shared pathways funded by the Change Fund. Similarly there is also an out of hours interface group that has delivered a single point of access to a range of out of hours services supporting alternatives to ED attendance and emergency admission.

IV. Tele-health and tele-care strategic and operational approaches are being developed with the involvement of acute, community, GP and local authority staff and patients.

V. Community hospital operational groups have developed transfer protocols with acute services.

VI. At individual patient level, the development of Anticipatory Care Plans is key to integrated care across acute and community settings 24 hours a day, 7 days a week.

Details of community service interventions and redesign are contained in the Reshaping Care Vision and CHP Change Fund projects. Key redesign measures which interface specially with acute include:
1. Reducing emergency admissions from care homes through coordinated training and support involving multiagency teams, including dementia training.

2. Community based Intermediate Care Integrated Care and Enablement teams supporting rapid, integrated interventions to encourage independence and avoid hospital admission.

3. Community Ward teams comprising GPs, Advanced Nurse Practitioners and Administrators in East, North and South Ayrshire using SPARRA data to support community based care of complex patients with pattern of high admissions.

4. Enhanced out of hours nursing services working jointly with Ayrshire Doctors On Call services, out of hours social work and home care from Single Point of Contact to provide more care at home, including palliative care and provide A&E staff with community based alternative to admission.

5. Enhanced district nursing training and Primary care based shared care working between acute physicians and GPs to support COPD care at home.

6. Support for GP leadership and MDT working in community and island hospitals to facilitate local care and avoid acute admission.

7. Enhanced falls service including pathways, training and links to telecare.

8. Allied Health Professions service change and enhancement including move to 7 day working and integrated OT approaches.

c) Statement

Community staff are redesigning their services in response to growing demand and changing needs. Activity pressures affecting the Emergency Departments and Acute Care wards are equally being experienced in community settings, although they are less visible. The key priority for the future must be to continue to develop integrated approaches where each element of service functions as part of a coordinated whole in order to provide effective, quality care to individual patients while focusing on service value and sustainability. Further priorities include:

- Integrated care planning across community, primary care and acute using Key Information Summary data to reduce length of stay and avoid admission where possible.
- Robust evaluation of the Change fund projects with approved projects mainstreamed to contribute to integrated approaches.
- Development of community based hubs where single point of contact will operate day and night to coordinate intermediate care services which will help GPs to avoid admissions and support acute hospitals to discharge patients safely from the front door and reduce their length of stay.
- Continued support to operational managers and local staff to deliver transformational change during the transition from Community Health Partnerships to Health and Social care partnerships.
- Focus on personalisation agenda, linked to roll out of co-production and self management approaches in order to encourage people more actively to manage their own health and wellbeing over a long period.
- Development of geriatrician led frail elderly pathways to support safe care at home.
- Communications strategy to publicise and celebrate change, share performance data and promote understanding across sites and services.

### 2.2 Strategic theme 2 - Getting urgent care needs met at the right time, in the right place: developing the primary care response.

#### a) Analysis

The overview presented at the beginning of the document clarifies the pressures facing the EDs and acute receiving facilities in NHS Ayrshire and Arran and the disparity between the local experience and other comparable Health Boards across Scotland. The high rates of presentation at local EDs and emergency admissions to local hospitals must be considered in the context of disease prevalence in Ayrshire and Arran. The latest dataset extracted from General Practice Disease Registers in Ayrshire and Arran confirms the following profile of disease:

<table>
<thead>
<tr>
<th>QOF Disease</th>
<th>Ayrshire Prevalence</th>
<th>Scottish Prevalence</th>
<th>A&amp;A Position</th>
<th>% Variance from avg</th>
<th>% of Scottish Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>6.21</td>
<td>6.02</td>
<td>8</td>
<td>3.16</td>
<td>7.54</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>1.59</td>
<td>1.49</td>
<td>7</td>
<td>6.71</td>
<td>8.18</td>
</tr>
<tr>
<td>Cancer</td>
<td>2.34</td>
<td>1.86</td>
<td>5</td>
<td>15.05</td>
<td>8.42</td>
</tr>
<tr>
<td>CHD</td>
<td>5.31</td>
<td>4.36</td>
<td>2</td>
<td>21.79</td>
<td>8.91</td>
</tr>
<tr>
<td>CKD</td>
<td>4.52</td>
<td>3.27</td>
<td>1</td>
<td>38.23</td>
<td>10.1</td>
</tr>
<tr>
<td>COPD</td>
<td>2.44</td>
<td>2.08</td>
<td>2</td>
<td>17.31</td>
<td>8.59</td>
</tr>
<tr>
<td>Dementia</td>
<td>0.83</td>
<td>0.73</td>
<td>4</td>
<td>13.70</td>
<td>8.34</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5.13</td>
<td>4.43</td>
<td>2</td>
<td>15.80</td>
<td>8.46</td>
</tr>
<tr>
<td>Depression</td>
<td>11.9</td>
<td>9.05</td>
<td>1</td>
<td>31.49</td>
<td>9.62</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0.83</td>
<td>0.74</td>
<td>1</td>
<td>12.16</td>
<td>8.17</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>1</td>
<td>0.81</td>
<td>2</td>
<td>23.46</td>
<td>9</td>
</tr>
<tr>
<td>Hypertension</td>
<td>15.59</td>
<td>13.75</td>
<td>4</td>
<td>13.38</td>
<td>8.29</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>3.47</td>
<td>3.69</td>
<td>11</td>
<td>-5.96</td>
<td>6.88</td>
</tr>
<tr>
<td>LVD</td>
<td>0.74</td>
<td>0.57</td>
<td>2</td>
<td>29.82</td>
<td>9.41</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0.82</td>
<td>0.85</td>
<td>7</td>
<td>-3.53</td>
<td>7.03</td>
</tr>
<tr>
<td>Obesity</td>
<td>9.71</td>
<td>8.63</td>
<td>5</td>
<td>12.51</td>
<td>8.22</td>
</tr>
<tr>
<td>Stroke</td>
<td>2.53</td>
<td>2.15</td>
<td>1</td>
<td>17.67</td>
<td>8.62</td>
</tr>
</tbody>
</table>

From this it is evident that NHS Ayrshire and Arran has the highest or second highest prevalence rates in Scotland for nine of the seventeen disease groups.

Further, a review of the emergency admission data from the corresponding time period confirms NHS Ayrshire and Arran’s admission rate for a selection of these disease groups, against the Scottish average.
Table 2: Admission rates, ISD Scotland

<table>
<thead>
<tr>
<th>Reason for admission</th>
<th>A&amp;A Admission Rate per 1000 population</th>
<th>Scottish Average</th>
<th>A&amp;A Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>All reasons</td>
<td>156.8</td>
<td>128</td>
<td>1</td>
</tr>
<tr>
<td>Asthma</td>
<td>1.3</td>
<td>1.1</td>
<td>3</td>
</tr>
<tr>
<td>CHD</td>
<td>3.5</td>
<td>3.4</td>
<td>4</td>
</tr>
<tr>
<td>COPD</td>
<td>4.4</td>
<td>3.1</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>15</td>
<td>9.5</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.1</td>
<td>0.1</td>
<td>7</td>
</tr>
<tr>
<td>Stroke</td>
<td>2.5</td>
<td>2.4</td>
<td>5</td>
</tr>
</tbody>
</table>

Linked to this, the most recent SIMD Data confirm the high levels of deprivation in Ayrshire and Arran, with North and East Ayrshire reported to have 26% and 21% of the local share of the 15% most deprived data zones in Scotland respectively.

Table 3: Local Share of 15% most deprived data zones, ISD Scotland

Recognising the link between deprivation, unhealthy lifestyles, disease prevalence and late presentation for treatment and care, there is a need to consider how best to meet the needs of the local population in a more proactive manner to prevent ill health wherever possible and to treat disease and illness at the earliest possible opportunity.
While the prevention of ill health is a longer term aspiration that sits out with the LUCAP, it is an important marker to lay down within this document. The main focus of this section, however, is the promotion and development of the role of General Practice in effectively and safely managing patients with a range of long-term conditions and often multiple co-morbidities, with the aim of improving the management of these conditions in the community and reducing demand on EDs and Acute Receiving Units.

For General Practice to effectively contribute to this aim, services must be readily accessible. The most recent GP Patient Experience Survey (2011/12) confirmed that, at a Health Board level, 92.5% of respondents indicated that they could access a member of the Primary Care Team within 48 hours. This compares favourably with the 90% target.

That said, it is acknowledged that this experience can be variable across the 55 local Practices, with the survey reporting a small number of Practices where only 70 – 80% of respondents reported that they could access the Primary Care Team within 48 hours.

It is accepted that a number of patients who cannot have their urgent care needs met within a Primary Care environment will attend an ED and there is some evidence of patient groups beginning to use EDs as a means of accessing General Medical Services, particularly when their place of residence is in close proximity to the facility1.

Linked to this, it is acknowledged that General Practice has a key role to play in supporting patients to make the right choice when accessing health services. It is known that patients with mental health and / or addiction problems often make disproportionately high use of ED services.

Finally, it is acknowledged that the nature of General Practice has changed significantly in recent years with a recent survey by the Royal College of General Practitioners reporting that 84% of GPs had confirmed their workload had increased substantially; over half stating that they conduct 40 – 60 patient consultations each day; and almost half reporting that they work at least 11 hours in Practice each day2.

Within NHS Ayrshire & Arran our out of hours (OOHs) doctors’ service (NHS ADOC) is provided predominantly by local GPs. This service covers mainland Ayrshire and is provided from three Primary Care Treatment Centres and a mobile service for those patients requiring a home visit. In common with other OOHs services, however, NHS ADOC is finding it increasingly challenging to fill all shifts over holiday periods. A number of issues raised from feedback from GPs regarding how we can improve recruitment and retention have been considered and actioned. A short-life task group has also been established, led by the Executive Medical Director, to develop options for improving the sustainability of the service into the future.

On that basis, General Practice cannot simply be asked to take on more work to support this programme, rather they must be supported to redesign service provision

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1 There is evidence that 16 – 35 year old males from North West Kilmarnock utilise University Hospital Crosshouse Emergency Department frequently for a range of minor conditions and ailments.

within Practices; develop capacity where appropriate; and improve joint working with wider community services to better meet the needs of patients at risk of attending EDs inappropriately and/or being admitted on an emergency basis when an alternative service option could better serve their needs.

b) Interventions and redesigns

In direct response to the analysis above the following interventions and redesigns are planned within Primary Care:

i) Improving Access

NHS Ayrshire and Arran has commissioned the development of an Access Improvement Toolkit for General Practice. This work is being led by a small group of Practice Managers, all of whom have delivered significant changes within their appointment systems, resulting in dramatic improvements in the accessibility of their respective Practices.

The toolkit will therefore draw on good practice locally and nationally, to support improved access across the local area, particularly for patients with urgent care needs to ensure rapid access to a member of the Primary Care Team. This toolkit will be formally launched at the Centre for Excellence Annual Conference in September 2013, with Practices being encouraged to adopt and adapt the learning from this to deliver tangible improvements in access.

Progress will be measured through quarterly monitoring by the Primary Care Management Team of toolkit uptake and the results from the regular GP Patient Experience Survey, with the anticipation that results from the 2014/15 survey will demonstrate improvement in this area.

In the meantime, NHS Ayrshire and Arran will continue to work with local Practices with known access pressures to support improvement. This will take the form of targeted interventions and independent facilitation of service re-design and service change, combined with more formal requirements for service improvements under the terms of the Contract where Practices refuse to engage constructively. Again, action taken and support offered will be recorded and reported quarterly by the Primary Care Management Team and shared with the newly constituted LUCAP Management Group.

The resource implications associated with the development, launch and rollout of the Access Improvement Toolkit will be in the region of £10,000. This cost will be absorbed by the Primary Care Management Team.

ii) Signposting Patients to Appropriate Services

From a review of patients who frequently attend Emergency Departments in Ayrshire and Arran, it is known that two most frequently attending patients from each Practice account for a disproportionately large number of attendances. The Clinical Director for Emergency Medicine in Ayrshire and Arran hypothesised to the National Primary Care Leads Group that this could equate to 10% of all attendances.
Through the QOF QP Process in 2012/13, Practices reviewed their five patients who attended the local Emergency Departments most frequently and identified that they had a range of complex and challenging conditions, often with an underpinning Mental Health and / or Addictions diagnosis. Further, it was reported that these patients also frequently attend their GP Practice and in the Peer Review sessions, where this work was discussed with colleagues from the ED, it was agreed that better signposting was required to ensure these patients could benefit from access to the services and clinicians best equipped to meet their care needs.

To support this, NHS Ayrshire and Arran has, as part of its Enhanced Services Commissioning Plan, introduced a Local Enhanced Service designed to support the signposting of patients who are utilising General Medical Services and ED services when alternative, more specialist services could better meet their needs.

This enhanced service is designed to:

- Target ED Frequent Attendees by shifting the emphasis from reactive to proactive intervention;
- Reduce ED Attendances for conditions which could be managed in Primary Care;
- Offer an alternative to ED attendances; and
- Educate inappropriate ED attendees by promoting self care/self management.

And requires participating Practices to:

- Compile a list of 5 patients who have attended the ED most frequently in the previous quarter;
- Invite each patient for a review of their multiple attendances at ED and where appropriate promote and provide education in relation to self care and self management;
- Document any refusal to attend by the patient;
- Initiate an Anticipatory Care Plan when appropriate;
- Use the SCI Gateway electronic notification form, where appropriate, to notify NHS ADOC /Nursing teams and secondary care should an ACP be created; and
- Refer to other NHS services if necessary.

At 14 June 2013, 48 out of 55 Practices had responded to the sign-up request for this enhanced service, with 40 confirming that they would deliver this in 2013/14. At this level of sign-up, there will be 800 patient reviews in line with the specification above during this financial year, with the potential to affect over 10% of attendances at the EDs in Ayrshire and Arran.

The total funding available to support this enhanced service is £52,500 and this is being resourced from the total enhanced service budget.

iii) Reducing Avoidable Emergency Admissions

In recognising the needs for more proactive management of patients in a Primary Care setting and a more integrated approach to the co-ordination of wider
community services to safely and effectively maintain patients at home, NHS Ayrshire and Arran has planned a more focused approach to the emergency admissions aspect of the QOF QP Process for 2013/14.

The Primary Care Management Team and the Integrated Care and Emergency Services (ICEs) Directorate jointly reviewed the emergency admission data from the Primary Care Information System, presented below:

Table 4: Summary of all admission, ISD Scotland, 2012/13

<table>
<thead>
<tr>
<th>Summary of All Admissions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>713</td>
</tr>
<tr>
<td>Endocrine</td>
<td>909</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>2073</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>1431</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>1920</td>
</tr>
<tr>
<td>Nervous System</td>
<td>1043</td>
</tr>
<tr>
<td>Circulatory</td>
<td>4618</td>
</tr>
<tr>
<td>Respiratory</td>
<td>11147</td>
</tr>
<tr>
<td>Digestive</td>
<td>7886</td>
</tr>
<tr>
<td>Skin</td>
<td>1261</td>
</tr>
<tr>
<td>Musc uskeletal</td>
<td>2157</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>3444</td>
</tr>
<tr>
<td>Poison</td>
<td>6418</td>
</tr>
<tr>
<td>Other factors</td>
<td>2329</td>
</tr>
</tbody>
</table>

Based on these data the teams agreed that local GP Practices should be invited to select three from the following four admission categories to review as part of the QOF QP Process:

- Respiratory;
- Digestive;
- Poison; and
- Circulatory.

In addition to this, participating GP Practices will be required to produce Anticipatory Care Plans for their registered patients who they believe to be at significant risk of emergency admission or unscheduled care. The QOF QP Guidance requires that in producing Anticipatory Care Plans, Practices will:

(QP006(S)) produce a list of 5 per cent of patients in the practice, who are predicted to be at significant risk of emergency admission or unscheduled care.

(QP007(S)) identify a minimum of 15 per cent (in 2014/15, 30 per cent) of those patients from the list produced in indicator QP006(S) who would most benefit from an Anticipatory Care Plan (the ACP must include a poly-pharmacy review), be shared with the local out of hours service and has an appropriate review date. The frequency of each patient’s review should be determined in the light of their clinical
and care needs. The contractor will be responsible for ensuring that an appropriate system is in place for monitoring and reviewing the patients identified in this cohort.

(QP008(S)) hold at least four meetings during the year to review the needs of the relevant patients in the practice ACP cohort, to agree any required changes in the patient management and to share learning/ identify learning needs. These meetings should be open to multi-disciplinary professionals who support the practice’s patients.

Drawing the Anticipatory Care Planning and targeted Emergency Admission reviews together, participating Practices will be required to:

- meet internally to review data on emergency admissions, for patients on the contractor’s registered list, provided by the NHS Board and the learning from at least 25 per cent of the Anticipatory Care Plans (ACPs) completed for QP007(S).

- participate in an external peer review with either a group of local practices, or practices from within the board area, to compare its data on emergency admissions and to share the learning from at least 25 per cent of the Anticipatory Care Plans (ACPs) completed for QP007(S), and proposes areas for internal practice improvement and service design improvements for the NHS Board.

With full participation across all GP Practices in Ayrshire and Arran, it is anticipated that 3,000 Anticipatory Care Plans will be developed in 2013/14, rising to 6,000 in 2014/15. Local guidance will confirm to Practices that this level of attainment will be required throughout the year.

In addition, local guidance will specify that Practices should review 5 of patients from each of the three emergency admission categories they select. This will result in a detailed review of a further 825 patients across Ayrshire with the learning being used to redesign services within General Practice and, through the QOF QP Peer Review Meetings, to inform wider service redesign to better meet the needs of patients.

The cost of this programme of work is fully funded through the QOF allocation.

iv) Care Home Pilot

The ability and capacity of care home to manage sick patients has been strengthened via a collaborative pilot that has seen a reduction in emergency admissions from Care Homes from 235 in October 2011 to 138 in October 2012.

The Primary Care Management Team are now keen to build on this success by developing stronger relationships between local GP Practices, Care Homes and Community Pharmacists to further improve the management of patients with complex care needs and reduce avoidable emergency admissions.

To support this, a pilot Local Enhanced Service has been introduced in South Ayrshire to test whether closer and more predictable working patterns between
General Practitioners and Care Homes can contribute to a reduction in polypharmacy, medicines waste and a further reduction in emergency admissions.

Each participating GP Practice is required to:

- Conduct a 'ward round' of the specified care home(s) on a set day of the week to be agreed with the Care Home and review all registered patients prioritised for medical assessment by the Care Home staff.
- In addition to this, ensure every registered patient is reviewed at least monthly. Review to include:
  - Review of basic health information: Weight, BP, pulse
  - Physical examination of patient including pressure areas
  - Review of dietary / nutritional information
  - Review of mobility and activities of daily living taking into account current diagnoses
  - Review of changes in behaviour or mood taking into account current diagnoses
  - Review of any noted change in vision or hearing – with subsequent referral for assessment where appropriate and recording of that referral

- Engage with the local Community Nursing Teams and specialist services as appropriate to ensure patients' care needs are fully met.
- Undertake a joint medicines review for each patient including use of sip feeds, wound products and catheters (with reference to the most appropriate health professionals for review e.g. Dieticians and District nurses) with Care Home staff as often as required and no less than once per quarter. This would be in accordance with the drug review process set out in the most recent guidance from the Scottish government on Polypharmacy\(^2\) (see Annex 1). If pharmacy input is available then the review would include the pharmacist.
- Ensure an ACP is established for each patient wherever appropriate; that this is developed jointly with Care Home staff and relatives; and communicate the plan to OOHs and secondary care colleagues through the agreed mechanism.
- Ensure Care Home staff are familiar with the content of the ACP and understand how the escalation plan should be implemented.
- As required, and at least quarterly, conduct a multi-disciplinary review of the functionality of this service, making any necessary adjustments as permissible within the terms of this specification.
- Report any concerns in relation to care standards to the Care Inspectorate and Local Authority

This pilot is underpinned by a detailed evaluation programme that will assess the impact of the service on a variety of measures including the number of emergency admissions, ED attendances, ADOC Calls, 999 Calls, etc. The pilot will be evaluated at the nine-month point to assess its impact and determine whether there is benefit in pursuing a rollout programme.
Creating Additional Minor Injury Capacity in General Practice

Within Ayrshire and Arran, the Minor Injuries (Lacerations) Enhanced Service has been provided, mainly by rural GP Practices, to enable the delivery of services designed to avoid unnecessary travel to Emergency Departments for patients who have suffered a minor injury.

This enhanced service funds:

- initial triage including immediately necessary clinical action to staunch haemorrhage and prevent further exacerbation of the injury
- history taking, relevant clinical examination, documentation
- wound assessment to ascertain suitability for locally based treatment and immediate wound dressing and toilet where indicated
- appropriate and timely referral and / or follow up arrangements
- adequate facilities including premises and equipment, as are necessary to enable the proper provision of a minor injury service for lacerations
- registered nurses, to provide care and support to patients undergoing treatment
- maintenance of infection control standards, medical devices that are invasive or come into contact with the mucosa must either be “single use” or be reprocessed at the Area Theatre Sterile Supplies Unit (TSSU) at Ayrshire Central Hospital. Local decontamination of these devices is not permitted. Re-use of Single Use devices is not permitted under any circumstances
- practices must implement all relevant Infection Control policies contained in the NHS Ayrshire and Arran Control of Infection Manual
- information to patients on the treatment options and the treatment proposed. The patient should give written consent for the procedure to be carried out and the completed consent form should be filed in the patient’s lifelong medical record
- maintenance of records of all procedures

In 2012/13 at total of 426 patients were treated under this scheme across 34 participating Practices at a cost of £22,697.28. Subject to the availability of additional funding this service could be more widely promoted and commissioned with the potential to treat additional patients.

c) Statement

The section above clarifies the five interventions and redesigns that are designed to create additional capacity and tailored services in Primary Care with the specific aim
of ensuring patients’ urgent care needs are met at the right time, in the right place. These interventions and redesigns have been devised to ensure primary care services are developed to better meet patient needs and support service areas within the local NHS System that are known to be under pressure.

While the Access Improvement Toolkit will not create additional capacity within Primary Care, it will offer GP Practices a useful resource to help inform the redesign of service provision, based on known good practice, with a view to improving the accessibility of General Medical Services and reducing the demand for such services from the Emergency Department. Similarly, with 48 of the 55 Practices in Ayrshire and Arran signed up to reviewing and redirecting patients who attend the Emergency Department most frequently, there will be 800 patient reviews in 2013/14 aimed at ensuring these patients access services that are more appropriate to their needs.

Turning to patients with more complex care needs, the inclusion of Anticipatory Care Planning within QOF should see the participation of all Ayrshire and Arran GP Practices in this programme and the completion of 3,000 Anticipatory Care Plans in 2013/14, rising to 6,000 in 2014/15. This level of uptake, combined with the work of the local Anticipatory Care Planning Programme Board will ensure that meaningful clinical information is available to everyone involved in the planned and unscheduled care provided to these patients, with a view to reducing avoidable admissions in our most at risk group. Alongside this, the approach being taken to QOF QP locally will ensure that in-depth reviews of a further 825 patient episodes will be undertaken with the learning being used to redesign services within General Practice and, through the QOF QP Peer Review Meetings, to inform wider service redesign to better meet the needs of patients.

Again looking at patients with complex care needs, the local enhanced service pilot for Care Home patients in South Ayrshire will fund over 300 sessions of GP time dedicated to the provision of weekly ‘ward rounds’. This is with a view to develop and nurture relationships between Practice and Care Home staff and to introduce more predictability into the care of patients within these facilities with a view to reducing avoidable emergency admissions.

Finally, subject to the provision of additional funding, the Minor Injuries (Lacerations) Enhanced Service could be offered to an additional 21 GP Practices to create an alternative to Emergency Department presentation for up to 400 patients.

In summary against the aims of strategic theme 2 the actions described above will:

- Ensure the review and redirection of the 800 patients who most frequently attend the Emergency Departments;
- Deliver 3000 Anticipatory Care Plans in 2013/14 and 6000 in 2014/15;
- Undertake a detailed review of 825 emergency admissions and develop proposals for service redesign in General Practice and across the wider healthcare system;
- Deliver over 300 additional GP sessions across 6 Practices in South Ayrshire designed specifically to provide enhanced care to patients in Care Homes; and
- Fund the Primary Care treatment of up to 400 additional patients with minor lacerations who currently access services at the Emergency Department.
2.3 Strategic theme 3 – *Getting emergency patients to the care they need at the right time: flow and the acute hospital.*

**a) Analysis**

The analyses suggest that mismatches between demand for beds and their availability at specific times of the day is the key determinant in patients not getting the right care at the right time. The evidence reveals that the distribution of discharges across each week and across each day is uneven with the majority of all discharges taking place later in the working day and fewer over the weekend. Patients often wait in the ED for a bed to become available and this is clearly illustrated by the pattern of patients waiting over 4 hours in the ED on both sites. There is clear evidence of low rates of morning discharges, which currently are around 9%.

Immediate availability of beds is a factor and recent capacity and demand modelling, undertaken as part of the BfBC programme highlights that UHA is short of acute medical beds, leading to boarding into surgical areas, which is confirmed by boarding figures. Bed waits also arise as a result of receiving ward capacity constraints, both in respect of bed availability and workforce which is not always matched to patterns of demand, particularly as many patient admissions to assessment areas are not taking place until the early evening, cutting across meal times and shift changes, displacing activity into times when fewer staff are on duty. In short by not starting the day with available beds there is a built-in lag that runs into the early evening creating patient flow challenges outwith core working hours, resulting in slower movement of patients into appropriate clinical areas.

Similarly, not discharging evenly across the 7 day week and allowing the two main hospitals to fill up beyond capacity each weekend results in long waits and inappropriate allocation of patients during this period as a range of solutions to accommodate patients is utilised, further complicating patient flow. This creates a specific challenge at the start of each working week as the hospitals manage the backlog and restore patient flow.

There is also evidence of a significant increase in the number of very elderly ED attendees, particularly at University Hospital Ayr (Tables 5 and 6), where a high number of these patients are admitted. This is turn is impacting on longer lengths of stay and the additional requirement for patient rehabilitation services as well as the need for additional community support services to be arranged to enable discharge. There is evidence that frail elderly patients do not benefit from waiting in EDs and the GP assessment and care of the elderly pathway initiatives described later in the action plan set out proposed improvements to this patient pathway. Alongside this the benefits of increased 7 day working and shifting the balance of care towards more rehabilitation at home is required. The number of formal delayed discharges occupying acute inpatient beds is negligible with the maximum wait now less than four weeks.
Chart 1: demonstrates the difference in the numbers of ED attendances and admissions between 2011/12 and 2012/13 at UH Ayr

Chart 2: demonstrates the difference in the numbers of ED attendances and admissions between 2011/12 and 2012/13 at UH Crosshouse

Paediatric in-patient services and Assessment Unit are centralised on the UH Crosshouse site for NHS Ayrshire & Arran.

In view of the current situation it is imperative that robust capacity planning and service modification are in place to meet these demands with sufficient flexibility to cope with surges in activity and other circumstances such as infection outbreaks and poor weather conditions in the winter months. The interventions outlined below are specifically targeted at the identified issues and intended to improve performance.
b) Interventions and redesigns

i) Standardisation of processes within wards

Key processes within the ward environment determine the operational functionality and productivity of each ward and drive the quality of patient care.

In response, a detailed programme of work is now underway at ward level reviewing the key processes in place and the testing of improvements, including ward round scheduling supported by the implementation of a ward round tool, the determination of estimated date of discharge, and criteria led discharge, time of discharge and a range of care quality standards.

This programme of work has established reference information for each process and will use this to monitor each of the measures to gauge improvement. A key process measure in relation to the LUCAP is the number of patients discharged from hospital early in the day.

ii) e-Whiteboard development and roll out

Following the successful implementation of e-Whiteboard systems linking both EDs with their respective medical AMAUs, e-Whiteboards are currently being introduced across all acute wards. Their introduction will support seamless ‘silent’ transfer of patients and will vastly reduce reliance on unnecessary telephone calls between staff that take up valuable time, releasing time to care for patients.

iii) Virtual hub – patient flow and bed management system

Proposals have been progressed to develop a bespoke Bed Management Hub to allow remote management of patient flow and release time that is currently spent by Bed Managers walking the wards and manually extracting data on bed occupancy and patient discharge information. This development will allow the Bed Management Team to support improvement around patient flow processes at ward level to enhance understanding of whole system patient management.

The infrastructure is now established but the necessary feeds that the system requires are dependent on real time entry of patient transfers and discharges into the Patient Management System (PMS). Current analysis confirms, however, that data entry is still being ‘batch entered’ by both clerical and nursing staff.

In response to this, an improvement plan with defined responsibilities and regular feedback on performance should improve this situation allowing the Hub to function as intended. Driven by accurate data both the Whiteboard and PMS information will provide accurate and well displayed real time bed management and flow information that will highlight early identification of flow problems and the instigation of early escalation and remedial actions whenever required.
iv) Discharge planning

Discharge planning is a key focus and the work of a Discharge Planning Group, including representation from the Acute, Social Work and Local Authority Partners, is guiding implementation of the following initiatives.

- Audit of delays to discharge within wards at University Hospital Ayr, University Hospital Crosshouse, Ayrshire Central Hospital and Biggart Hospital
- Development of a Discharge Flowchart to be shared with all wards detailing all agencies involved in discharge management and how these should be accessed
- Co-ordination of attendance of all agencies at daily Whiteboard meetings. A pilot is running in Ward 3B at Crosshouse using PDSA cycles
- Co-ordination of AHP input into discharge processes including during escalation at times of flow capacity issues
- Co-ordination of a review of the Discharge Policy to include recent developments
- Planning of education package around Discharge Management to be delivered to individual wards

v) Revised escalation plans

Work has just commenced on standardising the approach to managing weekend bed deficits to maintain patient flow and minimise transfer of patients outwith specialty beds. An ED Escalation Policy to deal with departmental overcrowding has also been developed and is currently being consulted upon. This information will be incorporated into the existing patient flow arrangements for use by managers.

vi) Provision of additional medical beds at University Hospital Ayr

The recent bed modelling exercise undertaken as part of the business case for the Building for Better Care capital investment programme highlights that University Hospital Ayr has fewer medical beds than required, resulting in high rates ofboarding and poor patient experience. In response a review will be undertaken over the next three months to understand the position and re-align beds where possible. In the meantime however and in response to the immediate need, 6 additional winter beds have remained open.

vii) GP Assessment Areas (GPAA) – University Hospital Crosshouse and University Hospital Ayr

GP assessment units have been successfully piloted on both sites as part of the improvement actions within the Emergency Care Quality Improvement Programme (ECQIP). In each case a positive impact on patient care has been proven and these facilities will now be established on each site.

An Acute Medical Assessment Unit at University Hospital Crosshouse has just been introduced and is a 6 bedded facility which with the addition of extra staff, can provide fast, early senior decision making that improves patient assessment and treatment. A similar service will now be established at University Hospital Ayr.
through re-designation of existing surgical beds in a ward adjacent to the Acute Medical Assessment Unit.

c) Statement
The interventions and redesign of services described above are all intended to facilitate timely access to the right hospital care in the right location. They seek to deliver sufficient capacity to address known demands and to make sure robust processes are in place to meet these demands consistently, coping with variations in supply or demand as they occur.

The action to provide more medical beds at UHA will introduce an additional 4380 bed days and reduce boarding. Likewise the introduction of new GPAA units at UHC and UHA will deliver additional capacity and throughput permitting early transfer of patients from the EDs and preventing many avoidable 4 hour breaches and up to 5 patients from being admitted each day who previously would have entered the receiving system and taken up a bed. Similarly the renewed focus on ward processes, discharge processes and standardisation of approaches in ward settings will deliver faster access to beds, improved assessment and reduced lengths of stay. The aim for each ward to discharge 50% of patients by midday will make a real difference, allowing patients to be moved on from EDs and assessment wards more quickly. The initiatives to enhance existing escalation policies, and the roll out of real time bed management information via the planned information hubs, will heighten awareness of patient flow performance and sharpen the hospitals’ response to impending difficulties or developing situations.

In summary against the aims of strategic theme 3 the actions described above will:

- Maintain the 10% increase in weekend discharges and drive this figure up through increased used of Criteria Led Discharge and effective implementation of improved ward based processes
- Improve patient flow information through the implementation of e-whiteboards and the full use of the new Patient Management System Bed Management Module – resulting in real time information and increased hospital responsiveness (September 2013)
- Provide a newly enhanced clinical escalation policy to support the reduction of patients waiting for long periods in the two EDs (September 2013)
- Increase the number of GP referred patients who will be assessed by Acute Physicians in newly established GP Assessment Units, bypassing the EDs

2.4 Strategic theme 4 – Making sure patients get the right care across unscheduled care: promoting senior decision making along the pathway.

a) Analysis
The acute receiving models presently used are no longer fit for purpose and rely on traditional ‘batch assessment’ models that require patients to often spend unnecessary time in hospital undergoing unnecessary tests that may have been avoidable had they been reviewed by a senior clinical decision maker shortly after initial presentation. A number of patients are currently not reviewed by the receiving medical consultant until the day after their admission as they have been transferred
to the acute assessment unit late in the afternoon, having been retained in the ED, due to unavailability of appropriate beds.

The general theme is that we are presently admitting patients to the acute assessment units to decide whether to admit rather than deciding whether admission is required at the outset. Evidence reveals that earlier decisions made by appropriate clinicians would shorten hospital stays and free up beds.

The interventions and redesigns outlined below address specific areas where performance could be improved and where additional senior decision making will have a significant impact on length of stay, overall capacity and the ability to see and treat patients in an efficient timely way.

b) Interventions and redesigns

i) Consultant weekend working at University Hospital Ayr

An additional receiving Physician has been working weekends at University Hospital Ayr since October 2012. The purpose of this development was to increase access to senior decision making at weekends and to improve patient flow through earlier discharge. Evaluation of this development has demonstrated a 10% increase in weekend discharges over the recent winter compared to last winter. This development will be continued with further evaluation undertaken in the run up to winter 2013.

ii) Acute Medicine Models at University Hospitals Ayr and Crosshouse

A new clinical model based on the Society of Acute Medicine indicators of quality listed below was tested at both main acute sites and found to be highly effective in all regards, following audit.

At University Hospital Ayr a total of 21 patients were assessed during the initial pilot with 14 of these patients discharged home on the same day, 4 patients admitted to medicine and 2 allocated to short stay beds, and the remaining patient transferred to urology. Further to this, subsequent pilots sustained a rate of 40% same day discharges. These tests strongly indicated that the new care model of earlier consultant review shortened the patient journey and reduced patient length of stay.

The model has now been tested on multiple occasions and results have been consistent. However, ongoing delivery of this model requires additional consultant Acute Physicians who are trained in the model of care. The pilot also confirmed that the University Hospital Ayr AMU (Station 7) should be increased in size so patients can be assessed in this way rather than current practice of transfer to specialty medical beds. A similar pilot study at University Hospital Crosshouse produced similar encouraging results as well as reducing the median time to see a junior doctor from 7 hours (traditional model) to around 90 minutes (pilot model), with similar improvement to see a consultant falling from around 15 hours to around 3 hours.
To sustain this model also requires additional Clinical Support Workers and Advanced Nurse Practitioners to function fully and efficiently.

In view of these proven benefits, support funding has been identified for 2 additional consultant posts in Acute Medicine and 2 new appointments have now been made for University Hospital Crosshouse. Further to this, additional recruitment of Acute Medicine consultants is still required, as until these posts are sufficient in numbers to form a stand-alone Acute Medicine model covering both sites, there will be a continued reliance on traditional general medical assessment models.

**Society of Acute Medicine: Guidelines for Acute Medical Assessment**

- Patients should be assessed by a competent decision maker within 30mins
- A treatment and investigation plan should be formulated and instigated within 60mins
- Consultant review and management plan should occur within 14hrs but for patients arriving on the AMU between 0800 and 1800 this should be less than 8hrs
- Patients should have a MEWS recorded at point of entry to care and regular MEWS
- Four hour standard applies regardless of their place of treatment (ED, AMU, CAU)
- Single sex accommodation
- Regular monitoring of key performance indicators in acute care
- NHS Boards have policies and guidance in place to ensure the timely undertaking of investigations

**iii) Cardiology 7 day working**

The Cardiology Service, as a high volume specialty, would greatly benefit from the presence of senior decision makers across all 7 days of the week to enhance patient assessment and therefore patient movement through the two coronary care units and general cardiology ward as well as assisting physician colleagues with specialist advice to enable timely discharge. The introduction of a 7 day consultant presence will also support the placing of Temporary Pacing Lines (TPL) that are best carried out by cardiologists. Discussions with the Board’s cardiologists have now been concluded and there is agreement to provide a 7 day cardiology consultant service by August 2013. An additional Cardiologist post is currently being recruited to support this new development.

**iv) Frail elderly pathway / geriatric assessment area**

Performance data shows an increase in the number of patients aged 75 and over admitted to our acute hospitals within Ayrshire and Arran with a corresponding
increase in bed days. Patients over the age of 65 are also more likely to exceed the four hour target for transfer or discharge from the Emergency Departments, due to time required for assessment and bed availability delays. During May 2013, a multidisciplinary team was established to plan and participate in a test of a Frail Elderly Pathway within University Hospital Crosshouse Emergency Department. The initial results were very encouraging and demonstrate a positive impact on: admission avoidance, 4 hour target performance for all clinical flows, reduction in boarding, quicker time for Consultant first review, time to comprehensive geriatric assessment, with frail elderly patients going direct to care of elderly wards rather than via other areas.

The Frail Elderly Pathway test will be extended for a further 6 months between August 2013 and February 2014 to further refine the model and determine how it could be embedded into mainstream service delivery on a sustainable basis within University Hospital Crosshouse. The Frail Elderly Pathway will also now be tested at University Hospital Ayr.

Analysis of Care of the Elderly demand for emergency admission for patients over 75 has just been undertaken by the Project Team. This analysis will enable us to identify capacity constraints and potential solutions, linking to the work of the Frail Elderly Pathway.

v) Emergency patient flow within surgery

The emergency flow of surgical patients through the ED at University Hospital Ayr has been recently reviewed with the development of a pathway to ensure that patients are seen on the Surgical Ward at an earlier juncture by a senior decision maker.

vi) Radiology extended day and weekend working

To support patient assessment and rapid diagnosis it is essential that radiology investigations are both undertaken and reported within a few hours of request. NHS Ayrshire and Arran has not yet set targets for such radiological investigations but other similar units have targets of between 2 and 6 hours from assessment.

In advance of the new CAUs, the ECQIP Programme Board has been piloting aspects of our new model of care, primarily the rapid assessment of GP admissions until 20.00 hours and consultant review of short stay patients at weekends. Some redesign work has been undertaken to provide Consultant Radiology cover between 0900 and 2015 hours Monday to Friday, and 0900 and 1500 hours on Saturday/Sunday, but to facilitate this on an ongoing basis requires additional resources.

It is therefore proposed that day and weekend Consultant cover is introduced for a period of 12 weeks (from August 2013) to allow further assessment of the Radiology service at University Hospital Crosshouse and its likely contribution to patient flow and unscheduled care.
c) Statement
The need to quickly increase and enhance appropriate senior decision making is clear and proven. The literature, evidence and work already concluded as part of our ECQIP and Building for Better Care programme all support this aim, with actions and implementation now required. The interventions and redesigns outlined above would make a difference to many patient journeys and in overall terms markedly improve efficiency and performance of our two acute hospitals.

The roll out of Acute Medicine receiving models on both sites will allow continuous review of patients between 9 am and 10 pm and result in many more decisions not to admit as well as rapid same day discharges. The commencement of a cross site 7 day cardiology rota will improve access to Cardiology opinion and enhance speed of assessment and weekend discharge from the cardiac care units and specialist cardiac wards. The introduction of the frail elderly pathway will greatly improve access to specialist opinion and improve overall care for this vulnerable group of patients, and the extended hour’s radiology pilot will seek to ensure rapid access to diagnostic tests and results, again supporting earlier senior decision-making.

In summary against the aims of strategic theme 4 the actions described above will:

- Maintain the 10% increase in weekend discharges and drive this figure up by another 10% through the continuation of additional weekend General Physicians at University Hospital Ayr and University Hospital Crosshouse together with the introduction of a 7 day cardiology service across both hospitals.
- The Implementation of the Acute Medicine models at both University Hospital Ayr and University Hospital Crosshouse will deliver the Society of Acute Medicine Guidelines for Medical Assessment and allow continuous review of patients for a prolonged part of the day, delivering safer, faster care for newly admitted patients and shortened times in the two EDs.
- Through the frail elderly pilot, older people will transfer from EDs quickly to more appropriate settings, either to home with support or direct to a care of the elderly bed, thereby avoiding unnecessary steps - making for a better patient experience, limiting avoidable admission and reducing length of stay.
- Improve surgical patient flow at University Hospital Ayr through earlier surgical review in the ED.
- Extend access to imaging promoting rapid decision making and improved patient journey times.

2.5 Strategic theme 5 – The right care every time: assuring effective and safe care 24/7 at the hospital front door.

a) Analysis
There is limited evidence to suggest that peaks in demand is the root cause of four hour breaches, but there is documented evidence of ambulance turn around delays, triage delays and first consult delays that are mainly attributable to bed waits apart from a small proportion of first consult delays at University Hospital Crosshouse which stem from the ongoing challenge of available doctors. Patient presentations...
confirm that this workload at University Hospital Crosshouse cannot be addressed by increasing the Emergency Nurse Practitioner (ENP) contribution. The issue is further exacerbated by increased average ED journey times for admitted patients who require more medical and nursing input as patients are remaining in the ED for longer periods due to bed waits, leaving less time to manage new patient presentations.

Alongside this, snapshot survey evidence demonstrated that a proportion of inpatients can wait lengthy periods for imaging and physiological medicine, particularly at weekends. There is evidence to support the need to shift the balance of inpatient and outpatient appointment slots to create more inpatient capacity and to redesign diagnostic services to be responsive throughout the 7 day, 24 hour period. There is however no clear cut evidence that improving access to these investigations (and the prompt provision of investigation results) will of itself significantly improve the speed of inpatient throughput.

Within NHS Ayrshire and Arran’s two acute hospitals, almost all emergency and GP arranged admissions are admitted via the two EDs. This is not a value adding step for all patients and the Building for Better Care Programme aims to address this through the support of new facilities. There is, however, scope to progress the thinking behind the BfBC care model and bring forward clinical pathway changes in advance of the completion of the capital project. There is scope for developing ambulatory care pathways at University Hospital Ayr and expanding the current ambulatory care pathways in place at University Hospital Crosshouse. There is also scope for expanding the acute/admissions avoidance clinic at University Hospital Ayr.

Work has been undertaken to develop skills and confidence of staff to redirect patients from the EDs to more appropriate services. The ‘Redirections’ programme is well established, and 1,631 patients who attended the Emergency Departments in 2012 were redirected to more appropriate care at the point of triage. There is also a system wide communication/engagement programme in place to ensure that patients are well informed and appropriately sign posted, with a long running ‘Know Who To Turn To’ social marketing campaign to support the redirection protocols agreed with primary care services.

b) Interventions and redesigns

i) Additional emergency medicine consultants

Additional posts are required to provide 12 hour per day consultant presence, over the 7 day period, in line with our NHS Board strategy. Additional consultant level input will enhance senior decision making and limit avoidable admissions. There is an urgency associated to this requirement, as there is a reduction in middle grade Emergency Medicine numbers in the West of Scotland that is likely to destabilise the service. Funding exists for 2 of these consultants, and Scottish Government funding has been provided to support an additional 2 posts on a non-recurring basis (50% in year 2, 25% in year 3, reducing to zero in year 4). If successful appointments are made, funding will be required to dovetail with the reduction of Scottish Government funding from local resources.
ii) **Acute pathway medicines reconciliation**

Pharmacy has been closely involved in the redesign work around the unscheduled care patient journey. Medicines reconciliation is a key component of successful emergency patient management. Published work from University Hospital Crosshouse ED has demonstrated that a prescribing error rate of 3.3 errors per patient (traditional model) reduced to 0.04 errors when medicines are reconciled within the ED by a Pharmacist or Independent Prescriber. This approach to emergency care patients has been extremely effective with clear improvements in patient safety.

iii) **Formation of Clinical Decision Unit (CDU) within the ED at University Hospital Ayr**

Creation of a CDU at University Hospital Ayr is one of the actions aimed at supporting the overall recovery of the 4 hour emergency access standard. University Hospital Crosshouse has operated a CDU since December 2005 with a positive impact across the whole system. The team has a staffing complement made up of nurses, doctors and clinical support services. Within University Hospital Ayr it is planned that a 6 bedded area (previously the observation ward) sited within the A&E department would be allocated as the CDU facility on a 24/7 basis from December 2013.

The introduction of specific pathways of care within a CDU model facilitates a change in practice which supports early senior clinical decision making, rapid diagnostics, evidence based clinical management, reduction in clinical risk, streamlined documentation, reduced length of stay and improved patient satisfaction. Plans are in place to ensure that the number of clinical pathways will increase within the next year. These pathways will operate across both hospital sites providing consistency and delivery of high quality care. The CDU pathway management model is one of the seminal strands of the new service model that will be incorporated into the new front door service (Building for Better Care) as ambulatory care, utilising the proposed new 11 ambulatory care bays on the University Hospital Crosshouse site and 8 on the University Hospital Ayr site.

iv) **Introduction of a Flow Co-ordinator at each Acute Hospital site**

A Flow Co-ordinator within each Emergency Department will support the management of patient flow within each hospital. Although sited in the ED these posts will dovetail with the current work of the bed manager in supporting patient flow across all wards and departments. These posts are initially for a 6 month period to allow for further testing of this service model which will be available on each acute site Monday – Friday, 1200 hours to 2000 hours.

c) **Statement**

The interventions and redesigns detailed, along with those described in response to the earlier strategic themes, will support the delivery of more effective care at the ‘front door’ of each of the acute hospitals. Additional consultant presence will help to offset the diminution of training grade staff and underpin our ambition to have consultants on both sites 7 days a week, for extended periods - a measure that will
reduce time to senior review and raise admission thresholds thereby preventing avoidable admissions. The redesign and development of the pharmacy services within each ED will address safety issues and streamline pharmacy provision throughout the patient journey. Similarly the introduction of ambulatory care pathways within a CDU at University Hospital Ayr and development of further pathways at University Hospital Crosshouse will bring forward elements of the new ‘front door’ model proposed in Building for Better Care and secure the advantages already in place at University Hospital Crosshouse, where the CDU provides rapid assessment and treatment for 12 common patient presentations.

In summary against the aims of strategic theme 5 the actions described will:

- By recruiting additional Emergency Medicine Consultants, help offset the planned reduction in middle grade trainees and reduce the number of first consult delays, as well as expanding senior decision making in the EDs
- Improve patient safety in the ED through enhanced pharmacy services
- Through delivery of a CDU on the University Hospital Ayr site, reduce LoS and reduce pressure on inpatient beds as well as support working towards the clinical model described in the Board’s BfBC capital investment programme.
- By introducing flow co-ordination at University Hospital Ayr and University Hospital Crosshouse, promote improved patient flow and compliance with the 4 hour target

3 WINTER 2013

The plan for Winter 2013 will follow the Scottish Government’s guidance for the preparation for Health Board Winter Plans and complement the action and measures outlined elsewhere in this LUCAP.

The service arrangements to manage anticipated increased demand will be developed through the NHS Ayrshire and Arran Winter Planning Group, which has representation from Health Services throughout Ayrshire, Local Authority partners in North, South and East Ayrshire together with representation from the Scottish Ambulance Service and NHS 24.

The service arrangements for this year are based on the continual review and adaptation of working arrangements and measures developed in response to operational pressures over the past few years, and will include the following:

In-patient services

An escalation plan for the management of in-patient services has been in place in for several years and is reviewed on an ongoing basis. The escalation plan is supported by a patient flow handbook which provides further detail for use by all Managers throughout the system. Together, the escalation plan and the handbook provide direction on essential cross system communication and rapid escalation in response to early identified pressure points which are indicated within the plan. A colour coded system is applied to a series of actions and responses which are directly linked to clinical safety patients triggers.
The infrastructure behind the escalation plan is in place all year round, as it is recognised that pressures throughout the year can trigger high amber or red responses (demand from unpredicted unscheduled admissions, reduction in discharges, infection outbreaks, severe weather and reduction in staff cover). To implement the actions required as a result of escalation, short patient flow meetings are held daily and these are held twice or thrice daily when there is evidence of pressure building within the system. The meetings are chaired by a Senior Manager on a rota basis to support the Bed Manager. The meetings are attended by receiving doctors, charge nurses and Allied Health Professionals, and are extended to include others based on the specific pressures being experienced. The escalation policy is well understood and tested throughout NHS Ayrshire and Arran on a regular basis.

It is normal practice within NHS Ayrshire and Arran to minimise elective activity in the early part of each new year. During this period surgical specialties limit their activity as far as possible to those patients with a diagnosis of cancer who require urgent surgery and those who require emergency surgery. Day surgery services run as usual with all possible cases being undertaken on a day case basis. This action over the years has reduced the number of elective cases cancelled at short notice due to pressures in the system through emergency activity.

A range of service enhancements to manage the anticipated increase in demand over the winter period will be in place, linked to the LUCAP developments. The elements for this year are based on continual review and adaptation of working practices and building upon experience gained over previous years. Specifically these measures will include:-

- **Additional medical bed capacity** will be in place at both University Hospital Ayr and University Hospital Crosshouse.

- **Temporary expansion of Clinical Decisions Unit** at University Hospital Crosshouse by 3 beds. This unit currently is located adjacent to the Emergency Department and utilises ten specific care pathways to rapidly diagnose and treat patients, preventing admission to the main medical receiving pathway as a result.

- **Patient flow co-ordination** (University Hospital Ayr) will be provided through the establishment of an additional member of staff in the Emergency Department during peak activity periods. This will support rapid and safe transfer of patients through the department and to medical areas, and address particular space issues in the department by helping to vacate assessment cubicles quickly.

- **Additional discharge/transfer ambulance capacity** for both University Hospital Crosshouse and University Hospital Ayr to support increased level of discharges at peak times, particularly over the 2 week festive holiday period and at weekends.

- **Additional medical ward rounds** will be delivered and targeted application of resources will support more out of hours clinical assessment and care planning, particularly at times of peak admissions when medical boarding becomes an issue. Further to additional consultant ward rounds, and as in previous years,
consideration will be given as required to Advanced Nurse Practitioner (ANP) additional working with a focus on assessment and discharge planning.

- **Additional acute medical clinics** will be provided to allow early supported discharge through the process of timely follow up and quick access to imaging services.

- **Additional pharmacy services** will be provided at weekends and on public holiday days

Winter rotas for all members of staff will be finalised by the end of October 2013. The rotas will ensure that the appropriate staff members are available to respond to the projected activity in the period leading up to, and during the period following, the festive period. All Managers across all clinical and all supporting services will also ensure that the number of staff taking annual leave during the festive period and across the winter period is within manageable levels, which will be measured against a recommended minimum of staff required for the service at any point in time. Regular clinical staff training will also not take place during the first 2 weeks of January 2014.

Whilst all staff contribute to service delivery, additional steps will be taken to identify additional core staff to include those clinical staff who normally work in clinical training services being rostered to support clinical services during the first 2 weeks of January 2014. In addition, where required, staff working hours will be increased through the implementation of flexible working arrangements during specific pressure periods. Guidance will also be in place for issue to all staff who may experience difficulties in travelling to work during severe inclement weather, and a contingency plan is in place to provide accommodation for staff if this is essential to sustain service delivery.

**Community services**
The intermediate care and enablement service (ICEs) will work in partnership with local authority, NHS Ayrshire and Arran, private and voluntary agencies to provide short term support for people with conditions that can be safely managed at home or in the community but require additional health and social support to facilitate this. The service can enable early and supported discharge from hospital or provide an alternative to hospital admission. It aims to maximise long term independence, choice and quality of life and as a consequence reduce the need for ongoing support from formal services. People’s needs are identified through a comprehensive multi-factorial assessment. Interdisciplinary treatments, rehabilitation and enablement plans are created in partnership with the service user. The focus is on setting goals and achieving outcomes for individuals that enable them to be as independent as possible. The core hours of the service are Monday to Friday, 0830 – 1730, and out of hours A&E and ADOC doctors can refer to the Out of Hours Single Point of Contact who in turn will pass the request to the enablement service for next day action. In summary the service provides rapid alternatives to hospital admission, early discharge and supported discharge, hospital screening, community geriatric services and common approaches to falls and strokes - all of which will improve patient flow and promote appropriate timely access to services.
The community nursing service will be available from 5.30 pm to 8.30 am and throughout the weekend to patients who already receive district nursing care or for whom care is planned. This will allow more care to be provided within both care homes and people’s own homes. An out of hours co-ordinator is responsible for co-ordinating the service across Ayrshire and working closely with the out of hours Primary Care GP service. Out of hours service staff will also be based at satellite centres at East Ayrshire Community Hospital, Ayrshire Central Hospital and University Hospital Ayr. The co-ordinator will also meet with A&E staff at 4pm each day to promote stronger links and to promote and further develop the service between hospital and community. In addition there is also a professional to professional phone line so out of hours staff can be readily contacted.

The three Community Wards are now in full operation, supporting patients to help manage long term conditions at home and reduce the need for admission to hospital, allowing patients to remain in the comfort and in the stability of their own home. Daily ward rounds are conducted each morning with referrals taken from both GPs and Hospital Consultants.

**Primary care services**
GP practices across Ayrshire will provide, throughout the core hours period, those services required for the management of their registered patients and temporary residents who are ill with conditions from which recovery is generally expected; terminally ill or suffering from chronic disease.

GPs, in discussion with their patients, will determine which services are required and will ensure they meet these requirements throughout the winter period by managing the capacity available to meet the anticipated increased demand for General Medical Services.

To support General Practices to meet increased demand during the winter period, the Primary Care Management Team will promote the following initiatives:

- **Influenza Vaccination Directed Enhanced Service** As part of the 2013/14 Enhanced Service Commissioning Plan this measure seeks to secure high levels of vaccinations by GP Practices to targeted groups as a means of reducing the likely incidence of influenza and the increased demand for services.

- **Community Ward** The Community Ward initiative summarised earlier provides an opportunity for General Practitioners to refer to Primary Care based Medical and Nursing Services which can offer intensive, targeted home support for individuals who are at risk of admission to hospital. The catchment areas for this initiative have been widened and practices are being supported to refer patients who would benefit from this service.

- **Business Continuity Planning** GP Practices continually review their Business Continuity Plans to ensure they remain fit for purpose. These plans are designed to ensure each practice will be able to continue to function in a wide range of circumstances, including damage to their facilities, pandemics, etc.
\begin{itemize}
\item **NHS ADOC** This service works continually with predictive demand data, and staffing establishments are enhanced to deal with peak demands. NHS ADOC plans will be in place to respond to the additional demand through flexible working arrangements over the winter period, and will continue to work closely with NHS 24 to ensure a safe, sustainable service.
\end{itemize}

**Communication**
The national campaign will address the main issues and messages via the local and national media.

The local campaign will however support the national messages and include the following:-
\begin{itemize}
\item Medication stock up;
\item Self care;
\item Request repeat prescriptions; and
\item Practices closed for two extra days at Christmas and New Year
\end{itemize}

With the additional local messages
\begin{itemize}
\item Responsible use of services
\item Flu vaccination uptake and the benefits
\item Where to get emergency contraception
\item Local dental helpline
\item Reminder of simple steps to keeping well/treating minor ailments
\item Appropriate use of antibiotics
\item How to get the most from your local pharmacist
\item NHS 24 health information line
\item Check dates and restock medications that are not used regularly
\item Pharmacy opening times on NHS 24 and NHS Ayrshire & Arran public websites
\item Difference between minor ailments and serious conditions
\item Minor ailment services
\end{itemize}

**Infection Control**
Infection Control Risk Assessments and Protocols are in place to support isolation and cohorting of patients in hospitals during outbreaks of Norovirus. A Norovirus LearnPro module is available for all staff for constant updating purposes and is accessed through personal LearnPro accounts.

The infection prevention and control Athena site is available for staff to access all policies and leaflets. This includes a section which outlines staff's responsibilities with regard to Norovirus outbreaks. A broadcast email to all staff and a weekly article e-news brief also provides a direct link to this section. In addition the front page of Athena will provide a link to the section for the duration of Norovirus season. Wider press releases, for both patients and visitors regarding Norovirus, including information on what to do if affected or visiting a closed area, have already been issued.

The infection control team will remind ward staff, each time they visit, about what to do if an outbreak is suspected, and will be available to reinforce this message at daily patient flow meetings where they will offer guidance and support when required. The introduction of this approach during outbreaks will support improved
patient flow and allow more confident, reasoned use of bed areas to prevent loss of available beds and delays. A scoring system for single room usage will be applied, allowing clinical staff to make rational decisions in line with infectivity and other patient requirements.

**Seasonal flu vaccination programme**
Every year NHS Scotland Health Boards are asked to offer immunisation against seasonal flu to all health care workers. The aim this year is to improve uptake of immunisation on last year. Flu champions for each directorate will be appointed to work with Occupational Health to help support the campaign and encourage high vaccine uptake.

The flu immunisation campaign will adopt the same three phase approach used in the last few years (Phase 1 – high risk clinical areas using ward /departmental immunisers supported by Occupational Health; Phase 2 - all other clinical areas using ward /departmental immunisers supported by Occupational Health; Phase 3 – all other areas not covered in Phase 1 and 2).

This year to try and increase uptake again, the changes from last year will be further developed. Data will be tracked to capture the following information:-

- How many staff have taken the flu vaccine
- How many staff have had the vaccine elsewhere, eg GP
- How many staff confirmed the offer of the flu vaccine but did not take the vaccine

All staff will be given a form to complete regardless of which option they have chosen, to support the completion of a full set of data.

**Severe Weather**
Severe weather has been a notable feature of recent winters and in view of that, specific winter contingency plans for each healthcare site are in place. The plans include traffic management information that has been developed and will continue to be reviewed in light of experience and lessons learned. These plans (held by Clinical Support Service staff and Estates staff) describe the processes and resources available to help ensure continued operation of services across all key healthcare sites and facilities. Gritting arrangements feature prominently and local estates/ facilities staff will work closely with the local authority emergency services during any adverse weather periods to ensure main access/egress roads are the priority.

Previously, severe weather has prevented some patients from getting home from hospital, or staff into or home from work. Managers are able to offer accommodation in these circumstances.

**Conclusion**
This winter plan draws on past experience and the systems already embedded within the organisation, and when delivered alongside the additional focus and initiatives of the LUCAP, provides a comprehensive and responsive set of arrangements to deal with the additional pressures and challenges of winter.
Table 5 below sets out an investment plan for the LUCAP listing direct investment and associated investment that is already in place through the CHP Change Fund, the Board’s Reshaping Care for Older People Strategy and the EQUIP programme that supports the new clinical model set out in Building for Better Care. These existing commitments are set within the context of new funding bids through the LUCAP process. The elements of the plan are categorised as either short or medium term and are linked to the milestones outlined in the performance trajectory.

Short term indicates that the investment is required by September 2013 and linked to immediate changes that will improve the 4 hour performance to at least 95% by the end of September 2013. Medium term indicates that investment will be required for the next financial year.

Table 5: Indicative financial investment schedule

<table>
<thead>
<tr>
<th>Intervention/re-design</th>
<th>Cost detail</th>
<th>Priority</th>
<th>NHS A&amp;A Funding in place (£000s)</th>
<th>SG LUCAP Bid (£000s)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Aim 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The outlined interventions and re-designs are all being taken forward under the Boards Re-shaping Care for Older People Strategy and the CHP Change Fund Plan.</td>
<td>Funding in place - refer to Change Fund and Re-shaping Care for Older People Strategy</td>
<td>VARIED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strategic Aim 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving access – access improvement tool kit</td>
<td>Funding in place - Primary Care</td>
<td>SHORT</td>
<td>10</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
<tr>
<td>Signposting to appropriate services – enhanced service targeting ED frequent attenders</td>
<td>Funding in place - Primary Care</td>
<td>SHORT</td>
<td>53</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
<tr>
<td>Reducing avoidable admissions – review of frequently admitted patients</td>
<td>Funding in place - Primary Care</td>
<td>MEDIUM</td>
<td>790</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
<tr>
<td>Care Home Pilot – GP ward rounding</td>
<td>Funding in place - refer to Change Fund and Re-shaping Care for Older People Strategy</td>
<td>SHORT</td>
<td>90</td>
<td>Non recurring</td>
<td></td>
</tr>
<tr>
<td>GP Minor injury development</td>
<td>New funding required</td>
<td>MEDIUM</td>
<td>15</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
<tr>
<td><strong>Strategic Aim 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardising ward processes</td>
<td>Redesign from within existing resources</td>
<td>SHORT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-Whiteboard</td>
<td>Funding in place - NHS A&amp;A</td>
<td>SHORT</td>
<td>255</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virtual hub</td>
<td>Funding required</td>
<td>SHORT</td>
<td>6</td>
<td>Non recurring</td>
<td></td>
</tr>
<tr>
<td>Discharge planning process</td>
<td>Redesign from within existing resources</td>
<td>SHORT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised escalation procedures</td>
<td>N/A</td>
<td>SHORT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Medical Bed Provision at UHA (All year round Stn 12 use)</td>
<td>New funding required</td>
<td>SHORT</td>
<td>257</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
<tr>
<td>Establishment of GP assessment units at UHA and UHC (including CSW)</td>
<td>New funding required</td>
<td>SHORT</td>
<td>669</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
</tbody>
</table>
Extended pharmacy provision within GP assessment units | New funding required | SHORT | 26 | Recurring (FYE)

### Strategic Aim 4

<table>
<thead>
<tr>
<th>Description</th>
<th>Funding Requirement</th>
<th>Duration</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Additional Acute Medicine Consultants</td>
<td>New funding required</td>
<td>MEDIUM</td>
<td>354</td>
</tr>
<tr>
<td>Cardiology 7 Day working</td>
<td>Funding in place - NHS A&amp;A</td>
<td>SHORT</td>
<td>118</td>
</tr>
<tr>
<td>Frail elderly pathway – 6 month pilot</td>
<td>New funding required</td>
<td>SHORT</td>
<td>470</td>
</tr>
<tr>
<td>Emergency patient flow within surgery</td>
<td>Redesign from within existing resources</td>
<td>MEDIUM</td>
<td>-</td>
</tr>
<tr>
<td>Introduction of radiology extended day and weekend working – 12 week trial</td>
<td>Funding in place – NHS A&amp;A</td>
<td>SHORT</td>
<td>25</td>
</tr>
</tbody>
</table>

### Strategic Aim 5

<table>
<thead>
<tr>
<th>Description</th>
<th>Funding Requirement</th>
<th>Duration</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Additional ED Consultants, University Hospitals Ayr and Crosshouse</td>
<td>Funding in place for 2 - NHS A&amp;A. The other 2 posts have SG funding support through LUCAP bid for 3 years</td>
<td>SHORT</td>
<td>236</td>
</tr>
<tr>
<td>Admin support to both EDs</td>
<td>Funding required</td>
<td>SHORT</td>
<td>67</td>
</tr>
<tr>
<td>Formation of CDU at UHA</td>
<td>New funding required. Proportion of funding available through reallocation of existing resources</td>
<td>SHORT</td>
<td>228</td>
</tr>
<tr>
<td>Introduction of a flow coordinators at UHA and UHC – for limited period</td>
<td>Funding in place – NHS A&amp;A</td>
<td>SHORT</td>
<td>31</td>
</tr>
<tr>
<td>ED enhanced pharmacy provision at UHA and UHC</td>
<td>Funding required</td>
<td>SHORT</td>
<td>106</td>
</tr>
</tbody>
</table>

To deliver the LUCAP, our funding support bid to the Scottish Government is **£2,156,000**.

Scottish Government provided the Board with £266,348 of winter funding monies in the financial year 2012/13 that was supplemented by a further £191,966 of additional Board funding. These monies were used to temporarily open extra beds on both main sites, temporarily expand the Clinical Decisions Unit at Crosshouse Hospital, provide extra domestic services, patient transport and to temporarily deploy extra doctors, therapists and pharmacists together with a number of other measures to expand capacity and enhance patient flow. In the main these schemes worked very well and will feature again alongside the elements of the LUCAP that will also address the winter challenge.

## 5 WORKFORCE

The proposals within the LUCAP require expansion of the workforce with a number of new consultant and other clinical roles identified.

In particular, the introduction of new multi-disciplinary teams to support the GP Assessment Areas in both University Hospital Crosshouse and University Hospital...
Ayr will bring significant improvements and also result in release of capacity within other areas, supporting service improvement across the patient pathway. The roll out of the Frail Elderly pathway by introducing a new multi-disciplinary team across both hospital sites will bring new opportunities for existing staff and also for the organisation to recruit staff who may wish to support the development of a new and innovative service. The new roles are entirely consistent with the model of care described within our Building for Better Care Programme, thereby helping to pave the way ahead in terms of workforce and service change.

There are, however, risks around the possibility of not being able to recruit suitable individuals within the prescribed timescales and every possible option will be considered including backfill of existing staff so they might take up new roles and establish the new ways of working.

6 PERFORMANCE FRAMEWORK

This LUCAP seeks to address performance across each of the 5 strategic themes and all of the key elements that together make up safe, effective and person centred unscheduled care with the overall goal of delivering a reduction in emergency admissions and consistently achieving the 4-hour access standard.

Unscheduled care is complex and the performance framework set out in this section focuses on the indicators set out in the local system health check which will be delivered through the outcomes of the interventions and redesigns of services as described in this document. The performance framework and its trajectories reflect the organisation’s expected progress and the practical implementation steps to be delivered along the way as the system is redesigned, invested in and developed with attendant trajectories used to gauge progress.

Table 6: Identified key performance trajectories

<table>
<thead>
<tr>
<th>Measure</th>
<th>June 2013 Baseline</th>
<th>End September 13</th>
<th>End December 13</th>
<th>End March 14</th>
<th>End June 2014</th>
<th>End September 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Hour Standard</td>
<td>92%</td>
<td>93%</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>12 Hours Waits</td>
<td>10</td>
<td>NIL</td>
<td>NIL</td>
<td>NIL</td>
<td>NIL</td>
<td>NIL</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>3962</td>
<td>&lt;4000</td>
<td>&lt;4000</td>
<td>&lt;4000</td>
<td>&lt;4000</td>
<td>&lt;4000</td>
</tr>
<tr>
<td>% emergency admission</td>
<td>70%</td>
<td>&lt;75%</td>
<td>&lt;75%</td>
<td>&lt;75%</td>
<td>&lt;75%</td>
<td>&lt;75%</td>
</tr>
<tr>
<td>Delayed discharge bed days lost</td>
<td>To be confirmed</td>
<td>To be confirmed</td>
<td>To be confirmed</td>
<td>To be confirmed</td>
<td>To be confirmed</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>ALOS UHA</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
<td>2.7</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>ALOS UHC</td>
<td>2.9</td>
<td>2.9</td>
<td>2.9</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Occupancy UHA</td>
<td>84.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupancy UHC</td>
<td>82.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available beds UHA</td>
<td>9218</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available beds UHC</td>
<td>14459</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UHC Boarding (as per winter reporting template)</td>
<td>To be confirmed</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>UHC Boarding (as per winter reporting template)</td>
<td>To be confirmed</td>
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<td>UHA % morning discharge</td>
<td>10% 25% 50% 50% 50% 50%</td>
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<td>UHC % morning discharge</td>
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A two tiered governance approach is envisaged with a LUCAP Management Group being established to oversee the ongoing development of the LUCAP, its implementation and all aspects of related performance across the 5 strategic themes culminating in the improvement of the 4-hour standard. Meeting monthly and featuring the input of senior level managers, the LUCAP Management Group will oversee the work of 2 site focused LUCAP Flow Groups that will meet each week to review performance over the past week whilst making plans for the weekend and the week to follow. The weekly LUCAP site flow meetings will be led by senior clinical managers and attended by managers with operational responsibility for unscheduled care services and/or responsibility for aspects of LUCAP delivery. Representatives from community services and primary care will also contribute to weekly LUCAP site flow meetings.

In summary the LUCAP Management Group will:

- Oversee implementation of the LUCAP actions/interventions/redesigns across each of the 5 strategic themes
- Oversee delivery of the LUCAP investment plan
- Monitor all indicators and measures against trajectory
- Review ‘Local System Health Check Data’
- Periodically re-run/review the 4 hour wait self assessment tool
- Liaise with Winter Planning Group around the 2013 Winter Plan
- Review output and work of the 2 LUCAP site flow groups
- Integrate the LUCAP in planning associated with BfBC Project
- Identify risks and report progress to NHS A&A Corporate Management Team/Scottish Government
- Ensure that the key recommendations of the Performance Support Team Diagnostic report are integrated and implemented through this process

In summary the LUCAP Site Flow Meetings will:

- Review breaches by flow group
- Review discharge performance by ward/unit/specialty
- Review use of discharge lounge by ward/unit/specialty
- Review use of Expected Date of Discharge by ward/unit/specialty
- Review use of criteria led discharge by ward/unit/specialty
- Instigate remedial action where required
- Escalate any obstacles or blockages within line management arrangements
- Ensure that sufficient capacity to meet predicted demand is available for weekend and week to follow

7 SUMMARY

The LUCAP is a timely ‘stock take’ of where NHS Ayrshire and Arran is with regard to unscheduled care and a reference point for future plans, developments and actions that will deliver the 4 hour standard and ensure better quality unscheduled care for people of Ayrshire and Arran. The whole system approach, across the 5 Strategic themes, is comprehensive and aimed at achieving system balance. The goal is to provide sufficient resources that are well organised and targeted in order that appropriate care is provided in the best setting by the most appropriate staff with the right skill and aptitudes, whilst making sure that all aspects of the system are complementary and supportive.

The fundamental principles behind the LUCAP are entirely consistent with the vision set out in our Building for Better Care Programme that sees a new and expanded ED at University Hospital Ayr and two new Combined Assessment Units, one on each main acute site, at the heart of a modern, integrated unscheduled care system.

The LUCAP presents the opportunity to refine and refocus present managerial and governance arrangements so that all elements of the plan can be effectively delivered, embedded and monitored against expected performance standards, notably the 4 hour standard.

Lastly, the findings and recommendations of the Scottish Government’s Performance and Support Team’s diagnostic visit will be cross checked against the wider LUCAP, with any outstanding issues or matters addressed as part of the overall LUCAP.