Ayrshire and Arran NHS Board

Monday 30 June 2014

Local Unscheduled Care Action Plan – Year 2

Author: Liz Moore, Director of Acute Services
Sponsoring Director: Liz Moore, Director of Acute Services
Date: 12 June 2014

Recommendation

The Board is asked to approve the annual Local Unscheduled Care Action Plan (LUCAP) - Year 2 (Appendix 1).

Summary

The attached LUCAP is NHS Ayrshire & Arran’s planned approach to building sustainability and transformation of unscheduled care services for Year 2 of the Scottish Government Programme.

It is set out under 5 Strategic Themes to support the delivery of interdependencies across the local system, thereby ensuring all important elements are considered and included.

The LUCAP (Year 2) is a shorter, focused action plan and flows from the Year 1 LUCAP, which is more detailed (attached – Appendix 2).

The LUCAP is consistent with the Board’s Emergency Care Quality Improvement Programme, established in August 2012 to ensure unscheduled care is safe, effective and person centred, with an improvement in performance of the 4 hour standard being achieved.

Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>NHS A&amp;A LUCAP</td>
<td>NHS Ayrshire &amp; Arran Local Unscheduled Care Action Plan</td>
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</tbody>
</table>

1. Situation

1 of 72
1.1 The attached LUCAP is NHS A&A’s planned approach to building sustainability and transformation of unscheduled care services in Year Two of the Scottish Government’s Unscheduled Care Programme, and has been further developed on Year One of the Programme.

2. **Background**

2.1 The LUCAP is set out under 5 Strategic Themes, as in Year One, to support the delivery of interdependencies across the local system, thereby ensuring all important elements are considered and included.

2.2 The LUCAP is a whole systems plan, focused on providing safe and effective patient-centred care, and through its delivery it is expected the 4-hour emergency care target of 95% will be met and maintained.

2.3 The LUCAP is consistent with the Board’s Emergency Care Quality Improvement Programme, and the action plan will be delivered and monitored through this Programme.

2.4 The recent development of Health and Social Care Partnerships provides an exciting and additional opportunity to further enhance whole systems working and to drive further improvement in unscheduled care pathways, enabling the population of Ayrshire & Arran to receive the most appropriate care at the right time and in the right place.

3. **Assessment**

3.1 The LUCAP is expected to demonstrate an understanding of acute hospital capacity and demand, and provide detail of multi-disciplinary working across the whole system, complementing strategic plans at Board and National level.

3.2 The attached LUCAP has undergone rigorous scrutiny as part of its development process by the Scottish Government prior to its submission to the NHS Board.

4. **Recommendation**

4.1 The Board is asked to approve the Board’s Year 2 LUCAP for final submission by 30 June 2014.
### Policy/Strategy Implications
The Board’s Unscheduled Care Programme of work is a key component of the Local Delivery Plan (2014/15).

### Workforce Implications
These are set out within the action plans, and will be further developed through the Board’s Workforce Plan.

### Financial Implications
Financial implications for the Board have been approved through the Board’s Revenue Planning Programme. The Financial Plan associated to the LUCAP makes specific request for Scottish Government support funding.

### Consultation (including Professional Committees)
The plan is a further iteration of last year’s developments, with no new developments.

### Risk Assessment
This is included in Section 3 of the LUCAP.

### Best Value

- Vision and leadership
- Effective partnerships
- Governance and accountability
- Use of resources
- Performance management

### Compliance with Corporate Objectives

### Single Outcome Agreement (SOA)

### Impact Assessment
The plan sets out a range of services to be delivered consistently across NHS Ayrshire & Arran.
Local Unscheduled Care Action Plan

Year 2

2014/2015

16 May 2014  (updated 12 June 2014)
1. Overview & Key Issues

OVERVIEW

NHS Ayrshire and Arran’s Local Delivery Plan (LDP) sets out the Board’s priorities for 2014/2015. The LDP provides assurance and underpins the NHS Board’s Annual Reviews. The Unscheduled Care programme of work is a key component of the LDP and will be reviewed and monitored through the LDP performance framework.

The Local Unscheduled Care Action Plan (Year 2) sets out the specific actions and outcomes to be taken forward to deliver the continuous improvement programme for unscheduled care over 2014/2015.

The Local Unscheduled Care Action Plan is a whole systems plan and focuses on providing safe and effective, person centred care and through its delivery it is expected the 4 hour Emergency Care target will be met and maintained.

The recent development of Health and Social Care Partnerships provides an exciting and additional opportunity to further enhance whole systems working and to drive further improvement in unscheduled care pathways, enabling the population of Ayrshire & Arran to receive the most appropriate care at the right time and in the right place.

NHS Ayrshire & Arran, however, continues to experience challenges in the delivery of unscheduled care activity and using comparative data between 2012/2013 and 2013/2014, indicates the total number of Emergency Department (ED) attendances has only decreased by 0.5%. Within this figure there are variations across age groups and across acute sites.

At University Hospital Ayr there has been an increase in ED attendances in the over 65–74 age group by 5.2% and a decrease in the over 75 age group of 3.4%. There has been a decrease of 4.7% in the 0–15 age group and 4.2% in the 16–24 age group.

At University Hospital Crosshouse there has been a decrease in ED attendances in the over 65–74 age group by 0.7% and the over 75 age group has increased by 5%. There has also been a reduction in the 0–5 age group by 2.5% and in the 16–24 age groups by 2.8%.

NHS Ayrshire & Arran continues to develop and deliver plans to reduce ED attendances across all age groups, and this data further emphasises the need to continue to focus on our older population. Ayrshire and Arran has an established strategic ‘Vision for Older People’s Services’ developed in 2013 by Health, the three Ayrshire Local Authorities and the third and independent sector organisations. Partners are currently developing and testing new models of care to deliver the shared vision to improve services for older people and reduce the current impact on acute services into the future.
Local Unscheduled Care Action Plan (LUCAP) Year 2 - 2014/2015

Emergency admissions have increased by 0.7% between 2012/2013 and 2013/2014. Comparing the following three age groups of under 65 years, 65–74 years and 75 and over, the 75 and over group has demonstrated a reduction of 1.6%. Paediatric emergency admissions have shown a more significant reduction by 7.5% over the same period.

Within this figure there has been a 5% growth in adult emergency admissions at University Hospital Crosshouse which has been offset by a decrease of 3.7% at University Hospital Ayr. The increase at University Hospital Crosshouse is mainly as a result of an increase in the under 65 year old age group.

As recently highlighted in the Audit Scotland Report, (Accident and Emergency, May 2014), NHS Ayrshire & Arran admits a higher percentage of patients through their EDs than all other Boards in Scotland. This places the unscheduled care system under strain and is an area of focus for 2014/2015.

The 4 hour access target performance for year 2013/2014 was 92.2%. This indicates that further significant improvement work is necessary to move towards a sustainable performance of 95%. It should be noted, however, that the performance in the latter part of 2013/2014 has demonstrated an incremental improvement and more recently in April 2014, NHS Ayrshire & Arran’s performance was 94.4%.

KEY ISSUES

Primary Care

Offering the first and often only contact with healthcare professionals, General Medical Practices must be accessible and provide a skilled workforce to meet the vast majority of urgent and routine care needs. With increasing demands on General Practices, there is a real risk that patients who experience difficulty in accessing appointments, particularly for urgent care needs, will visit the Emergency Department. The actions contained within this plan are targeted at supporting General Practice to meet the care needs of their registered patients by learning from good practice in access improvement; matching capacity to demand; and tailoring services to local needs.

Similarly, it is recognised that, like other NHS Boards across Scotland, NHS Ayrshire and Arran is experiencing increasing fragility in sustaining the Out of Hours General Medical Capacity required to meet the increasing demands faced by the service. There will therefore be an increased focus on skill mix development in the coming year to ensure patient needs continue to be fully met while enhancing the sustainability of the Out of Hours rotas.

It is anticipated that the actions contained within this plan will ensure people of Ayrshire and Arran will continue to access General Medical Services in a community setting and reduce the demands placed on the Emergency Departments for minor illness and minor injury services.


Community Services

The improvement and development of services for older people is a priority and our vision for older people is for them to enjoy full and positive lives within their own communities. The local model for reshaping care for older people supports community wellbeing and independence as the norm, and focuses on rehabilitation and enablement developments with intensive support provided within hospital when this is needed. Intermediate Care Pathways (including reviews of Day and Community Hospitals), the review of Step Up, Step Down provision within care homes, and a continued focus on stronger links between Intermediate Care and Enablement Services (ICES) and Community Wards, are key improvement areas. Enhancement of Anticipatory Care Planning, Telehealth and Telecare interventions, and the development of a comprehensive and sustainable approach to the provision of Out of Hours services, are expected to support the future care requirements of the growing older population.

Acute Services

As detailed in our LUCAP (Year 1 - 2013/14), change is required to move away from traditional methods of patient assessment and from the reliance on batch based "post take" ward rounds towards a modernised unscheduled care service over seven days. The Board’s ‘Building for Better Care’ programme sets out the new vision for unscheduled care for acute services and describes the continuous assessment models and pathways driven care. Over the past year significant testing and development of new ways of working have taken place along with a very positive recruitment drive for Acute Physicians. This work continues to be driven through the Board’s established vehicle for unscheduled care improvements which is the Emergency Care Quality Improvement Programme. Key successes from testing new ways of working over 2013/2014 include the introduction of a Frail Elderly Pathway on both Acute Hospital sites, which is provided in both EDs by a dedicated multi-disciplinary team led by senior clinical decision makers, the development on the University Hospital Ayr site of a GP Assessment Unit in December 2013 and the development of a new Clinical Decisions Unit in January 2014, alongside the increase in the number of clinical pathways delivered within the already established Clinical Decisions Unit at University Hospital Crosshouse.

The majority of these developments have occurred in the latter part of 2013/2014 and have contributed to the recent improvement in performance against the 4 hour target.

A new General Management model for both Acute Hospitals was established by the end of March 2014 and has included the recruitment of an Assistant Director for Acute Services for each site, along with dedicated site based senior management teams. The aim of this new management model is to provide site specific management focus to secure continuous service improvement. In addition, from June 2014 senior managers will be present on both acute sites to 8pm week days and throughout weekends. This is a welcomed development and fully supports the Board's improvement programme for safe, effective, person centred care.
Local Unscheduled Care Action Plan (LUCAP) Year 2 - 2014/2015

Unscheduled Care Capital Development

Building for Better Care

The Board has recently been supported by Scottish Government through a significant investment of £27m for a major capital programme which will further improve the delivery of unscheduled acute care. This capital investment has been provided to build a new Emergency Department at University Hospital Ayr and Combined Assessment Units on both acute sites. The completion date for the Emergency Department at Ayr and the Combined Assessment Unit at Crosshouse is December 2015, with the Combined Assessment Unit at Ayr completed by February 2017.

ACTION PLAN

The following sections provide the detailed action plans set out under 5 strategic unscheduled care themes. The plans support the delivery of interdependencies across the system, thereby ensuring all important service elements are included. The quality health check information (attached) provides baseline data and will continue to be used to monitor progress and direct improvement action.
## 2. Action Plan

### 1. Making The Community The Right Place and Developing The Primary Care Response

Please add rows as required. *Example response provided below. **Target dates required.

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<tr>
<th>No</th>
<th>Action</th>
<th>Description/ Output</th>
<th>Status % Complete</th>
<th>Commentary</th>
<th>Measurable outcome</th>
<th>Completion Date</th>
<th>Lead</th>
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<tbody>
<tr>
<td>1.</td>
<td>Target access improvement initiatives within Practices where patient experience demonstrates difficulty in securing timely access to appointments</td>
<td>Direct General Practices experiencing difficulties in delivering timely access for patients to the locally developed toolkit and peer support network</td>
<td>25%</td>
<td>The results from the Patient Experience Survey will be reviewed when published in Summer 2014 and those Practices for whom patients report difficulty in accessing appointments or appointment systems will be invited to utilise the local access improvement toolkit and draw on the peer support available to deliver tangible improvements. Secure Practice agreement to regular monitoring of patient experience of accessibility through targeted questionnaires</td>
<td>The number of Practices utilising the local access improvement toolkit</td>
<td>Improvements in patient perception of accessibility of GP appointments</td>
<td>Oct 2014</td>
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<td>Mar 2015</td>
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<td></td>
<td>Secure delivery of the Minor Injuries Enhanced Service to offer immediate treatment in a local setting</td>
<td>Support local GP Practices to deliver an immediate assessment and treatment service for minor injuries, including lacerations to reduce demand for Accident and Emergency</td>
<td>50%</td>
<td>Through the Enhanced Service Commissioning Plan for 2014/15 secure sign-up from local Practices to deliver the Minor Injuries Enhanced Service</td>
<td>The number of Practices committing to the delivery of the Minor Injuries Enhanced Service</td>
<td>June 2014</td>
<td>Head of Primary Care Development</td>
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<td>The number of Practices actively delivering the Minor Injuries Enhanced Service</td>
<td>Sept 2014 (quarterly thereafter)</td>
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<td>The number of patient benefiting from the Minor Injuries Enhanced Service</td>
<td>Sept 2014 (quarterly thereafter)</td>
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<td>The number of Practices actively delivering the Minor Injuries Enhanced Service</td>
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<td>The number of patient benefiting from the Minor Injuries Enhanced Service</td>
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<p>|   | Pilot the provision of dedicated GP sessions to Care Homes in South Ayrshire | Improve the provision and predictability of GP Services to care homes to enhance the quality of care offered to patients and support offered to staff, assessing the impact this has on acute admissions | 75% | Evaluate the pilot to determine the effectiveness of the service against the outcome measures specified in the Enhanced Service specification, paying particular attention to the number of admissions avoided | The results of the evaluation i.e. number of avoided admissions | Oct 2014 | Associate Medical Director/ Primary Care/ Associate Nurse Director |
|   |   |   |   |   | Develop proposals to secure sustained improvement in the delivery of medical services to care homes | Mar 2015 |   |
|   |   |   |   |   | Recommendations presented to Directors |   | Head of Primary Care Development/ Associate Medical Director/ Primary Care/ Associate Nurse Director |</p>
<table>
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<tr>
<th>4.</th>
<th>Support the development of capacity in General Practice to aid Practices in better meeting the increasing demands on their services</th>
<th>Provide targeted Nursing capacity from the NHS ADOC OOHs service to General Practice to support the maintenance of skills and competencies of the staff and offer additional clinical time within Practice</th>
<th>25%</th>
<th>Develop an Advanced Nurse Practitioner Training Plan that supports the development and maintenance of a General Practice skill set</th>
<th>Training plan delivered</th>
<th>June 2014</th>
<th>Associate Nurse Director</th>
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<td></td>
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<td></td>
<td>Number of additional clinical sessions delivered by NHS ADOC Nurse Practitioners within General Practice</td>
<td>Sept 2014 (quarterly thereafter)</td>
<td>Associate Nurse Director</td>
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<tr>
<td>5.</td>
<td>Work with Practices to pilot new contractual arrangements aimed at: • Supporting individuals at home; • Managing Long Term Chronic conditions; • Supporting Vulnerable Children and Families; • Reducing Emergency Admissions; and • Dealing with Poverty</td>
<td>In-hours General Medical Services are configured to fully meet the needs of patients and better support frail and vulnerable patients at home.</td>
<td>10%</td>
<td>Assess health needs at a Practice level and design services to meet these, ensuring they are tailored and targeted to local circumstances.</td>
<td>Models of service delivery matched to patient needs;</td>
<td>Oct 2014</td>
<td>Head of Primary Care Development</td>
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<td>Measurable outcomes agreed; Contractual arrangements finalised ready for April 2015 implementation</td>
<td>Nov 2014</td>
<td>Head of Primary Care Development</td>
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<td>March 2015</td>
<td>Head of Primary Care Development</td>
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### Local Unscheduled Care Action Plan (LUCAP) Year 2 - 2014/2015

| 6. | Review NHS ADOC service model and capacity levels to ensure patients needs can be fully met, thereby avoiding presentations to the Emergency Department | OOHs GMS capacity matches demand | 25% | The skill mix of the NHS ADOC workforce will be reviewed and adapted to ensure patient needs can be fully met while the sustainability of the clinical service is enhanced | Reduction in Number of active GP shifts unfilled each quarter; Reduction of stand-by shifts unfilled each quarter; Reduction of Nurse Practitioners shifts unfilled each quarter; Triage times met each quarter; Reduction of double-booked appointments each quarter; Reduction of patients directed to the Emergency Department by NHS ADOC as a result of demand exceeding capacity | June 2014 (quarterly thereafter) | Head of Primary Care Development/Associate Nurse Director |
| 7. | Increase the number of patients with a formal robust and flexible care plan (from 3000 to 6000) to confirm the preferences and choices made by patients and carers | Improve anticipatory care planning for patients deemed by GP Practices to be at greatest risk of emergency admission and readmission | 50% | Monitor ACP production in-year to ensure attainment of target numbers | Number of ACPs produced by General Practice; Number of ACPs updated quarterly; | June 2014 (quarterly thereafter) | Associate Nurse Director |
| 8. | A dedicated programme of work with Associate Medical Director leadership will be established to develop standards for communication at the interface between Primary and Secondary Care, ensuring the systems and processes are in place to support the timely and accurate transfer of information critical to the continuing care of patients. | Improve communication at the interface between Primary and Secondary Care to enhance patient safety and reduce the potential for emergency admission and readmission | 10% | Establish a formal improvement programme with specific goals and wide clinical involvement for the improvement of information and patient care at the interface between Primary and Secondary Care | Development of standards and clear ownership across Primary Care and Hospital-based clinicians to support their rollout | Jan 2015
June 2014 (quarterly thereafter) | Associate Medical Director for Women’s, Children’s & Diagnostics Division/ Associate Medical Director Primary Care/ Head of Primary Care Development |
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<td>9.</td>
<td>Pilot and test additional services through SPOC</td>
<td>Further development of integrated Single Point of Contact (SPOC) to community services</td>
<td>25%</td>
<td>To extend SPOC to community services through service hubs SPOC contact to also extend to integrated community rehabilitation and enablement services to provide information regarding available services</td>
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<td>10.</td>
<td>Further develop Intermediate Care Services, integrating and developing current models, using ICES, Frail Older Peoples Pathway, Community Ward, Day Hospital and Community Hospitals</td>
<td>Delivered the integration of Intermediate care services and Anticipatory Care Plans.</td>
<td>50%</td>
<td>Review and evaluate as pathway develops Reshaping Care for Older People performance matrix</td>
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<td>11.</td>
<td>Develop a managed approach to Anticipatory Care</td>
<td>Delivered an Integrated approach to anticipatory care planning, including all</td>
<td>15%</td>
<td>Review current approaches and develop utilising SDS and End of Life care Increase in ACPs completed. Range of</td>
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<tr>
<td></td>
<td>Planning and self management</td>
<td>health and social care practitioners</td>
<td>approaches</td>
<td>practitioners completing ACPs</td>
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| 12. | Develop integrated monitoring facilities within community premises  
   Extend telehealth pilots working closely with GP practices  
   Align developments with European programmes | Increase the use of smart developments and telehealth to help support people manage their own conditions and remain in their own homes | 50%  
Explore the IT and data sharing arrangements required for integrated monitoring facilities  
Review current models and determine resource requirements | Utilise performance indicators in place through European programmes | Review progress 2015 | HSCP |
| 13. | Further integrate services in the out of hours period to include community nursing and Social Care services | Established enhanced Out of Hours Services with links to Accident & Emergency | 50%  
Further review integration of OOHS services | No of emergency admissions OOHs  
Referral rates to OOHs services | Review progress 2015 | HCSP |
| 14. | Review available primary care information/data and work through partnerships to assess if data points to further service change or redesign solutions | Explored local intelligence available through General Practices and link to acute and out of hours information to improve locality planning | 25%  
Primary care intelligence will add significant value to local planning to inform proposals for future unscheduled care service delivery options | To be developed | Review progress 2016 | HSCP |
<table>
<thead>
<tr>
<th></th>
<th>Review process continuing to determine future plans</th>
<th>Robust evaluation of change fund projects has indicated the developments to be mainstreamed</th>
<th>75%</th>
<th>Successful change fund projects will be integrated into new Health and Social Care Partnership services</th>
<th>Change fund projects have measurable outputs and outcomes to support evaluation process</th>
<th>March 2015</th>
<th>HSCP</th>
</tr>
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<tbody>
<tr>
<td>16.</td>
<td>Develop integrated approaches across acute and community services</td>
<td>Developed agreed pathways of care and joint working across acute/community services</td>
<td>10%</td>
<td>Integrated and shared pathways will be developed to support Building for Better Care programme;</td>
<td>Number of whole system pathways developed</td>
<td>Review progress March and September 2015</td>
<td>HSCP, Primary care and Acute services</td>
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## 2. Flow and the Acute Hospital

<table>
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<tr>
<th>No</th>
<th>Action</th>
<th>Description/ Output</th>
<th>Status % Complete</th>
<th>Commentary</th>
<th>Measurable outcome</th>
<th>Timescale</th>
<th>Lead</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Pathway facilitators seconded from clinical roles to lead the development of ambulatory care pathways</td>
<td>Patients on specific ambulatory care pathways are assessed, diagnosed, treated and discharged through Clinical Decision Units and not admitted to inpatient beds</td>
<td>30%</td>
<td>Clinical Pathways developed within the agreed programme of work reporting through clinical governance framework Patient experience work carried out so far has indicated positive feedback</td>
<td>15% of daily ED activity is signposted to CDU Admission from CDU to inpatient wards is less than 10%</td>
<td>Review progress Dec 2014</td>
<td>Pathway Facilitators Nurse Consultant</td>
</tr>
<tr>
<td>2.</td>
<td>Project plan in place and continuing to embed patient flow coordination through the new central information hubs on each acute site</td>
<td>Flow of information from ED to patient flow teams is seamless and phone calls negligible</td>
<td>70%</td>
<td>New electronic whiteboards provide real time data delivering opportunities for further patient flow improvements The current project will be extended to Community Hospitals and to the current developing community service hubs</td>
<td>Accuracy of real time data analysed on a daily basis and formally reported through the patient safety huddles (to be established in June 2014) A project plan is in place to roll out to community hospitals and will be monitored against project timeframes</td>
<td>Review progress in August 2014</td>
<td>General Managers</td>
</tr>
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<td>3.</td>
<td>Daily presence of site management teams</td>
<td>Managers visible on each Acute Site supporting patient flow across the</td>
<td>80%</td>
<td>The recent reorganisation of Acute Hospital Services (site based Staff feedback Time released to care.</td>
<td>June 2014</td>
<td>Site Management</td>
<td></td>
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</table>
## Existing arrangements for patient flow being transformed to patient safety huddles

Managers present over an extended working day and over 7 days

| 4. | Continue to embed the Acute Medical Model of assessment for GP assessed patients | All medical patients who have been assessed by their GP prior to transfer to ED’s, will be directed to the newly established GP Acute Medical Assessment Units | 40% | Challenges have been experienced through delays in recruitment of Acute Physicians and also a number of Medical specialty Consultant post vacancies | Vacancies filled and job plans in place | October 2015 | CD for Acute Medicine |

To further develop service model to cover longer periods of the day and weekends

Service extended to support unscheduled care activity surges early evening and weekends

Education and redesign ongoing on the new models of care across multi disciplinary teams

Tests of change part of the Building for Better Care programme for new developments of Combined Assessment Units

<p>| 5. | Short life working group to be established to progress review and develop improvement programme | Progressed towards the National average of 27% of patients admitted from ED to acute hospital beds | 10% | NHS Ayrshire and Arran is currently an outlier for Emergency Admissions through EDs. Improvement in figure will be shown as patients are directly admitted to alternative assessment areas like other Boards in Scotland | Reduction of emergency admissions across NHS Ayrshire and Arran | Reduction of 4 hour standard | September 2014 with ongoing review | ECQIP |</p>
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<tr>
<td>6.</td>
<td>Redesign the model of care for surgical patients arriving at EDs</td>
<td>Improved emergency care pathways for surgical patients</td>
<td>10%</td>
<td>Planning this improvement work is in the early stages of development. Improvement work will include tests of change to explore service re-design options</td>
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<tr>
<td>7.</td>
<td>Analyse winter planning outcomes from 2013/14 to identify lessons and improve plan for 2014/2015</td>
<td>Winter Plan for 2014/15 will have fully considered the learning from previous years and will aim to deliver a plan to provide safe, effective person centred care during the higher demand period</td>
<td>50%</td>
<td>Winter Planning review scheduled to discuss lessons learned and to commence development of plan for 204/15</td>
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## 3. Assuring Effective And Safe Care 24/7 At The Hospital Front Door

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<tr>
<th>No</th>
<th>Action</th>
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<th>Lead</th>
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<tbody>
<tr>
<td>1</td>
<td>Plans further developed to Improve the recruitment and retention of medical staff across a range of specialities</td>
<td>Consultants and Middle Grade Doctors in place(vacancies) providing Board assurance of continuous effective and safe provision of care for patients</td>
<td>30%</td>
<td>A short life working group has been established to consider attractive job descriptions and adverts and methods to enhance success rate of filling appointments. New service models are also being discussed and considered to ensure the continuation of services where there are hard to fill posts in particular specialties</td>
<td>The number of vacancies successfully filled</td>
<td>Ongoing</td>
<td>AMDs</td>
</tr>
<tr>
<td>2</td>
<td>Project Plan in place and huddles commencing in June 2014 on both sites</td>
<td>Daily, early morning, multi disciplinary Patient Safety Huddles established on both acute sites</td>
<td>50%</td>
<td>This initiative is being led by one of our Scottish Patient Safety Fellows and Associate Medical Directors Further development of this project will include daily contact through telelinks across the whole healthcare system There has been</td>
<td>Improved flow across all hospital services – scheduled and unscheduled care</td>
<td>June 2014 with ongoing evaluation</td>
<td>Assistant Directors</td>
</tr>
<tr>
<td>3.</td>
<td>Continually assess Acute Inpatient wards against the Day of Care audit methodology to ensure patients are provided with the most appropriate service</td>
<td>Patients are provided with the care they require by the most appropriate service and not in an Acute Hospital where this is not necessary to provide the best patient outcomes</td>
<td>20%</td>
<td>Weekly review meeting is being established to review key indicators associated to the methodology to facilitate patients being directed to more appropriate services. Plans are in place to undertake further snapshots using Day of Care Methodology</td>
<td>Number of patients in acute beds unnecessarily beyond 14 days. Trajectories to be agreed as part of overall plan</td>
<td>September 2014</td>
<td>GMs/CDs</td>
</tr>
<tr>
<td>4.</td>
<td>Rota in place and roles and responsibilities agreed. Site specific management teams will take responsibility for own site location. Review impact and effectiveness.</td>
<td>Presence of Senior Managers on extended days and weekends on both Acute sites</td>
<td>50%</td>
<td>To ensure each Acute Hospital has senior management support during peak periods of unscheduled activity, a new Duty Management model has been developed to support this improvement.</td>
<td>Hospital Senior managers accessible to staff and clinical areas during pressure periods. Stakeholder views and experience to be evaluated to assess impact of visible leadership and support</td>
<td>June 2014</td>
<td>Site Management teams</td>
</tr>
<tr>
<td></td>
<td>Pilot project currently in place and moving into evaluation phase. The evaluation will inform the future model of care for older people presenting on an unscheduled care basis at EDs</td>
<td>Established an unscheduled Frail Elderly model of care in both EDs</td>
<td>50%</td>
<td>An increasing number of older people are presenting at EDs with complex health and social care challenges. An Acute Hospital admission does not always deliver the best possible outcomes for this group of patients and can often lead to poorer health outcomes. A new model of care commenced testing in both EDs last October. The model’s aim is to ensure a defined group of older patients presenting to EDs receive a full multi-disciplinary assessment to ensure the best possible care pathway is put into place. The models slightly differ on both sites which will allow a comparison of outcomes by site. This development is currently receiving National attention and to date has had significant positive benefits for older people.</td>
<td>Model of Care to be formally evaluated and presented through Board’s Governance structure. Agreement on model for delivery to be presented through Boards planning framework</td>
<td>Review July 2014</td>
<td>AMD/ECQIP</td>
</tr>
</tbody>
</table>
|   | Deliver Implementation plan for recruitment of Clinical Directors | Clinical Directors in place and working within General Management Teams to enhance cohesive engagement in service planning, service delivery and priorities | 70% | Senior Clinical leadership is essential to support service planning and delivery
The organisation recognised gaps in the previous model of Medical Management and developed a new model for implementation in partnership with staff | Effectiveness of the new General Management Model to which include CDs
Effectiveness of planning, performance and financial management in teams
Effectiveness in Governance frameworks which are clearly defined for specialties through CDs and General Management structure | June 2014 with ongoing review and assessment | AMDs/CDs/GM's |
<table>
<thead>
<tr>
<th>No</th>
<th>Action</th>
<th>Description/ Output</th>
<th>Status % Complete</th>
<th>Commentary</th>
<th>Measurable outcome</th>
<th>Timescale</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assessment of the impact of the cardiology rota in terms of planned care and improvement in unscheduled care pathway</td>
<td>Cardiology: Presence of senior decision maker (Cardiologist) across 7 days to provide patient assessment and direct patient management to improve care for this patient group</td>
<td>60%</td>
<td>An increasing number of patients with cardiology related symptoms have been presenting in the out of hours period. The Physician on call for the hospital provided assessment and treatment. Due to the increasing complexity of this patient group and many with co-morbidities it was necessary to develop a dedicated service</td>
<td>Patient Safety measures Length of stay</td>
<td>Review in June and quarterly thereafter</td>
<td>CDs/GMs</td>
</tr>
<tr>
<td>2</td>
<td>Test to assess benefit and redesign methods through earlier intervention</td>
<td>Patients who would benefit from early assessment and support from AHPs to receive this in ED or Assessment areas</td>
<td>50%</td>
<td>Currently the majority of AHP assessment and treatment for unscheduled care patients is provided in specialty wards or not at all. As part of the Board’s new model of care associated to ‘Building for Better Care’ the aim is to bring this closer to patients’ presentation to hospital. It is expected that by</td>
<td>Measures in place to include avoided admissions and length of stay</td>
<td>September 2014</td>
<td>Associate Director for AHPs/ ECQIP</td>
</tr>
<tr>
<td>No</td>
<td>Proposal for test to be agreed and implemented</td>
<td>Radiology diagnostic services for specific modalities extended over weekend where it is demonstrated this improves patient outcomes and flow</td>
<td>25%</td>
<td>As part of the model of care associated to the ‘Building for Better Care’ development, it is essential there is access to rapid diagnostic testing. Although services are available across the 24 hour period, and developments into the evening have occurred, it may be beneficial for improved access to particular tests services at specific times</td>
<td>Evaluation report of test</td>
<td>October 2014</td>
<td>ECQIP/CD Radiology</td>
</tr>
</tbody>
</table>
## 5. Cross Cutting Themes

### Information Management; Leadership and Management & Workforce Development

<table>
<thead>
<tr>
<th>No</th>
<th>Action Description/ Output</th>
<th>Status % Complete</th>
<th>Commentary</th>
<th>Measurable outcome</th>
<th>Timescale</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Information Management</td>
<td>80%</td>
<td>The previous bed management/patient flow model of care relied on bed managers visiting wards throughout the day and phone calls back and forth regularly to check bed availability. The new electronic system linked directly to the Board’s Patient Management system allows flow managers to monitor real time movement of patients in and out of wards. This is a significant development and supports improved inpatient planning and daily management of Scheduled and Unscheduled Care</td>
<td>Effectiveness of the application of Expected Date of Discharge, Time of Discharge from wards, Utilisation of discharge lounge, Discharge Performance for each ward, Community Hospital bed availability</td>
<td>October 2014</td>
<td>GM/AND</td>
</tr>
<tr>
<td>2</td>
<td>Leadership and Management</td>
<td>80%</td>
<td>As a result of the recent approval of the major capital developments for each acute hospital site associated to Unscheduled care, and the management</td>
<td>Assessment and monitoring framework in place for each group and overall plan monitored by the ‘Building for Better Care Programme’</td>
<td>August 2014</td>
<td>AMD/Assistant Director Acute Services</td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td>Percentage</td>
<td>Details</td>
<td>Responsible Party</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 2   | Teams to fully participate in Values, Cultures and Behaviour improvement programme, and to demonstrate positive leadership behaviours at all levels of the organisation | 30%        | As part of the Organisation’s development programme, significant work with staff/partnership has been concluded to review and reset Culture, Values and Organisation Behaviours.  
A programme of development is being rolled out and is integral to the improvement work associated with this plan | Staff Survey Results                       |
|     | Established full site specific General Management teams including Senior Clinical leadership displaying the Values, Cultures and Behaviours of the Organisation                                                                                           |            | This has been completed and a new framework agreed for implementation. Membership of the various groups has been reviewed and enhanced in recognition of site based management and also as a result of the new opportunities available through HSCPs | Board                                    |
### Workforce Development

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Progress</th>
<th>Measure</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Continue ongoing work to redesign current workforce to deliver new models of Care. Identify gaps in workforce and develop proposals to fill and progress through Board’s annual planning/budget setting framework. Continue Scenario based pathway work to ensure full understanding of new models of care for specific staff groups and to embed knowledge and understanding of benefits.</td>
<td>70%</td>
<td>Measured against the Project Plan for Building for Better Care. This work will continue and evolve further as the move progresses towards the opening of new Combined Assessment Units and new ED at Ayr.</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
3. Key Risks

The plan sets out the specific actions required to deliver the Unscheduled Care Improvement Programme, and the range of the challenges is evident within each of the action plans under the 5 themes.

The provision of Unscheduled Care is complex and requires a range of initiatives and developments to come together at the right time to deliver sustainable improvement. It also requires the engagement, involvement and participation of cross system partners and services to deliver the best possible outcomes. The plan has been developed and delivered using a cross system partnership approach to ensure the specified outcomes can be achieved. It is expected that previous risks associated with the challenges of Primary/Community Care and the Integration with Acute Services will be much reduced due to the very welcomed local development of our three Health and Social Care Partnerships. These partnerships will bring exciting new opportunities for further integration and enhancement to unscheduled care approaches.

The main risk the Board faces is further increases in Emergency Department attendances and Emergency Admissions, as our current improvement programme is based on detailed bed modelling carried out in 2012. The bed modelling has a built in predicted increase in emergency admissions of 3% at 2016/2017. This is at the point when the Board will be in a position to fully deliver the new model of care in new fit for purpose facilities. The Board’s established Emergency Care Quality Improvement Programme (ECQIP) is however currently testing and establishing new ways of delivering services, redesigning the current workforce and looking at innovative ways to recruit medical staff to continue to deliver within programme and improve performance on the 4-hour target. This work forms the majority of the Acute Services action plans in the LUCAP.

The other key risk is the Board’s inability to recruit to current and future Consultant vacancies. As a result of this there is a high reliance on Locum doctors which is not ideal in terms of providing a sustainable safe and effective person centred service. The use of Locum doctors and also carries financial risk for the Board due to the cost of Locum cover. Work is ongoing to mitigate this risk where this is possible.
## 4. Financial Planning

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Narrative/Description of Expenditure</th>
<th>Projected Expenditure 2014/15 £000s</th>
<th>Recurring/non-recurring costs 2014/15 £000s</th>
<th>Total Costs £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Aim 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding in place through Enhanced Services allocation and Quality and Outcomes Framework, and through Change Fund (refer to Reshaping Care for Older People)</td>
<td>The outlined interventions are being progressed under the Board’s Action Plan as specified in the Local Delivery Plan and the Board’s Reshaping Care for Older People’s Strategy (10 Year Vision)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Strategic Aim 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Funding (LUCAP)</td>
<td>Pathway Facilitators</td>
<td>70</td>
<td>Non-Recurring</td>
<td>70</td>
</tr>
<tr>
<td>Board Funding (LUCAP)</td>
<td>Further Roll-Out of eWhite Boards</td>
<td>264</td>
<td>Non-Recurring</td>
<td>264</td>
</tr>
<tr>
<td>Board Funding (LUCAP)</td>
<td>Establishment of GP Assessment Units at both Ayr and Crosshouse Hospitals</td>
<td>669</td>
<td>Recurring</td>
<td>669</td>
</tr>
<tr>
<td>SG Funding Request (2014/15)</td>
<td>Winter Surge Capacity</td>
<td>300</td>
<td>Non-Recurring</td>
<td>300</td>
</tr>
<tr>
<td>SG Funding Request (2014/15), based on 50%</td>
<td>Additional ED Consultants</td>
<td>100</td>
<td>Recurring</td>
<td>100</td>
</tr>
<tr>
<td>Strategic Aim 3</td>
<td>Board Funding (LUCAP)</td>
<td>Additional ED Consultants</td>
<td>376</td>
<td>Recurring</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------</td>
<td>---------------------------</td>
<td>-----</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>SG Funding Request</td>
<td>ED Pharmacy Service</td>
<td>106</td>
<td>Recurring</td>
</tr>
<tr>
<td>(2014/15)</td>
<td></td>
<td>To increase Receiving / Assessment Ward at UH Crosshouse by 12 beds</td>
<td>366</td>
<td>Recurring</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic Aim 3</th>
<th>Board Funding (LUCAP)</th>
<th>Frail Elderly Pathway Test</th>
<th>160</th>
<th>Non-Recurring</th>
<th>460</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SG Funding Request</td>
<td>Frail Elderly Pathway Test</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2014/15)</td>
<td></td>
<td>Frail Elderly Pathway Test</td>
<td>200</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Board Funding (LUCAP)</td>
<td>Formation of Clinical Decisions Unit at UH Ayr</td>
<td>388</td>
<td>Recurring</td>
<td>890</td>
</tr>
<tr>
<td></td>
<td>SG Funding Request</td>
<td>Formation of Clinical Decisions Unit at UH Ayr</td>
<td>502</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic Aim 4</th>
<th>Board Funding (LUCAP)</th>
<th>Cardiology Rota</th>
<th>160</th>
<th>Recurring</th>
<th>160</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Board Funding (LUCAP)</td>
<td>Additional Medical Beds at UH Ayr</td>
<td>257</td>
<td>Recurring</td>
<td>257</td>
</tr>
<tr>
<td></td>
<td>Board Funding (LUCAP)</td>
<td>Extended Pharmacy Service</td>
<td>26</td>
<td>Recurring</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Board Funding (LUCAP)</td>
<td>3 x Acute Medicine Consultants</td>
<td>354</td>
<td>Recurring</td>
<td>354</td>
</tr>
</tbody>
</table>
Local Unscheduled Care Action Plan (LUCAP) Year 2 - 2014/2015

<table>
<thead>
<tr>
<th>Strategic Aim 5</th>
<th>Board Funding (LUCAP)</th>
<th>Administrative Support to EDs</th>
<th>Recurring</th>
<th>67</th>
</tr>
</thead>
</table>

**SG Funding Request (2014/15):** to deliver LUCAP (Year 2), our funding support bid to Scottish Government is £1,468,000
Local Unscheduled Care Action Plan

NHS Ayrshire & Arran

June 2013
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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 Kirklandside 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 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
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 1: Prevalence rates, Disease Registers, Source ISD Navigator 2011/12.

<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>2.14</td>
<td>1.86</td>
<td>5</td>
<td>15.09</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>17.51</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>17.87</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.
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 LUCA P, 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 facility\(^1\).

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 day\(^2\).

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 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

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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.

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>Musculoskeletal</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.

v) 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

![Ayr hospital change in admissions and attendance by age group 2011/2012 V 2012/2013](chart1.png)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Extra Admission</th>
<th>Extra Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>-15</td>
<td>-155</td>
</tr>
<tr>
<td>16-64</td>
<td>19</td>
<td>-806</td>
</tr>
<tr>
<td>65-74</td>
<td>107</td>
<td>208</td>
</tr>
<tr>
<td>75+</td>
<td>628</td>
<td>686</td>
</tr>
</tbody>
</table>

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

![Crosshouse hospital Change in Admission and Attendance by age group 2011/2012 V 2012/2013](chart2.png)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Extra Admission</th>
<th>Extra Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>716</td>
<td>768</td>
</tr>
<tr>
<td>16-64</td>
<td>-777</td>
<td>-869</td>
</tr>
<tr>
<td>65-74</td>
<td>405</td>
<td>774</td>
</tr>
<tr>
<td>75+</td>
<td>345</td>
<td>689</td>
</tr>
</tbody>
</table>

*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 of boarding 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 multi-
disciplinary 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 2100 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.

- **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.

**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:-

- Medication stock up;
- Self care;
- Request repeat prescriptions; and
- Practices closed for two extra days at Christmas and New Year

With the additional local messages

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

**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.

4 FINANCIAL INVESTMENT PLAN

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>
<tr>
<td>Extended pharmacy provision within GP assessment units</td>
<td>New funding required</td>
<td>SHORT</td>
<td>26</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
<tr>
<td><strong>Strategic Aim 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Additional Acute Medicine Consultants</td>
<td>New funding required</td>
<td>MEDIUM</td>
<td>354</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
<tr>
<td>Cardiology 7 Day working</td>
<td>Funding in place - NHS A&amp;A</td>
<td>SHORT</td>
<td>118</td>
<td>Recurring (FYE)</td>
<td></td>
</tr>
<tr>
<td>Frail elderly pathway – 6 month pilot</td>
<td>New funding required</td>
<td>SHORT</td>
<td>470</td>
<td>Non Recurring (PYE)</td>
<td></td>
</tr>
<tr>
<td>Emergency patient flow within</td>
<td>Redesign from within</td>
<td>MEDIUM</td>
<td></td>
<td></td>
<td></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 2014</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 NIL</td>
<td>NIL</td>
<td>NIL</td>
<td>NIL</td>
<td>NIL</td>
<td>NIL</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>3962 &lt;4000</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>UHA Boarding (as per winter</td>
<td>To be confirmed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting template)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UHC Boarding (as per winter</td>
<td>To be confirmed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting template)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UHA % morning discharge</td>
<td>10%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>UHC % morning discharge</td>
<td>10%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
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.