Grampian Unscheduled Care Programme

A New Approach to Unscheduled Care

Unscheduled Care Action Plan
2013/14 – 2015/16

June 2013
NHS Grampian

Local Unscheduled Care Action Plan

Introduction

1. NHS Grampian and partners aim to be the best performing health board delivering the highest quality healthcare services and contributing to the best health outcomes in Scotland. There are significant pressures on unscheduled care services across the health system and NHS Grampian, working with partners, aims to develop an improved whole system approach which will maximise the contribution of every service with the aim of caring for patients in the right place, at the right time and by the right care team.

2. This action plan is part of a three year rolling plan which has been prepared against the background of the developing Healthfit 2020 vision for unscheduled care set out in appendix 1. The action plan aims to:

   • Make immediate improvements against locally and nationally agreed standards including the maintenance of the 95% four hour standard during 2013/14, reducing unscheduled attendances, improving patient flow across the system, reducing delayed discharges and increasing direct admissions for those who require to be admitted.

   • Implement a transformed unscheduled care service which will provide a sustainable approach to the delivery of high quality, person-centred, effective and efficient care whilst meeting future population needs. It is proposed that NHS Grampian develops this approach on behalf of the NHS in Scotland.

3. NHS Grampian is well placed to deliver a transformed approach to unscheduled care as the foundations have already been laid i.e. the new Emergency Care Centre (ECC) was opened in December 2012, there is a high level of clinical engagement across the area and excellent cross-system and partnership working.

Background

4. Grampian covers 3,360 square miles and has a population of 555,280. 60.3% of the population live in Moray and Aberdeenshire local authority areas with the balance in Aberdeen City. Each Community Health Partnership (CHP) has agreed joint strategic commissioning plans with actions which contribute to the wider unscheduled care agenda. The local authorities are currently reviewing delivery arrangements as part of the implementation of the national integration policy.

5. There are three emergency departments (ED’s) within Grampian i.e. at the Royal Aberdeen Children’s hospital, Aberdeen Royal Infirmary (ARI) and Dr Gray’s Hospital in Elgin, together with 14 community minor injury/casualty units across Aberdeenshire and Moray. In Aberdeen City there is a minor injury unit (MIU) at the ECC and a pilot MIU within one of the Aberdeen City Boots pharmacies. Primary care out of hours unscheduled care is delivered by GMED with in hours care provided by a range of services including general practice, pharmacies, optometrists, dentists, specialist teams both in and out of hospital, within the home setting, ED’s and community hospitals. NHS Grampian also provides services to the North of Scotland Boards as the main tertiary centre.

6. Grampian’s population is projected to increase by 7.2% by 2020. The 65+ age group is projected to increase from 16.8% to 19% in the same time period. If admission rates and average length of stay remain at current levels, taking into account the population predictions, it is estimated that overall length of stay will increase from 8.39 days to 8.72 days, emergency admission bed days will increase by 15.9% and emergency department attendances will increase by 7.4% by 2020.
7. Appendix 2 provides a snapshot against both the ‘health check’ and the four hour self-assessment. This intelligence has confirmed the pressure points within the system and has guided the development of our action plan in relation to delivering the four hour standard and the wider patient and service benefits. This information has and will continue to be used to support the modelling of the predicted impact of the proposed actions within the plan.

8. Although there is significant evidence of improvements over recent years, further changes are required to continue to enhance patient, carer and staff experience, meet the challenges of projected demand for services, meet current and future standards of care and achieve Grampian’s aim to be the best healthcare provider. Augmenting the existing system of care will assist in alleviating the pressures in the short term, however, it is clear a new approach is necessary to manage the current and future predicted challenges in a sustainable way.

New Approach to Unscheduled Care

9. NHS Grampian’s proposed approach to unscheduled care will focus on organising resources around an individual’s needs in the most efficient and clinically effective way. Figure 1 indicates the integrated approach and the five key elements are summarised below (see appendix 3 for further detail):

- **Investment in an integrated and flexible workforce** involving all agencies providing unscheduled care
- **Establishing real time decision support** that will be accessed by clinicians and others at the first point of contact with patients requiring unscheduled care
- **Commitment to action and follow through of decisions made** to ensure that there is trust and confidence in the system
- **Investment in re-enablement to support discharge** and following discharge to help the transition to self care/management and maintaining people at home or in the community

- **Supporting individuals** and the population of Grampian to make the best decisions about their own care and choose the right service should they need support/treatment.

10. The key benefits of the model are:

- **Person-centred care which will improve patient/carer experience**
- **Reduction in ED attendance, emergency admissions and unscheduled care episodes in primary care/community.** When a person requires to be admitted, they will be directly admitted to the right speciality/team in the most appropriate setting for their specific needs
- **Integration of all key services – ED/GMED, primary/secondary NHS care, SAS, NHS24, local authorities, and the independent/third sectors**
- Consistent delivery of the four hour standard
- Reduction in delayed discharges
- Reduction in boarders
- Asset building in local communities and empowering patients and carers
- Creating greater workforce and service sustainability across the system, including additional investment in supporting safe community alternatives to hospital admission
- Improved staff experience, confidence and education

Key Areas of Transformation

11. Within the balanced approach to transforming the whole unscheduled care system it is recognised that there are two linked priority areas for change – the creation of a comprehensive system of clinical decision support and a flexible workforce.

12. **Clinical Decision Support:** It is essential that clinicians at the first point of contact with patients are provided with the right support to make the best decision for the patient. If this is not done there will be a low threshold to the management of risk and a likelihood that patients attend an ED or are admitted to hospital.

13. Many community care and planned care options are and could be available for patients requiring unscheduled care. The key to accessing these alternatives, and support for admission/ED attendance if required, is the provision of timely access to the right advice at all times to support and promote effective and efficient decision making. This support will be provided by a multi-agency network of professionals at local level. This network will be accessible directly to those at the first point of patient contact. If local networks cannot provide support, the “hub” of the network operating from the ECC, will be available to provide advice and coordination to assist in the management of a patient.

14. The service from the hub will be available to those requiring advice 24 hours per day, seven days per week. The system will start implementation on a phased basis from September 2013 covering the peak hours for four hour breachers and will be expanded in accordance with the results of evaluation after the first six months. Figure 2 provides an overview of the decision support network.
15. In addition to the decision support hub, advice will also be accessible through:

- Local networks e.g. GPs, Dr Grays, community hospitals, social workers, pharmacists and specialist service networks (e.g. palliative care). Information on local services will be available via a service directory. It is recognised that some of these networks may not operate outside daytime hours.

- The Clinical Guidance Intranet contains guidance, protocols, contact information, video clips and the service directory of local networks which can support decision making and follow through.

- E-mail and telephone advice for non-urgent care will ensure that, if appropriate, planned care is the norm and will reduce the demand for unscheduled care.

16. The approach also includes supporting the follow through of decisions made i.e. booking next day specialist clinics and primary care appointments, securing community support and a range of other services to ensure that those at the first point of contact with a patient requiring unscheduled care have the necessary trust and confidence in the system to manage and share risk effectively in relation to patient care.

17. Technology is critical in supporting the timely access to patient information, real time transfer of patient data and information, recording of decisions, communication of agreed decisions and the organised delivery of the agreed decisions/management plans.

18. **Flexible Workforce:** In order to implement the new approach, a range of workforce changes will be made relating to role purpose, location of delivery, skills and competencies including:

- A different skill blend which will create a system-wide multi-professional/multi-agency team with staff working together across the care continuum including NHS24, Scottish Ambulance Service, NHS Grampian, NHS independent contractors, local authorities, third and independent sector as highlighted in the model on page seven.

- Greater and more cross-system clinical leadership and management of services with the patient at the centre

- More patients will be assessed outwith hospital and within their local communities by those with the appropriate skills supported through decision support clinicians and relevant technology

- More appropriately trained advanced clinical practitioners (advanced nurse practitioners, paramedics and physician assistants). This may also include an increase in number of non-medical prescribers for the above cohort, as well as pharmacy staff

- Decision support consultants and GPs providing timely support to agreed professionals across the care system

- Supporting Health Care Support Workers in terms of increased numbers and specifically trained band 2, 3 and 4 roles to support the decisions made

- The use of physician assistants to work within unscheduled care, thereby increasing the capacity of the multi-disciplinary team to assess and initiate treatment of patients

- Telehealth/telecare and general skills associated with using technology to support the provision of advice and care

- The development of unscheduled care clinical skills with consistent and agreed competencies across the different roles recognising the need to respond to different levels of service and patient demand

- Re-enablement as part of all health and care roles.
Action Plan

19. A range of actions identified and agreed with partners is set out in appendix 4. This plan also includes a look ahead for a further two years as part of the development of a three year NHS Grampian plan.

20. The actions have been prepared with reference to the “health check” and self-assessment, and link directly to the five key elements of NHS Grampian’s approach to unscheduled care. The actions are also consistent with many of the priorities set out in the three local authorities’ Joint Strategic Commissioning Plans\textsuperscript{1-3}, third sector plans and the plans of partner NHS agencies\textsuperscript{4-5}.

21. In addition the actions are informed by lessons learned from a review of the 2012/13 winter season including:

- Greater focus on anticipatory care plans for vulnerable and at risk practice patients in advance of the winter period
- The requirement for optimal cross-system working to minimise delayed discharges ahead of predicted peaks in demand and timely care during the holiday period
- The need to increase bed capacity flexibly during the peaks in a timely manner
- The need to manage patient flow and better manage predicted peaks of activity to minimise the impact on elective care
- The responsiveness of specialist services in relation to decision making and the impact on patient flow
- Increased capacity for diagnostics required during the winter/holiday period to cope with demand and improve patient flow
- Requirement for improved communication of availability of infection prevention and control advice during holiday periods.

22. The actions summarised in appendix 4 are supplemented by:

- The agreed trajectory for the delivery of the four hour standard within appendix 5
- An initial training/workforce plan which aims to deliver real time clinical decision support and sustain an integrated workforce within appendix 6 – a fully integrated plan is currently under development
- A detailed financial investment plan within appendix 7

Priorities for 2013/14

23. The key focus for 2013/14 is the establishment of a flexible and integrated system to manage the predicted unscheduled peaks of demand in the coming winter and maintaining the four hour standard by:

- Providing capacity for peaks of demand i.e. bed capacity and actions to maximise patient flow
- Creating a more sustainable integrated workforce model and building capacity for primary care and secondary care teams, non-medical roles and carers
• Commencing the establishment of clinical decision support at the first point of contact based on timely access to senior clinical advice and the follow-through of the agreed actions by linking up the relevant professionals, services and teams to organise resources to meet the needs of individual patients, regardless of whether there is a decision to admit or to maintain the person in the community

• Continuing to reduce delayed discharges to meet the 2 week national standard

• Reinforcing and targeting the self care and self management messages to the public and staff via the Know Who To Turn To campaign and building on improved access to information for the public through community planning partnerships

• Ensuring high risk patients within practice populations have an anticipatory care plan in place which has been developed with the patient, family/carers and appropriate health and care teams, together with a commitment to ensure that there is timely activation of these plans with the appropriate response and capacity in place to meet the individual’s needs

Key Actions Beyond March 2014

24. NHS Grampian and its partners have identified a number of actions for the following two years to ensure continuity and consistency of approach. The actions cover the following areas:

• Building on the establishment of professional decision making support through widening to other health professionals and ensuring all relevant NHS/Non-NHS staff have access to appropriate support and patient/client information

• Continuing to redesign and integrate the workforce through further training and opportunities within appropriate service models

• Implementing plans for enhancing remote monitoring and near patient testing using digital technologies developed and tested during 2013/14

• Implementing a non-clinical portal for patients to access quality assured information.

Integrated Workforce plan

25. Figure 3 below summarises the comprehensive workforce model.
26. The model identifies the range agencies and professionals involved in the provision and transformation of the approach to unscheduled care in Grampian which seeks to use decision support to lever change throughout the system.

27. The workforce plan contained in appendix 6 sets out the anticipated changes to the numbers and mix of the local workforce to support the changes as set out within the action plan in Appendix 4. The workforce plan will also focus on the specific issues outlined in paragraph 18. The plan will continue to be developed in detail over the coming months.

Financial Investment Plan

28. The focus of the financial plan is on improving connectivity across the system to optimise and enhance the organisation of resources. This approach will minimise additional spend whilst ensuring sustainability, resilience and improving quality of care whilst meeting the future demographic challenges.

29. It is difficult to estimate the full costs of unscheduled care as many services across the system use the same resources to deliver both planned and unscheduled care. In relation to unscheduled care within the acute sector, the recurring revenue budget is £24m. This budget incorporates the adult and children’s ED’s in Aberdeen and in Dr Gray’s, acute medical initial assessment/receiving units, short stay medical unit and the hospital at night service. This does not include speciality level unscheduled care, community minor injury units or primary/community care input.

30. Section A of appendix 7 sets out NHS Grampian’s requirements against the unscheduled care national funding. The £150k allocated for 2013/14 by the Scottish Government for 1.5 WTE emergency medicine consultant posts has been included within the finance plan. The net total bid comes to £1.749m in 2013/14, £2.610m in 2014/15 and £2.772m in 2015/16. Costs are lower in 2013/14 as many of the initiatives will only commence from September onwards with costs only being incurred for part of the 2013/14 financial year. The bids for 2014/15 and 2015/16 generally assume full year costs.

31. There are also a number of non-recurring funding streams (change fund, national funding) which have been allocated from various sources and these are set out in section B of the financial plan within Appendix 7.

Performance Framework

32. Dr Roelf Dijkhuizen is the Executive Lead for unscheduled care and has a clear mandate to execute change within NHS Grampian and is supported by the Grampian Unscheduled Care Programme. The Programme Steering Group has overseen the development of the new approach and has approved this plan. The Programme Steering Group will also review performance against the unscheduled care plan to ensure it supports an integrated, system-wide approach.

33. Within Grampian there is an established performance framework in place. The Unscheduled Care Programme Steering Group provides assurance through bi-monthly performance reports to the Cross System Performance Review Group which subsequently provides reports to the Performance Governance Committee which is a subcommittee of the NHS Grampian NHS Board. The Programme Steering Group submits reports to the Strategic Management Team, Clinical Operational Management Team and other governance groups as appropriate. The NHS Grampian Board will also receive reports regarding the development of unscheduled care and performance through the Performance Governance Committee.

34. NHS Grampian will continue to provide formal and informal reports and updates to the Scottish Government and when required. The first formal progress update will be submitted in October 2013 and the quarterly and annual updates against the trajectory to reach and sustain the 98% 4 hour standard up to September 2014.
Endorsement of Plan

35. The approach set out in the plan was approved by the NHS Grampian Board on the 4th June 2013. This plan was formally endorsed by Unscheduled Care Executive Group and the Unscheduled Care Programme Steering Group on the 25th June 2013.

Areas for National Support

36. Proposed areas for support through the national improvement programme include:

- Development of the NHS Grampian approach to be adopted as a whole Scotland approach
- Development of pre-hospital clinical decision support as a means of levering change across the health system including evaluation, preparation of support materials etc
- Delivery and evaluation of VISION 360
- Support in terms of integrated (NHS/local authority) communication regarding public expectations of the public sector and the need to work together to deliver the best possible services
- Support in developing innovative ways to create sustainable unscheduled care out of hours services
- Appropriate succession planning for future consultant capacity through specialty training programmes.

Conclusion

37. The NHS Grampian Unscheduled Care Action Plan is set in the context of a clear vision for the future. The actions focus on the short term issues highlighted by the health check and also the medium to long term transformation required to deal with the current and future challenges.

38. The plan has been prepared with the involvement of all parts of NHS Grampian, partner NHS agencies, local authorities and the third sector. The plan details the 2013/14 actions and also looks ahead to the further work that will be necessary in the following two years as part of a rolling programme of change and development. It will therefore continue to be refined to ensure that the actions are targeted and effectively meet the requirements of the people of the north east of Scotland and the Scottish Government.

References

4 Working Together for Better Patient Care 2010-2015 (January 2010), Scottish Ambulance Service
5 NHS24 2020 Vision. Scottish Government
NHS Grampian

Unscheduled Care – A Vision of the Future

A plan for change needs to be developed in the context of a vision for the future. In NHS Grampian the vision is set out in practical terms to describe how health and care could be organised around the year 2020. This “Healthfit” 2020 vision takes account of trends, aspirations and current good practice applied consistently and comprehensively across the whole system.

This unscheduled care action plan has been prepared to move in the direction of Grampian’s unscheduled care Healthfit vision set out below. This vision is in draft form and will continue to develop in the coming months. It is written from the perspective of someone in 2020 describing unscheduled care and looking back at how it was achieved. It describes a possible future in 2020 but the changes could be achieved sooner with the appropriate investment.

A Possible Future…

In 2020 ………….the unscheduled care provided for the people of Grampian has been transformed following an ambitious approach which was started in 2013. At that time there was significant pressure on the Emergency Department and the primary care out of hours services. The pressure was also experienced in other services with every prospect that activity levels would continue to increase due the ageing of the population and rising expectations. Concerns regarding the sustainability of the workforce and the real aim to provide excellent person centred care prompted the formulation of a radical approach for the future.

Clinical Decision Support

In 2020 an extensive system of clinical decision support manages the demand for unscheduled care. The number of people requiring unscheduled care stabilised with many more now being treated by routine daytime services. People only use unscheduled care services if they need them and not because they are more convenient or as a substitute for other services not being available.

The phased introduction of a clinical decision support started in 2013. This has developed to include a Grampian wide network which means that generalist and specialist advice is immediately available to health and care professionals at the first point of patient contact. The communications hub of the network is in the control centre in the Emergency Care Centre (ECC) which manages the calls for support from first responders throughout the area. The system ensures that all calls for support are provided with consultant/senior GP level advice on patient management and follow through within 5 minutes to ensure that, if appropriate, a patient can be maintained in the community. The support is supplemented by a range of specialties, access to next day urgent treatment, and the activation of the appropriate community services.

The system provides a wide range of information to first responders through the use of technology. The support is now accessed via telephone, video-conferencing, and e-mailing data/images etc. All first responders have tablets to access patient records, anticipatory care plans, social care information and the range of contacts and services within any locality. This, together with the advice available via the hub, means that first responders can make better informed decisions about patient care, share risk with clinical colleagues with real-time recording of decisions.
Integrated Workforce

In response to workforce challenges in 2013 a fully integrated 24 hours per day, 7 days per week unscheduled care workforce was achieved in 2015. This integration included medical nursing staff and physicians assistants (PAs) in what was the Emergency Department, the G-MED out of hours service and the NHS24 hub in Aberdeen. This approach also extended to Advanced Clinical Practitioners – advanced nurse practitioners, paramedics and PAs), PAs and paramedics who provide in and out of hours unscheduled care in communities and patients’ homes. There are now more than 80 advanced clinical practitioners who are mainly employed in daytime primary care but also provide out of hours unscheduled care for, on average, one session per week. This sustainable workforce provides the vast majority of direct patient contact supported by accessible and trusted clinical decision support. The impact of health and social care integration through the creation of Community Health and Social Care Partnerships in 2014/15 was also significant. This resulted in the greater integration of health and social care teams at local level which provided more responsive population care at cluster/area/locality level.

Follow Through and Re-Enablement

The changes not only transformed unscheduled care but also had a major impact on planned care services. Many planned care and daytime services are now focused specifically on minimising the need for unscheduled care. The top ten acute specialties have daily urgent clinics or clinic time to accommodate patients requiring unscheduled care. In addition first responders and those providing clinical decision support now book patients directly into GP appointments the day after an unscheduled care patient contact. These changes have significantly improved the ability of clinicians providing unscheduled care to manage risk and convert unscheduled care cases to planned care.

In 2015 50% of patients had anticipatory care plans (ACPs) and 100% had ACPs by 2017. This was achieved by focusing the GP contract funding on ACP development and Change Fund resource on reshaping health, social care and third sector services to support the needs of collective requirements of ACPs. In 2020 the support required to respond efficiently to patients with ACPs accessed through the decision support system resulting in many more patients being dealt with at home or in their own communities without the need for unscheduled care.

Public and Patient Participation

A significant impact has resulted from the change in public attitudes and behaviour. In 2014 the Know Who To Turn To Campaign, developed in Grampian in 2010, started to focus consistently and persistently on specific groups who did not use services appropriately. This, together with the continued redirection of patients to use the most appropriate services including self care and pharmacies, started to have a discernible effect from 2015 and in 2020 the vast majority of people in Grampian use the right service first time.

Sustainable Outcomes

In 2020 the combined effect of the radical approach taken in 2013 has resulted in a health and care system that has shifted the balance from unscheduled care to planned care, created confidence and trust between the agencies and teams providing care, and supports the management of risk on a cross system team basis. The outcome has been the ability to absorb the projected impact of demand for unscheduled care broadly within the resources available. In workforce terms there are no significant pressures and the integration process, whilst challenging at first, has created a broad team approach and a range of roles with much improved job satisfaction. The pressures experienced in 2013 are a thing of the past.
Overview of Unscheduled Care System

1. No general correlation between high volume demand & breachers
2. 25% 4hr breachers due to bed availability
3. 27% admitted to hospital from A&E attendance
4. Delayed discharges increasing
5. Average length of stay 8.4 days, and increasing.
6. 65+ population increasing
7. 53% of emergency admissions from A&E
8. 12% 65+ emergency admissions due to falls, fractures, TIA, DVT, geriatric assessment

Numbers 1-8 refer to key points from the draft NHS Grampian 4 hour Self Assessment report – available upon request

Remains underdevelopment
Local System ‘Health Check’ and Self-Assessment Against the Four Hour Standard

The table below provides a snapshot against the local system ‘health check’.

<table>
<thead>
<tr>
<th>Measure/Indicator</th>
<th>Value</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 hour A&amp;E wait performance</td>
<td>95%</td>
<td>March 2013</td>
</tr>
<tr>
<td>Number of 12 hour breaches</td>
<td>55</td>
<td>2012/13</td>
</tr>
<tr>
<td>Rate of A&amp;E attendances</td>
<td>1573 per 100,000 pop</td>
<td>12 month average to March 2013</td>
</tr>
<tr>
<td>% of people in high risk groups with Anticipatory Care Plan</td>
<td>23.9% over 75s</td>
<td>Aberdeen City CHP to March 2013</td>
</tr>
<tr>
<td>No. of emergency admissions</td>
<td>51249</td>
<td>2012/13</td>
</tr>
<tr>
<td>Rate of emergency admissions</td>
<td>9228 per 100,000 pop</td>
<td>Quarter ending March 2013</td>
</tr>
<tr>
<td>Proportion of admissions from A&amp;E</td>
<td>53%</td>
<td>Quarter ending March 2013</td>
</tr>
<tr>
<td>Average emergency length of stay</td>
<td>8.41 days</td>
<td>2012/13</td>
</tr>
<tr>
<td>Average occupancy</td>
<td>73.1% AMIA (75.1% NHSG)</td>
<td>March 2013</td>
</tr>
<tr>
<td>Number of beds available</td>
<td>27 AMIA (2012 NHSG)</td>
<td>March 2013</td>
</tr>
<tr>
<td>Number of boarders</td>
<td>3295</td>
<td>Quarter ending March 2013</td>
</tr>
<tr>
<td>Number of delayed discharges</td>
<td>1154</td>
<td>2012/13</td>
</tr>
<tr>
<td>Bed days lost to delayed discharges</td>
<td>37087</td>
<td>2012/13</td>
</tr>
<tr>
<td>Effective policy on am discharge</td>
<td>12% discharged 8am-12noon</td>
<td>2012/13</td>
</tr>
<tr>
<td>Effective policy on senior decision making</td>
<td>Policy is implemented and under continuous review, this has shown to improve flow via timely senior decision making (specific information available upon request – see bullet point 6 below)</td>
<td></td>
</tr>
<tr>
<td>Success of recruitment to GP out of hours</td>
<td>This continues to prove problematic in terms of both recruitment of salaried GP’s, and filling the out of hours GP rota sessions. Data regarding this is currently being validated.</td>
<td></td>
</tr>
</tbody>
</table>

Summary of Key Points from Initial Four Hour Self-Assessment - June 2013

Below are the key points from the NHS Grampian initial four hour self-assessment. A detailed report is available upon request providing further trends and information.

- Grampian projected population increase of 7.2% by 2020. 65 years and over is projected to increase from 16.8% to 19% for same time period. If admission rates and average length of stay for under and over 65s remain at current levels, taking into account the population predictions, it is estimated that overall length of stay will increase from 8.39 days to 8.72 days, emergency admission bed days will increase by 15.9% and A&E attendances will increase by 7.4% by 2020.
- Number of attendances at emergency departments (ED’s) follow a seasonal pattern with demand generally increasing through first four months of the year, dips to July, before rising during August and September and decreasing to the end of the year.
- During April 2010-April 2013, the rolling 12 month average shows an overall increase in ED attendance. Over that time there has been a reduction in performance against the four hour standard. This is predominantly seen in the ARI and Dr Gray’s departments.
- There is a clear pattern of a higher number of four hour breaches occurring between 1pm and 3am. Despite low attendance numbers during the early hours of the morning, the patients breaching is double of those attending through the rest of the day.
- The main causes of breaches in 2012/13 were for beds (24.9%), first assessment (22.8%) and treatment (19%). There is variation in breach type dependent on the time of day. There is a slight variation of cause between ARI and Dr Gray’s departments.
- January to May 2013 shows a 57% reduction in bed breaches from 2012 to 2013. This is consistent with the change in practice whereby the senior ED clinicians make the decision about the admission speciality based on patient clinical need.
- The number of boarders varies considerably both on a daily and weekly basis. Medical patients usually account for the majority of boarders.
- In 2012/13 there was an increase in the number of delayed discharges, particularly non-complex cases. During February and March 2013, there was a significant reduction in the number of delayed discharges and therefore bed days lost.
Overview of Future Unscheduled Care Model

High Level Aim
Person-centred, high quality effective and efficient planned care is the norm. When this cannot be achieved due to clinical presentation, we will deliver high quality, safe and sustainable unscheduled care at the point of contact which is person-centred and organised to bring expertise to the patient/client.

Objectives
By September 2013, GP’s, unscheduled care advanced clinical practitioners and NHS24 advisors referring or considering referring an unscheduled care patient to hospital will access immediate senior clinical decision support to optimise management and if appropriate, admission pathway to ensure the patient is accurately placed for their clinical condition.
By March 2014, all NHS staff and by March 2015, non-NHS staff will be able to access senior pre-hospital clinical decision making support for unscheduled care patients. By September 2013, GP’s and other referrers can access planned decision support via e-mail and telephone.

How Will We Know?

- Know Who To Turn To (KWTTT).
- Peer Support.
- Healthpoints.
- Quality assured patient/carer information.
- Self Management Plans/Anticipatory Care Plans (ACP’s).
- No Delays electronic postcards for self management .
- Full Clinical Guidance Intranet (CGI) will be the platform for linking the above into one central access point.

- Hospital At Home/Community Support Team.
- Risk stratification/ACP’s.
- Self care/management.
- Discharge home/to community when clinically appropriate with right package of care.
- No Delays postcards.

- Unscheduled/Urgent Planned
  - Same/Next Day Assessment in primary care and specialties.
  - 24/7 USC Outreach teams.
  - Telehealth assessment/follow-up and monitoring.
  - Responsive Care Packages.
  - Diagnostics.
  - Certainty through direct booking.
  - Admission to right place at right time.
  - Commencement of treatment prior to admission.
  - Transportation/Retrieval.

- Access to up-to-date patient/client information at point of contact.
- Access to GP appointment/visit via online booking.
- Access to diagnostics and/or required treatment/care package.
- Risk satisfaction/ACP’s.
- Signposting via KWTTT.
- Access to timely decision support.

Planned/Non Urgent
- Timely access to decision support via local networks.
- SCI Gateway Speciality E-Mail Advice.
- Telephone advice provided by specialties.
- CGI - Speciality contact details, referral guidance, directory, protocols/guidance and No Delays.

Unscheduled/Urgent Planned
- Timely access to decision support via local networks.
- 24/7 Dedicated immediate telephone support via Decision Support Unit (DMSU) for advice and optimise access for admission (via single no).
- Video Conference assessment, agree joint management and review.
- No Delays/Protocols/Guidance via CGI.
- Professional Directory via CGI.
Grampian Unscheduled Care Action Plan for 2013/14

This action plan will continue to be refined over the coming months. It sets out the priorities for 2013/14 focussed on improving patient/carer experience, patient outcomes by tackling the identified pressure points and ensuring maintenance of the four hour standard over the winter period. Within the action plan, we have set out the agreed timescales and measures for success which relate to the ‘health check’ and the four hour standard self-assessment. We have framed the actions around the five key components as set out in the local model of care and cross-referenced these with the strategic themes contained within the national unscheduled care action plan.

National unscheduled care themes:
1. Flow and the Acute Hospital (Right Time)
2. Promoting Senior Decision Making (Right Care, Right Time)
3. Assuring Effective and Safe Care 24/7 at the Hospital Front Door (Right Care)
4. Making the Community the Right Place (Right Place/Right Care)
5. Developing the Primary Care Response (Right Place/Right Time)

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Action</th>
<th>National Themes</th>
<th>Timescales</th>
<th>Expected Impact &amp; Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Supporting Self Care/Management</td>
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<tr>
<td>1.</td>
<td>Further communicate and target the Know Who To Turn To (KWTTT) messages/campaign and reinforce via redirection by staff in ED and MIUs.</td>
<td>1</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>a. staff KWTTT campaign rolled-out and evaluated</td>
<td>2</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>b. KWTTT generic campaign and targeted campaign e.g. high post code users, parents of under 5’s and mental health</td>
<td>3</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>c. Roll-out of redirection policy/framework to Royal Aberdeen Children’s Hospital, Dr Gray’s and MIUs</td>
<td>4</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>2. 15% of 5% of practice population identified as high risk of requiring unscheduled care have in place an up-to-date anticipatory care plan (ACP) which has been developed by the patient, carer/family and appropriate multi-disciplinary/agency team.</td>
<td>5</td>
<td>✓</td>
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<tr>
<td></td>
<td>31 Mar 2014</td>
<td>• 15% of high risk population have an ACP developed in partnership.  • Increased access to ACPs.  • ACPs are actively used and activated.  • Improved patient/carer experience.  • Improved staff experience.  • Reduction in USC episodes (in and out of hours GP and ED).  • Reduction in emergency admissions.</td>
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</table>
3. **ACP is easily accessible in-hours and out of hours via eKIS.**
   - ✔
   - ✔
   - ✔
   - As per national programme

4. **Through the work of the three Health and Care Partnerships, the development of appropriate capacity to respond to the activation of ACPs in a timely way is being taken forward.**
   - ✔
   - ✔
   - 31 Mar 2014
   - As per no. 2.

### Developing a sustainable primary, community and secondary care workforce

5. **Increase the capacity for training of advanced clinical practitioner roles in USC by:**
   - ✔
   - ✔
   - ✔
   - ✔
   - 31 Mar 2014
   - **• Increased clinical capacity in the short term by an additional 12 nurse/paramedic posts. In the longer term increased sustainability of workforce model.**
   - **• Vacancies in USC out of hours service filled by trained staff.**
   - **• 20 USC advanced clinical practitioners trained during 2013/14. (8 physician assistants, 10 ANPs and 2 paramedic practitioners).**
   - **• Release of consultant and GP capacity to deliver DMS.**
   - **• Contribute to meeting 4 hour standard.**
   - **• Network is established to provide peer support and share learning and good practice.**
   - - Funding an additional 6 training places (4 nurse & 2 paramedic practitioners) to allow a total of 12 places for 2013/14
   - - Funding of remuneration/backfill for additional 6 places to support training within clinical settings.
   - - Increasing mentoring capacity to supporting training in 2013/14 and beyond.
   - - Further identify demand and training capacity requirements for 2014/15 and 2015/16 (anticipated total of 18 for 2014/15 and 24 for 2015/16)
   - - Develop a network to support both the advanced clinical practitioners and the teams/GP’s
   - - Providing USC clinical placements for 8 physician assistants in their intern year from September 2013.

6. **Create greater sustainability of clinical capacity in emergency medicine unscheduled care through workforce redesign by moving towards an integrated and blended USC workforce by:**
   - ✔
   - 31 Mar 2014
   - **• Increased clinical capacity in the short term. In the longer term increased sustainability of workforce model.**
   - **• More integrated workforce and multi-skilled model which will allow the release of consultant and GP capacity to deliver DMS and deal with complex cases.**
   - **• Maintaining the 95% standard and reducing 4 hour breaches.**
   - **• Increased cover for the middle grade rota.**
   - - introducing physician assistant roles (see no.5)
   - - increasing Nurse Practitioner workforce and developing a rotational role for them in ED and the community
   - - increasing consultant capacity by 2.0 WTE to deliver Consultant level pre-hospital decision support and a greater focus on clinical leadership and co-ordination of patient care.
   - - Greater development of the role of GPs in decision support
   - - Increase in speciality doctors in ED by 3.0wte to cover middle grade rota changes.
   - - Review of workforce changes required in view of middle
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<td>6. cont.</td>
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<tr>
<td>• grade rota changes</td>
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<tr>
<td>• Link to action no.’s 5, 7, 9, 10, 11 and 12.</td>
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<tr>
<td>• Improved flow within ED.</td>
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<td>7.</td>
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<td>Expand capacity and create greater sustainability in general practice in-hours and out of hours unscheduled care by:</td>
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<td>• Formally appointing shared advanced nurse practitioner posts working within both general practices and out of hours unscheduled care.</td>
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<td>• Successfully recruiting to the 7 vacant out of hours nurse practitioner posts.</td>
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<td>• Creating out of hours physician assistants bank</td>
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<tr>
<td>• Training physician assistants in general practice unscheduled care</td>
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<td>• Exploring the opportunities for the wider non-medical USC workforce model, including minor illness nurses.</td>
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<tr>
<td>• Link to action no.’s 5, 6, 9, 10, 11 and 12</td>
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<tr>
<td>• Improved patient/carer experience.</td>
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<td>• Increased capacity and responsiveness in general practice in-hours.</td>
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<tr>
<td>• Increased capacity and responsiveness in general practice out of hours by recruiting to the 7 vacant posts and recruitment to additional posts.</td>
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<td>• Retention of staff by creating posts which cover both in and out of hours USC.</td>
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<td>• Release of GP capacity to deliver DMS and deal with complex cases.</td>
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<td>• Reduction in ED attendances.</td>
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<td>8.</td>
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<td>Agree what a sustainable 24/7 USC workforce model will look like across Moray, including Dr Grays.</td>
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<td>• Improved client experience.</td>
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<td>• Reduced vacancies.</td>
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<td>• Increased capacity and responsiveness to client needs.</td>
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<td>9.</td>
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<td>The three Health and Care Partnerships are implementing local plans to improve recruitment and retention of care workers. Specific examples are:</td>
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<td>• Aberdeen is focusing on establishing a Care Sector Recruitment Post and a Health and Social Care Workforce Project.</td>
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<td>• Aberdeenshire is continuing to progress their recruitment campaign to increase home care by 1,200 hours.</td>
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<td>• Moray is continuing to implement the ongoing bi-monthly campaign to recruit to care workers and to use and maintain the scheduling system to improve efficiency in relation to domiciliary care services.</td>
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<td>• Improved workforce model and underpinning implemented plan.</td>
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</table>
| 10. | Explore and describe the future role of pharmacists and potential opportunities as part of the USC model and wider workforce model.  
- Identify and support opportunities to utilise community pharmacist and community pharmacy premises to deliver care to support the USC priorities e.g. walk-in minor injuries service, EHC provision, self care, shift from unscheduled to planned care  
- Fully explore the role of the Minor Ailments scheme (MAS) and opportunities for local extension to the national service to allow transfer of care from General Practitioners/GMED to support appropriate access to services by patients.  
- Support community pharmacists and their staff with training support in order to better manage USC presentations and with access to decision support. | ✓ | ✓ | 31 Jan 2014 | • Agreed description of role of pharmacists and potential opportunities in relation to the delivery of sustainable USC.  
• Patients treated in the most appropriate care setting as close to their home as possible.  
• Increased capacity and utilisation of appropriate staff.  
• Supports and reinforces the KWTTTT campaign. |
| 11. | Create capacity and assess the impact of the redirection of care for the treatment of uncomplicated urinary tract infection’s (UTI’s) in women to 15 community pharmacies in Grampian. | ✓ | ✓ | 31 Mar 2014 | • Faster access to effective treatments for women with uncomplicated UTI closer to patients home.  
• Between 600 - 1800 women with uncomplicated UTI seen over a 6 month period by Pharmacists.  
• Reduction in USC demand/appointments at GP’s, GMED and ED for uncomplicated UTI in women. This will release capacity to deliver various standards e.g. GP access, 4 hour standard etc.  
• Potential reduction in unnecessary urine specimens.  
• Full understanding of impact and future opportunities. |
| 12. | Redesign of mental health workforce model to ensure appropriate clinical capacity and responsiveness by introducing a 24/7 Mental Health Nurse Practitioner Service in Aberdeen. The service will also streamline contact points for seeking professional decision support regarding patients with mental health needs. | ✓ | ✓ | ✓ | ✓ | 1st Phase by Oct 2013  
2nd Phase by Mar 2014 | • Reduction in 4 hour breaches by 80% (during 5pm – 8am) for mental health patients.  
• More responsive assessment of patient in and out of hours. |
12. cont.

- Improved patient/carer experience.
- Improved staff experience.
- Improved flow across patient pathway.
- Improved access to professional decision support re patient with mental health needs.

13. Explore and describe the future role of allied health professionals and potential opportunities as part of the USC model and wider workforce model.

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<tr>
<td>✓</td>
<td>✓</td>
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<td>31 Jan 2014</td>
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</tbody>
</table>

Agreed description of role of allied health professionals and potential opportunities in relation to the delivery of sustainable USC.

Delivering ‘real time’ professional decision support as per agreed standards

14. Enhance current local decision support networks by developing, testing and implementing a mobile clinical assistant device to provide real time access to patient information, Clinical Guidance Intranet, links to local networks and decision support hub.

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<td>31 Mar 2014</td>
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</table>

- Mobile clinical assistant device tested and implemented.
- Increased access to decision support tools.
- Enhancement of local decision support networks.
- Improved patient, carer and staff experience.
- Greater person-centred high quality care in right place and at right time.
- Staff feel better supported.
- In the longer term improved access to patient/client information at the point of patient contact.

15. Implementing phase 1 of the decision making support hub for urgent professional advice based in the ECC from September 2013. Key actions are:

- roll-out to paramedics, USC nurse practitioners, NHS 24 advisors, GPs and nursing home staff.
- learning from recent developments/testing of the concept across the system

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<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Phase 1 commenced in Sept 2013</td>
</tr>
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</table>

- Improved access to decision support for paramedics, USC nurse practitioners, NHS24 advisors, GP’s and nursing home staff.
- Reduction in ED attendance.
- Reduction in 4 hour breaches
- Improved patient/carer experience.
15. cont.

- recruiting and training of appropriate workforce to support robust delivery (ED consultants/GPs, call handlers, administration, operational support etc)
- co-location and enhancing integrated working between NHS24, USC staff and others within the ECC Hub.
- testing and implementing technological solutions (see no. 13 and 15)
- governance and evaluation built into implementation phase 1 in order to inform phase 2 and make improvements on a real time basis.

16. Technology supports the access to real time patient information, professional decision support, communication and follow through of agreed management plans by:

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<tbody>
<tr>
<td>a.</td>
<td>Roll out and activation of eKIS as part of national programme.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>b.</td>
<td>Access to patient clinical record at the point of contact with the patient.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>c.</td>
<td>Single telephone number which enables the recording/storage of conversations and appropriate re-routing of calls.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>d.</td>
<td>Appropriate recording and sharing of agreed actions with relevant patient information systems.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>e.</td>
<td>Set-up e-mail to receive images/patient information and the transfer of this information into the patient record.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>f.</td>
<td>Agreed policy in place for dealing with technical issues around videoconferencing e.g. training, second bridge, convert to telephone/e-mail images etc.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>g.</td>
<td>Identify, test and implement secondary and primary care solutions to e-booking of appointment/diagnostics to create increased access to patient ACPs which reduces some emergency attendances and admissions.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</table>

- Increased access to patient ACPs which reduces some emergency attendances and admissions.
- Increased and easy access to decision support tools.
- Enhancement of local decision support networks.
- Improved patient, carer and staff experience.
- Greater person-centred high quality care in right place and at right time.
- Staff feel better supported.
- Improved access to patient/client information at the point of patient contact.
- Ebooking of appointments.
| 16. cont. | certainty of agreed decisions/management plans.  
- Explore and agree solution for NHS and Non-NHS staff to access patient/client information across health and social care. |  |  |  |  | - Appropriate communication and transfer of information to patients electronic notes/record.  
- Robust governance arrangements around clinical information.  
- Solution in place for sharing health and social care information.  
- Care closer to patients home and reduced journeys to ARI and Dr Gray’s. |
| 17. | Non-urgent advice via telephone and e-mail/SCI to be available by top three USC specialities to GPs/primary care. (link to no. 15) | ✓ | ✓ | ✓ | 31 Mar 2014 | - Advice by telephone or email/SCI reduces the need of referral/admission.  
- Quicker diagnosis made and commencement of treatment.  
- Improved patient/carer experience.  
- Reduced number of journeys to ARI and Dr Gray’s.  
- Care closer to patients home.  
- Right care, right time, right place by the right person/team. |
| 18. | Development of Hospital At Home/Geriatric Community Outreach services by:  
- Exploring the opportunities for a hospital at home type model within Aberdeenshire.  
- Commencement of the Geriatric Consultant and Multi-Disciplinary Community Outreach Assessment, Management and Follow-up Service within Aberdeen City from August 2013.  
- Agree plans for the further development of Geriatric Community Outreach Service’s with exploration of provision of immediately available domiciliary nursing or carer support | ✓ | ✓ | ✓ | a. 31 Mar 2014  
  b. 31 Aug 2013  
  c. 31 Mar 2014 | - Clarity and agreed way forward in developing this model of care.  
- Improved patient/carer experience.  
- Timely person-centred assessment and care.  
- Reduced risk of significant reduction in patient functionality.  
- Increase in care closer to the persons home.  
- Reduced emergency admissions  
- Reduced A&E attendances. |
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<tr>
<td><strong>19.</strong></td>
<td>Redesign of community health and social care teams to create greater integration and potentially capacity to respond to local population need at cluster/locality level.</td>
<td>✓</td>
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<td>✓</td>
<td>31 Mar 2014</td>
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<td></td>
<td>Improved integrated working.</td>
<td>More effective and efficient use of capacity.</td>
<td>Improved client/patient/carer experience.</td>
<td>Increased responsiveness to client/local needs.</td>
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<tr>
<td><strong>20.</strong></td>
<td>Timely access to:</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>31 Mar 2014</td>
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<tr>
<td></td>
<td>• Common diagnostic tests which reduce the need for outpatient attendances or admission through GP direct access where acceptable and feasible</td>
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<td></td>
<td>• diagnostics required by USC patient in ED are requested asap when patient presents</td>
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<td></td>
<td>• appropriate capacity is in place to deal with ED demand</td>
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<td>• increase in diagnostic sessions over the winter months/holiday period to cope with increased demand</td>
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<td></td>
<td>More direct access to tests at scale reducing the need for admission or planned outpatient appointment.</td>
<td>Quicker diagnosis made and commencement of treatment.</td>
<td>Improved patient/carer and staff experience.</td>
<td>Care closer to the patient’s home.</td>
<td>Reduction in 4 hour breaches due to diagnostics.</td>
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<tr>
<td></td>
<td>Appropriate capacity in place to meet demand.</td>
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<td><strong>21.</strong></td>
<td>Roll-out of the ‘Intelligent Bed Placement Tool’ to Dr Grays and community hospitals in 2013/14.</td>
<td>✓</td>
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<td>31 Mar 2014</td>
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<tr>
<td></td>
<td>Real time access to bed states and facilities in all sites across Grampian.</td>
<td>Better facilitate flow across Grampian.</td>
<td>Improves forward planning at ward/site level and determine action to meet predicted unscheduled and planned bed demand.</td>
<td>Reduction in boarding.</td>
<td>Supports right care, right place at the right time.</td>
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<td><strong>22.</strong></td>
<td>Testing and evaluating the impact of the Automated Vehicle Location System (AVLS) in Aberdeen City in relation to enhancing the co-ordination of USC community capacity.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>30 Sept 2013</td>
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<tr>
<td></td>
<td>AVLS tested and evaluation of impact and benefits.</td>
<td>Improved co-ordination of USC capacity and responsiveness to patient needs within the community</td>
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|   |   |   |   | setting.  
|   | Reduced attendance/demand at ED. Positive impact on 4 hour standard.  
|   | Care closer to the patient’s home.  
|   | Improved patient, carer and staff experience.  

| 23. | Implement and evaluate the pre-hospital primary response service to provide rapid assessment and intervention in conjunction with agreed operating criteria and pan Grampian decision support for USC. | ✓ | ✓ | 31 Jul 2013 | Pre-hospital service implemented and evaluated.  
|   |   |   |   | Improved co-ordination of USC capacity and responsiveness to patient needs pre-hospital.  
|   |   |   |   | Care closer to the patient’s home.  
|   |   |   |   | Improved patient/carer and staff experience.  

| 24. | Appropriately supporting unpaid carers within each of the local health and care partnerships. Specific actions are:  
|   |   |   |   | Aberdeen Health and Care Partnership to retender the Carer Support Service and open a new Carerpoint in the Aberdeen Health Village in December 2013.  
|   |   |   |   | Aberdeenshire Health and Care Partnership are focussing on sustaining carer support through a dedicated carers team and a respite bureau.  
|   |   |   |   | Moray Health and Care Partnership are implementing the agreed carer strategy focusing on the carers network, delivery of formal carer qualification for informal carers, short breaks bureau and interdependent carers assessment.  
|   |   |   |   | ✓ | ✓ | 31 Mar 2014 | Unpaid carers know where to access support and receive this when they require it.  
|   |   |   |   | Enhancing the menu of support mechanisms available for carers.  

| 25. | Same day/next day assessment available within specific specialities/services. Initial focus on the top three USC specialities. | ✓ | ✓ | 31 Mar 2014 | Improved patient/carer experience.  
|   |   |   |   | Improved patient-centred care.  
|   |   |   |   | Reduced unnecessary admissions to hospital.  
|   |   |   |   | Right care, right place, right time and by right team/person.  

DRAFT  
Page 23 of 40
|   | Creation of a in-hospital transfer team to support the flow of patients and capacity throughout the hospital system (ARI and Dr Gray's) | ✓ | ✓ | 30 Sept 2013 | Improve flow and co-ordination throughout the hospital.  
Patients are in the right clinical environment for their needs.  
Improve discharge flow.  
Improve turn around of bed availability.  
Improved support for ward staff. |
|---|---|---|---|---|---|
|   | Provision of sustainable AHP assessment and co-ordinated activity across the system for USC patients in ED and the community by:  
• Evaluating impact and based upon this mainstreaming pilot service funded via change fund  
• Assessing demand for extending current Mon-Fri service to 8-10pm and further explore roll-out across Grampian.  
• Exploring the benefits of further developing model within USC in-hours and out of hour’s primary care setting. | ✓ | ✓ | ✓ | ✓ | 30 Nov 2013, dependent on outcome of Change Fund bid. | Understanding of impact and benefits of pilot and agree next steps.  
Increased numbers of falls patients are referred and seen by the local falls teams (via ED team).  
Reduced unnecessary admissions to hospital.  
Reduced 4 hour breaches.  
Improvement patient/carer experience.  
Improved person-centred co-ordinated care.  
Care closer to home.  
Improving response and capacity within acute, primary and community/social care services.  
Reducing length of stay. |
|   | Formalisation and implementation of the agreed policy of delegated authority to allocate patients to specialities by ED consultants. | ✓ | ✓ | ✓ | 31 Oct 2013 | Improved flow and reduced 4 hour breaches.  
Patient is allocated to the right speciality based on clinical needs.  
Improved patient/carer experience.  
Improved deployment of staff resource due to timely acceptance. |
<table>
<thead>
<tr>
<th></th>
<th>29. Implement communication strategy for provision of infection prevention and control advice during holiday periods, including any identified increase in capacity.</th>
<th>✓</th>
<th>✓</th>
<th>30 Nov 2013</th>
<th>• Improved patient safety. • Reduced cross-infection. • Increased access to prevention advice/management. • Reduced delays in management plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Timely and appropriate discharge of medically fit patients and that re-enablement is a mainstreamed component of services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Embedding the re-enablement approach within health and community care teams across the three partnership areas. Specific areas of focus are:</td>
<td>✓</td>
<td>✓</td>
<td>31 Mar 2014</td>
<td>• Increase in the number of staff with re-enablement skills. • Re-enablement is an integral component of staff roles. • Improved functionality of clients/patients and therefore fewer requirements for continued high levels of intensive care.</td>
</tr>
<tr>
<td></td>
<td>• Aberdeen Health and Care Partnership are working to maximise impact their re-enablement/rehabilitation services/capacity. • Aberdeenshire Health and Care Partnership are training all care workers in re-enablement/recovery model. • Moray Health and Care Partnership will continue to ensure all care workers are trained in re-enablement by incorporating this within the induction programme.</td>
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</tr>
<tr>
<td>31.</td>
<td>Stabilise capacity of intermediate beds in the community in partnership with local authority, private and third sector.</td>
<td>✓</td>
<td>✓</td>
<td>31 Mar 2014</td>
<td>• Stabilised intermediate bed capacity. • Delivery of the right care, right time and in the right place. • Reduced delayed discharges. • Improved patient/carer and staff experience.</td>
</tr>
<tr>
<td>32.</td>
<td>Implementation of partnership plans to maintain the 4 week standard and actively working towards the delivery of the 2 week standard for delayed discharges.</td>
<td>✓</td>
<td>✓</td>
<td>31 Mar 2015</td>
<td>• Delivery of the right care, right time and in the right place. • Reduced delayed discharges and delivery against national standard. • Improved patient/carer and staff experience. • Release in acute bed capacity.</td>
</tr>
<tr>
<td>33.</td>
<td>Embedding the delivery of anticipatory care plans as part of discharge management within community hospitals in 2013/14.</td>
<td>✓</td>
<td>✓</td>
<td>31 Mar 2014</td>
<td>• As per action no. 2.</td>
</tr>
</tbody>
</table>
|   | 34. Increase transport capacity in partnership with ambulance service and community planning partners by testing and evaluating additional transport mechanisms to create capacity to take people home from hospital and transfer patients from one hospital/care site to another. | ✓ | ✓ | 30 Sept 2013 | • Improved flow by minimising delayed discharges due to lack of transport.  
• Reducing cause of admission from ED due to transport issues.  
• Reduced 4 hour breaches.  
• Improved patient/carer/staff experience.  
• Right care, right place and at the right time. |
|   | 35. Provision of sustainable AHP assessment and co-ordinated activity across the system for USC patients in Geriatric Assessment Unit:  
• Evaluating impact and based upon this mainstreaming extended service provision funded via change fund  
• Exploring the further development of the model within USC in-hours and out of hour’s primary care setting. | ✓ | ✓ | ✓ | 30 Nov 2013, dependent on outcome of Change Fund bid. | • Understanding of impact and benefits of pilot and agree next steps.  
• Reduced unnecessary admissions.  
• Improvement patient/carer experience.  
• Improved person-centred co-ordinated care.  
• Care closer to home.  
• Improving response and capacity within acute, primary and community/social care services.  
• Reducing length of stay. |
|   | 36. Additional capacity to support the delivery of the existing hospital discharge lounge in ARI and Dr Gray's. | ✓ | 30 Sep 2013 | • Improved flow from wards and consequently from ED.  
• Increased number of discharges by 12noon (target 30% of non-elective patients).  
• Improved discharge planning.  
• Reduced number of 4 hour breaches due to bed availability. |
37. Implement local Falls Improvement Plan, specifically focussing on:
   a. Development of an agreed alternative pathway for falls within
      the community which incorporates access to professional
      decision support.
   b. Continued roll-out of the Falls Bundle work and identify the
      impact on repeat fallers.
   c. Develop and make available resources on the Clinical
      Guidance Intranet (CGI).
   d. Develop professional education tools

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<tr>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>31 Mar 2014</td>
</tr>
</tbody>
</table>

- Reduced number of falls and repeat fallers.
- Reduced ED attendances and emergency admissions.
- Reduced mortality due to falls.
- Improved person-centred, high quality care.
- Right care, right place and at the right time.
- Decision support resources for professionals available on CGI.
- Robust training package and training plan in place to support professionals.

38. Ability to respond to increased demand over the predicted winter peak by creating additional surge capacity beds within ARI and Dr Gray’s.

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<tr>
<td>✔</td>
<td>✔</td>
<td>31 Dec 2013</td>
</tr>
</tbody>
</table>

- Improved flow.
- Decrease in boarding patients.
- Improvement in elective flow.
- Improved patient/carer experience.
- Improved staff experience.
- Right care, right place and at the right time.

Specific Support Required to Effectively Manage the Redesign and Implementation of the Future Model for Unscheduled Care

39. Dedicated clinical leadership, project management and health intelligence support in place to effectively lead, oversee implementation, ongoing communication and evaluation of the redesign of the model of care.

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</table>

- ASAP Effective leadership, implementation, evaluation and communication of the phased professional decision making support element of the model commencing September 2013.

40. Robust evaluation of changes and interventions:
   a. Introduction of systematic data collection recording processes and analysis, including patient and staff experiences
   b. Formative evaluation of professional and staff receptiveness to change
   c. Production of an evaluation framework for the three year programme
   d. Initial evaluation report produced in April 2014

<p>| | | | |</p>
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<tbody>
<tr>
<td>✔</td>
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</tr>
</tbody>
</table>

- Robust evaluation framework in place.
- Clear understanding of barriers and opportunities for change.
- Appropriate data recording processes to demonstrate impact/benefits of various components.
- Independent and credible evaluation process.
| 41. | Improve the communication of the direction of the unscheduled care model through the development of a number of short films depicting various scenarios. | ✓ | ✓ | ✓ | ✓ | ✓ | 31 Aug 2013 | • Enhance mechanisms, consistency and quality of communication.  
• Improve staff, public, carer and partner colleagues understanding of the model and benefits.  
• Create greater ownership and support for implementation. |
Appendix 5

NHS Grampian Trajectory For 4 Hour Standard

Month/Year

Percentage

Workforce/Training Plan For Unscheduled Care

The workforce and training plan underpinning the Grampian Unscheduled Care Action Plan is underdevelopment. As part of its development a number of risks have been identified. As part of the agreed workforce plan, an outline of the specific changes to the number and mix of the local workforce, including partner agencies will be included. This plan will evolve as the model becomes embedded.

At the time of submitting this document to the Scottish Government, the specific changes known are outlined in the table below.

<table>
<thead>
<tr>
<th>Workforce Group</th>
<th>Anticipated Changes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14</td>
<td>2014/15</td>
</tr>
<tr>
<td><strong>Medical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department Consultants/Speciality Doctor</td>
<td>↑ 2.2 WTE Consultant &amp; 3.0 WTE Speciality Doctors</td>
<td>To be defined</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision Support General Practitioners</td>
<td>↑2.0 WTE</td>
<td>To be defined</td>
</tr>
<tr>
<td><strong>Advanced Clinical Practitioners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Nurse Practitioners (ANP) (in/out of hours)</td>
<td>↑ 10 posts</td>
<td>↑18 posts from 2013/14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paramedic Practitioners</td>
<td>↑2 posts</td>
<td>To be defined</td>
</tr>
<tr>
<td>Emergency Nurse Practitioners in Emergency Department</td>
<td>↑ 0.37 WTE Band 7 (ARI)</td>
<td>To be defined</td>
</tr>
<tr>
<td>Physician Assistants (PA)</td>
<td>11 intern year c/o Sept 2013</td>
<td>14 intern year (Number for USC to be defined)</td>
</tr>
</tbody>
</table>
### Unscheduled Care Training Plan for 2013/14

Specific initiatives planned for 2013/14 are:

- **Advanced Clinical Practitioners** - an additional 6 nurse/paramedic practitioners will be trained (based on 2012/13 figures) and 8 physician assistants will have dedicated training placements in unscheduled care as part of their intern year.

- **Training of clinical and non-clinical staff operating within the Clinical Decision Support Hub**

- **Training for those professionals (advanced clinical practitioners, NHS24 advisors, GP’s and nursing home staff) in how, when and where to access decision support**

- **Increasing the number of mentors to support the increase in training numbers of Advanced Clinical Practitioners**

- **Increasing the number of staff with re-enablement skills (NHS and non-NHS staff)**

- **Increasing the number of non-medical prescribers**

- **Roll-out and evaluate the success of the staff KWTTT programme**

- **Delivering training to support the utilisation of the ‘Intelligent Bed Placement Tool’**

- **Develop and make available an elearning package on Falls for professionals (NHS/non-NHS staff).**

---

<table>
<thead>
<tr>
<th>Role</th>
<th>Full-time Equivalent (FTE)</th>
<th>Band</th>
<th>Band 6</th>
<th>Band 5</th>
<th>Band 7</th>
<th>Band 8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nurses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Operational Support (Dr Gray’s/ARI)</td>
<td>↑1.2 ↑0.2 ↑0.2</td>
<td>To be defined</td>
<td>To be defined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED (Dr Gray’s/ARI)</td>
<td>↑1.14 ↑5.1</td>
<td>To be defined</td>
<td>To be defined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Lounge (Dr Gray’s/ARI)</td>
<td>↑1.5 ↑3.4</td>
<td>To be defined</td>
<td>To be defined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Hospital Transfer Team (Dr Gray’s/ARI)</td>
<td>↑3.65 ↑1.5</td>
<td>To be defined</td>
<td>To be defined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Nurse Service</td>
<td>↑1.6</td>
<td>To be defined</td>
<td>To be defined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allied Health Practitioners</strong></td>
<td></td>
<td></td>
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<tr>
<td>To be defined</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Administration/Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call handler</td>
<td>↑2.0</td>
<td>To be defined</td>
<td>To be defined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Secretary</td>
<td>↑1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Manager</td>
<td>↑1.0</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Project Officer</td>
<td>↑1.0</td>
<td></td>
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</tbody>
</table>

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## Financial Investment Plan

### Section A – Bids Against National Funding (Relating to Actions Set Out With Appendix 4)

<table>
<thead>
<tr>
<th>Appx 4 Ref No</th>
<th>Initiative / Development</th>
<th>2013/14 Funding Bid</th>
<th>2014/15 Funding Bid</th>
<th>2015/16 Funding Bid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KWT TT generic campaign and targeted campaign e.g. high post code users, parents of under 5’s and mental health</td>
<td>£30k</td>
<td>Anticipated £30k (to be confirmed)</td>
<td>Anticipated £30k (to be confirmed)</td>
</tr>
</tbody>
</table>
| 1b.           | 5. Increase the capacity for training of advanced clinical practitioner roles in USC by: -  
• Funding an additional 6 training places (4 nurse & 2 paramedic practitioners) to allow a total of 12 places for 2013/14  
• Funding of remuneration/backfill for additional 6 places to support training within clinical settings.  
• Increasing mentoring capacity to supporting training in 2013/14 and beyond.  
• Further identify demand and training capacity requirements for 2014/15 and 2015/16 (anticipated total of 18 for 2014/15 and 24 for 2015/16)  
• Develop a network to support both the advanced clinical practitioners and the teams/GP’s  
• Providing USC clinical placements for 8 physician assistants in their intern year from September 2013. | £129k (6 WTE Band 7 for 6 months)  
£6k Educational sessions  
£2k GP Trainer Time  
£36k Remuneration for GP Training Placements  
£10k Co-ordination Support for Training Programme (0.4 WTE Band 7)  
£21k Contribution to study fees and module costs | £388k (18 WTE Band 7 for 6 months)  
£6k Educational sessions  
£4k GP Trainer Time  
£108k Remuneration for GP Training Placements  
£17k Co-ordination Support for Training Programme (0.4 WTE Band 7)  
£62k Contribution to study fees and module costs | £518k (24 WTE Band 7 for 6 months)  
£6k Educational sessions  
£4k GP Trainer Time  
£144k Remuneration for GP Training Placements  
£17k Co-ordination Support for Training Programme (0.4 WTE Band 7)  
£83k Contribution to study fees and module costs |
|               | 6. Create greater sustainability of clinical capacity in emergency medicine unscheduled care through workforce redesign by moving towards an integrated and blended USC workforce by:  
• Introducing physician assistant (PA) roles (see no.5)  
• Increasing Nurse Practitioner workforce and developing a rotational role for them in ED and the community  
• Increasing consultant capacity by 2.0 WTE to deliver Consultant level | £150k (1.5 WTE Consultant posts for Grampian) Allocation confirmed  
£117k (3.0 WTE Specialty Doctor posts for middle) | £75k (0.75 WTE Consultant posts for Grampian) Allocation confirmed  
£200k (3.0 WTE Specialty Doctor posts for middle) | £38k (0.38 WTE Consultant posts for Grampian) Allocation confirmed  
£200k (3.0 WTE Specialty Doctor posts for middle) |
### 6. Cont.

- Greater development of the role of GPs in decision support
- Increased focus on clinical leadership and co-ordination of patient care.
- Review of workforce changes required in view of middle grade rota changes.
- Link to action no.’s 5, 7, 9, 10, 11 and 12.

<table>
<thead>
<tr>
<th>Grade rota from Sept</th>
<th>£72k (4 WTE PAs from Sept)</th>
<th>£72k (4 WTE PAs from Sept)</th>
<th>£72k (4 WTE PAs from Sept)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Gray’s yet to be confirmed</td>
<td>£124k (4 WTE PAs)</td>
<td>£124k (4 WTE PAs)</td>
<td>£124k (4 WTE PAs)</td>
</tr>
<tr>
<td>£111k (5.1 WTE Band 5 Nurses ARI from Sept)</td>
<td>£111k (5.1 WTE Band 5 Nurses ARI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Gray’s yet to be confirmed</td>
<td>£191k (5.1 WTE Band 5 Nurses ARI)</td>
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</table>

### 7.

- Expand capacity and create greater sustainability in general practice in-hours and out of hours unscheduled care by:
  - Formally appointing shared advanced nurse practitioner posts working within both general practices and out of hours unscheduled care.
  - Successfully recruiting to the 7 vacant out of hours nurse practitioner posts.
  - Creating out of hours physician assistants bank
  - Training physician assistants in general practice unscheduled care
  - Exploring the opportunities for the wider non-medical USC workforce model, including minor illness nurses.
  - Link to action no.’s 5, 6, 9, 10, 11 and 12

| £33k (PA Bank Shifts from Sept) | £33k (PA Bank Shifts from Sept) | £33k (PA Bank Shifts from Sept) |
| £9k (PA GP Input from Sept) | £9k (PA GP Input from Sept) | £9k (PA GP Input from Sept) |
| £113k (2 WTE GP input to Decision Support from Sept) | £113k (2 WTE GP input to Decision Support from Sept) |
| £56k (PA Bank Shifts from Sept) | £56k (PA Bank Shifts from Sept) | £56k (PA Bank Shifts from Sept) |
| £15k (PA GP Input from Sept) | £15k (PA GP Input from Sept) | £15k (PA GP Input from Sept) |
| £194k (2 WTE GP input to Decision Support) | £194k (2 WTE GP input to Decision Support) |
| £191k (5.1 WTE Band 5 Nurses ARI) | £191k (5.1 WTE Band 5 Nurses ARI) |

### 11.

- Create capacity and assess the impact of the redirection of care for the treatment of uncomplicated urinary tract infections (UTI’s) in women to 15 community pharmacies in Grampian.

| £32k | £32k | £32k |
| To be confirmed Dec 2013 | To be confirmed Dec 2013 | To be confirmed Dec 2013 |

### 12.

- Redesign of mental health workforce model to ensure appropriate clinical capacity and responsiveness by introducing a 24/7 Mental Health Nurse Practitioner Service in Aberdeen. The service will also streamline contact points for seeking professional decision support regarding patients with mental health needs.

| £41k (1.6 WTE Band 7 from Sept) | £41k (1.6 WTE Band 7) | £41k (1.6 WTE Band 7) |
| £70k (1.6 WTE Band 7) | £70k (1.6 WTE Band 7) | £70k (1.6 WTE Band 7) |
15. Implementing phase 1 of the decision making support hub for urgent professional advice based in the ECC from September 2013. Key actions are:
- roll-out to paramedics, USC nurse practitioners, NHS 24 advisors, GPs and nursing home staff.
- learning from recent developments/testing of the concept across the system
- recruiting and training of appropriate workforce to support robust delivery (ED consultants/GPs, call handlers, administration, operational support etc)
- co-location and enhancing integrated working between NHS24, USC staff and others within the ECC Hub.
- testing and implementing technological solutions (see no. 13 and 15)
- governance and evaluation built into implementation phase 1 in order to inform phase 2 and make improvements on a real time basis.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>£32k (1 WTE Band 7 Operational Support ARI from Sept)</td>
<td>£12k (increased hours for Elgin Operational Support from Sept)</td>
</tr>
<tr>
<td>£22k (2 WTE Band 2 Call Handlers from Sept)</td>
<td>£15k (1 WTE Band 4 Medical Secretary from Sept)</td>
</tr>
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</table>

16. Technology supports the access to real time patient information, professional decision support, communication and follow through of agreed management plans by:
- Roll out and activation of eKIS as part of national programme.
- Access to patient clinical record at the point of contact with the patient.
- Single telephone number which enables the recording/storage of conversations and appropriate re-routing of calls.
- Appropriate recording and sharing of agreed actions with relevant patient information systems.
- Set-up e-mail to receive images/patient information and the transfer of this information into the patient record.
- Agreed policy in place for dealing with technical issues around videoconferencing e.g. training, second bridge, convert to telephone/e-mail images etc.
- Identify, test and implement secondary and primary care solutions to e-booking of appointment/diagnostics to create certainty of agreed decisions-management plans.
- Explore and agree solution for NHS and Non-NHS staff to access patient/client information across health and social care.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Description</th>
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<tbody>
<tr>
<td>£45k</td>
<td>£20k</td>
</tr>
<tr>
<td>£20k (To be confirmed)</td>
<td>£20k (To be confirmed)</td>
</tr>
<tr>
<td></td>
<td>Timely access to:</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 20. | • Common diagnostic tests which reduce the need for outpatient attendances or admission through GP direct access where acceptable and feasible  
• diagnostics required by USC patient in ED are requested asap when patient presents  
• appropriate capacity is in place to deal with ED demand  
• increase in diagnostic sessions over the winter months/holiday period to cope with increased demand |                           |                           |                           |
|   | Roll-out of the ‘Intelligent Bed Placement Tool’ to Dr Grays and community hospitals in 2013/14. | £10k                      |                           |                           |
| 21. | creation of a in-hospital transfer team to support the flow of patients and capacity throughout the hospital system (ARI and Dr Gray’s) | £50k (1.5 WTE Band 5 & 2 WTE Band 2 from Sept for ARI)  
£23k (1.65 WTE Band 2 from Sept for Elgin) | £86k (1.5 WTE Band 5 & 2 WTE Band 2 for ARI)  
£39k (1.65 WTE Band 2 for Elgin) | £86k (1.5 WTE Band 5 & 2 WTE Band 2 for ARI)  
£39k (1.65 WTE Band 2 for Elgin) |
| 26. | Creation of a in-hospital transfer team to support the flow of patients and capacity throughout the hospital system (ARI and Dr Gray’s) | £50k (1.5 WTE Band 5 & 2 WTE Band 2 from Sept for ARI)  
£23k (1.65 WTE Band 2 from Sept for Elgin) | £86k (1.5 WTE Band 5 & 2 WTE Band 2 for ARI)  
£39k (1.65 WTE Band 2 for Elgin) | £86k (1.5 WTE Band 5 & 2 WTE Band 2 for ARI)  
£39k (1.65 WTE Band 2 for Elgin) |
|   | Increase transport capacity in partnership with ambulance service and community planning partners by testing and evaluating additional transport mechanisms to create capacity to take people home from hospital and transfer patients from one hospital/care site to another. | £96k (ARI Transport Service) | £96k (ARI Transport Service) | £96k (ARI Transport Service) |
| 34. | Additional capacity to support the delivery of the existing hospital discharge lounge in ARI and Dr Gray’s. | £54k (ARI Discharge Lounge from Sept)  
£30k (Elgin Discharge Lounge from Sept) | £92k (ARI Discharge Lounge)  
£52k (Elgin Discharge Lounge) | £92k (ARI Discharge Lounge)  
£52k (Elgin Discharge Lounge) |
38. Ability to respond to increased demand over the predicted winter peak by creating additional surge capacity beds within ARI and Dr Gray's.

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost (in £)</th>
</tr>
</thead>
<tbody>
<tr>
<td>£110k (ARI ECC Beds 4 months)</td>
<td>£250k (ARI Unstaffed Beds 4 months)</td>
</tr>
<tr>
<td>£60k (Elgin Emergency Beds)</td>
<td>£60k (Elgin Emergency Beds)</td>
</tr>
</tbody>
</table>

39. Dedicated clinical leadership, project management and health intelligence support in place to effectively lead, oversee implementation, ongoing communication and evaluation of the redesign of the model of care.

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost (in £)</th>
</tr>
</thead>
<tbody>
<tr>
<td>£49k (1 WTE Band 7 &amp; 1 WTE Band 5 from Aug)</td>
<td>£10k (0.2 WTE Consultant Clinical Leader from Aug)</td>
</tr>
<tr>
<td>£16k Health Intelligence Input</td>
<td>£16k Health Intelligence Input</td>
</tr>
</tbody>
</table>

40. Robust evaluation of changes and interventions:
   - Introduction of systematic data collection recording processes and analysis, including patient and staff experiences
   - Formative evaluation of professional and staff receptiveness to change
   - Production of an evaluation framework for the three year programme
   - Initial evaluation report produced in April 2014

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost (in £)</th>
</tr>
</thead>
<tbody>
<tr>
<td>£25k</td>
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</table>

41. Improve the communication of the direction of the unscheduled care model through the development of a number of short films depicting various scenarios.

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost (in £)</th>
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<tbody>
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<td>£30k</td>
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**Total**

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<tr>
<td>£1.899m</td>
<td>£2.685m</td>
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<tr>
<td>£1.899m</td>
<td>£2.685m</td>
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**Funding Already Confirmed**

<table>
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<tr>
<th>Description</th>
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<td>(£0.075m)</td>
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<td>(£0.150m)</td>
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**Net Total Funding Bid**

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<th>Description</th>
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<td>£1.749m</td>
<td>£2.610m</td>
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<tr>
<td>£1.749m</td>
<td>£2.610m</td>
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</table>

**Total**

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<td>£2.810m</td>
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<tr>
<td>£2.810m</td>
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</table>

**Funding Already Confirmed**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost (in £)</th>
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<td>(£0.038m)</td>
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<td>(£0.038m)</td>
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**Net Total Funding Bid**

<table>
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<th>Description</th>
<th>Cost (in £)</th>
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<td>£2.772m</td>
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<td>£2.772m</td>
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</table>
### Financial Investment Plan

**Section B – Developments Supported By Existing NHS Grampian Resources (Relating to Actions Set Out With Appendix 4)**

<table>
<thead>
<tr>
<th>Appx 4 Ref No</th>
<th>Initiative / Development</th>
<th>2013/14 Funding Source</th>
</tr>
</thead>
</table>
| 1.            | 1. Further communicate and target the Know Who To Turn To (KWTTT) messages/campaign and reinforce via redirection by staff in ED and MIUs.  
2. 15% of 5% of practice population identified as high risk of requiring unscheduled care have in place an up-to-date anticipatory care plan (ACP) which has been developed by the patient, carer/family and appropriate multi-disciplinary/agency team.  
3. ACP is easily accessible in-hours and out of hours via eKIS  
4. Through the work of the three Health and Care Partnerships, the development of appropriate capacity to respond to the activation of ACPs in a timely way is being taken forward.  
6. Create greater sustainability of clinical capacity in emergency medicine unscheduled care through workforce redesign by: increasing consultant capacity by 2.0 WTE to deliver Consultant level pre-hospital decision support and a greater focus on clinical leadership and co-ordination of patient care  
7. Expand capacity and create greater sustainability in general practice in-hours and out of hours unscheduled care by successfully recruiting to the 7 vacant out of hours nurse practitioner posts.  
8. Agree what a sustainable 24/7 USC workforce model will look like across Moray, including Dr Grays.  
9. The three Health and Care Partnerships are implementing local plans to improve recruitment and retention of care workers. Specific examples are:  
   - Aberdeen is focussing on establishing a Care Sector Recruitment Post and a Health and Social Care Workforce Project.  
   - Aberdeenshire is continuing to progress their recruitment campaign to increase home care by 1,200 hours.  
   - Moray are continuing to implement the ongoing b-monthly campaign to recruit to care workers and to use and maintain the scheduling system to improve efficiency in relation to domiciliary care services | Existing NHS Grampian resource  
NHS/Change Funds  
Existing NHS Grampian resource  
NHS/Change Funds  
0.5 WTE Consultant post Aberdeen - £50k  
Existing GMED Budget  
Existing resource/further resource implications yet to be quantified  
Existing local authority budgets |
<table>
<thead>
<tr>
<th></th>
<th>Explore and describe the future role of pharmacists and potential opportunities as part of the USC model and wider workforce model.</th>
<th>Existing resource/further resource implications yet to be quantified</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>Explore and describe the future role of allied health professionals and potential opportunities as part of the USC model and wider workforce model.</td>
<td>Existing resource/further resource implications yet to be quantified</td>
</tr>
<tr>
<td>14.</td>
<td>Enhance current local decision support networks by developing, testing and implementing a mobile clinical assistant device to provide real time access to patient information, Clinical Guidance Intranet, links to local networks and decision support hub.</td>
<td>Samsung Pilot/Existing NHS resource</td>
</tr>
<tr>
<td>17.</td>
<td>Non-urgent advice via telephone and e-mail/SCI to be available by top three USC specialities to GPs/primary care. (link to no. 15)</td>
<td>NHS resources/redesign of existing services</td>
</tr>
<tr>
<td>18.</td>
<td>Development of Hospital At Home/Geriatric Community Outreach services by:  - Exploring the opportunities for a hospital at home type model within Aberdeenshire.  - Commencement of the Geriatric Consultant and Multi-Disciplinary Community Outreach Assessment, Management and Follow-up Service within Aberdeen City from August 2013.  - Agree plans for the further development of Geriatric Community Outreach Service’s with exploration of provision of immediately available domiciliary nursing or carer support</td>
<td>Existing resource/further resource implications yet to be quantified</td>
</tr>
<tr>
<td>19.</td>
<td>Redesign of community health and social care teams to create greater integration and potentially capacity to respond to local population need at cluster/locality level.</td>
<td>Existing NHS/Local Authority resource</td>
</tr>
<tr>
<td>22.</td>
<td>Testing and evaluating the impact of the Automated Vehicle Location System (AVLS) in Aberdeen City in relation to enhancing the co-ordination of USC community capacity.</td>
<td>Aberdeen City Change Fund</td>
</tr>
<tr>
<td>23.</td>
<td>Implement and evaluate the pre-hospital primary response service to provide rapid assessment and intervention in conjuction with agreed operating criteria and pan Grampian decision support for USC.</td>
<td>NHS Grampian Endowments</td>
</tr>
<tr>
<td>24.</td>
<td>Appropriately supporting unpaid carers within each of the local health and care partnerships. Specific actions are:  - Aberdeen Health and Care Partnership to retender the Carer Support Service and open a new Carerpoint in the Aberdeen Health Village in December 2013.  - Aberdeenshire Health and Care Partnership are focussing on sustaining carer support through a dedicated carers team and a respite bureau.  - Moray Health and Care Partnership are implementing the agreed carer strategy focussing on the carers network, delivery of formal carer qualification for informal carers, short breaks bureau and interdependent carers assessment.</td>
<td>Existing local authority budgets/Change Fund</td>
</tr>
<tr>
<td>25.</td>
<td>Same day/next day assessment available within specific specialities/services. Initial focus on the top three USC specialities.</td>
<td>Existing NHS Resource/Redesign of existing services</td>
</tr>
</tbody>
</table>
| 27. | Provision of sustainable AHP assessment and co-ordinated activity across the system for USC patients in ED and the community by:  
- Evaluating impact and based upon this mainstreaming pilot service funded via change fund  
- Assessing demand for extending current Mon-Fri service to 8-10pm and further explore roll-out across Grampian.  
- Exploring the benefits of further developing model within USC in-hours and out of hour’s primary care setting. | Aberdeen City Change Fund |
| 28. | Formalisation and implementation of the agreed policy of delegated authority to allocate patients to specialities by ED consultants. | Existing NHS Grampian resource |
| 29. | Implement communication strategy for provision of infection prevention and control advice during holiday periods, including any identified increase in capacity. | Existing NHS Grampian resource/further resource implications yet to be clarified |
| 30. | Embedding the re-enablement approach within health and community care teams across the three partnership areas. Specific areas of focus are:  
- Aberdeen Health and Care Partnership are working to maximise impact their re-enablement/rehabilitation services/capacity.  
- Aberdeenshire Health and Care Partnership are training all care workers in re-enablement/recovery model.  
- Moray Health and Care Partnership will continue to ensure all care workers are trained in re-enablement by incorporating this within the induction programme. | Change Funds |
<p>| 31. | Stabilise capacity of intermediate beds in the community in partnership with local authority, private and third sector. | NHS/Local Authority/Change Funds |
| 32. | Implementation of partnership plans to maintain the 4 week standard and actively working towards the delivery of the 2 week standard for delayed discharges. | Existing Integrated Care Funding |
| 33. | Embedding the delivery of anticipatory care plans as part of discharge management within community hospitals in 2013/14. | Resource implications yet to be quantified |</p>
<table>
<thead>
<tr>
<th></th>
<th>Provision of sustainable AHP assessment and co-ordinated activity across the system for USC patients in Geriatric Assessment Unit:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Evaluating impact and based upon this mainstreaming extended service provision funded via change fund</td>
</tr>
<tr>
<td></td>
<td>• Exploring the further development of the model within USC in-hours and out of hour’s primary care setting.</td>
</tr>
<tr>
<td></td>
<td>Aberdeen City Change Fund</td>
</tr>
<tr>
<td></td>
<td>Implement local Falls Improvement Plan, specifically focussing on:</td>
</tr>
<tr>
<td></td>
<td>• Development of an agreed alternative pathway for falls within the community which incorporates access to professional decision support.</td>
</tr>
<tr>
<td></td>
<td>• Continued roll-out of the Falls Bundle work and identify the impact on repeat fallers.</td>
</tr>
<tr>
<td></td>
<td>• Develop and make available resources on the Clinical Guidance Intranet (CGI).</td>
</tr>
<tr>
<td></td>
<td>• Develop professional education tools</td>
</tr>
<tr>
<td></td>
<td>Existing NHS Grampian/Partner</td>
</tr>
</tbody>
</table>