Local Unscheduled Care Action Plan for
Grampian – 2014/15
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1. Overview & Key Issues

Introduction

1. NHS Grampian aims to be the best performing health board delivering the highest quality health and care services in Scotland. There are significant pressures on unscheduled care (USC) services across the health system. NHS Grampian, along with partners, seeks 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 team. A key milestone was agreeing and commencing the implementation of the Grampian USC approach which was approved by the Grampian NHS Board in June 2013.

2. This plan is part of a three year rolling plan which aims to:

- make immediate improvements against locally and nationally agreed standards including the delivery and maintenance of the 95% four hour standard by September 2014, reducing unscheduled attendances, improving patient flow across the system, reducing delayed discharges and increasing direct admissions for those who require to be admitted.

- continue the transformation of USC services in Grampian which will provide a sustainable approach to the delivery of high quality, person-centred, effective and efficient care whilst meeting future predicted population needs as set out in the Grampian USC Action Plan for 2014/15.

- create stability in the medical workforce within the Emergency Department’s (ED) ahead of August 2014 and agreeing and implementing the medium term workforce sustainability plan for ED’s.

- build on successes of 2013/14 and create a greater focus on sustainability. Appendix 1 outlines some of the key areas of progress made over the last year.

3. Appendix 2 contains the response to the national ‘self assessment’. This intelligence, along with the hospital site capacity and demand and the 4 hour self-assessment, has reaffirmed 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.
4. Although there is significant evidence of improvements over recent years, further improvements are required to continue to enhance patient, carer and staff experience, meet future predicted demand, meet current and future standards of care and achieve Grampian’s aim to be the best healthcare provider. It is clear, therefore, that whilst augmenting the existing system of care will assist in the short term, the implementation of Grampian’s refreshed approach to USC is necessary to meet the challenges in a sustainable way.

**Key Issues and Focus for 2014/15**

5. There have been a number of challenges identified which are outlined within Appendix 3. Key challenges to be addressed or managed relate to the:
   - significant challenges in relation to the stability of the ED workforce in terms of reduction in medical training numbers, recruitment of middle grade doctors and recruitment and retention to ED consultant posts.
   - increasing challenges regarding availability, recruitment and retention of GP’s, advanced clinical practitioners, some speciality consultants, and a significant issue around the recruitment and retention of care workers, particularly in Aberdeen City.
   - impact of population growth, including those 65 and over. The total population is projected to increase by 6.2% by 2020. The population over 65 is projected to increase to 19% by 2020.
   - increased complexity of episodes of care due to frailty, dementia and multiple co-morbidities of an increasing number of patients.
   - increased sickness absence in certain services.
   - increase in ambulance activity that rose by 4.3% in 2013/14 compared to the previous year.
   - increased workload within primary and community care.
   - number of ED attendances which continue to show an annual increase at Dr Grays, RACH and in the Minor Injury Units (MIU’s).
   - delivery and maintenance of 95% 4 hour standard has fluctuated in ARI and Dr Grays – this has in the main been due to flow through and out of the hospital. However, there has been a significant reduction in 8 and 12 hour breaches. The top four causes of four hour breaches are beds, first assessment, specialist assessment and treatment.
   - increase in attendances to Acute Medical Initial Assessment (AMIA) Unit.
   - predictability of peaks in activity across the whole system in terms of day, time of day and seasonal.
   - significant increase in the number of delayed discharges, particularly in Aberdeen City. This has created significant constraints in managing flow and has negatively impacted upon the number of boarders. A total of 48,736 bed days were lost in 2013.
• 12% of patients discharged between 6am-12noon.
• lack of capacity or appropriate alternatives within the community and specialities to prevent unnecessary ED attendance or hospital admission.
• variability of the quality of discharges.
• number of embargoed care homes.
• increase in treat and transfers from Dr Grays.
• issues associated with access to transport or alternatives.

It is recognised that a number of issues exist which are negatively affecting flow within the acute hospital setting which has created a negative impact on patient flow through ED to other parts of the hospital. In addition to this, there are workforce sustainability issues in the two ED’s. Specific actions are contained within this Plan and detailed plans have been developed at operational level to manage these challenges.

6. In addition to the above, a Grampian Winter Planning Debrief Event was held on 25th April 2014. This provided clarity on the impact in terms of activity, what worked well and areas for further improvement. Clearly 2013/14 was untypical in terms of winter weather and winter illness but the system continued to feel under pressure. The actions within this plan are informed by the lessons learned and will inform the detailed Grampian Winter Plan for 2014/15. Key learning points are outlined below.

• We cannot model demand and capacity based on winter 2013/14 due to its untypical nature. We will, however, require to closely monitor and plan for a potential increases in delayed discharges for certain geographical areas and learn from those areas where delayed discharges were not a significant issue.
• There is a requirement to further build upon the weekly cross-system huddles.
• More explicit plans require to be in place in relating to the creation of surge beds/capacity.
• Flow across the system, including discharge planning requires to be improved.
• Greater focus required on the development, access and use of anticipatory care plans.
• Closer working between the NHS and social care, and specifically with care homes.
• Improving transfer process for patients within acute and to primary/community care facilities.
• Explore increasing staff uptake of flu vaccinations via mobile flu vaccination teams.
**Priorities for 2014/15**

7. The key areas of focus for 2014/15 are summarised below. By focusing on these it is believed this will have significant benefits for patients and staff in the short term, in addition to delivering and maintaining the national standard of 95% by September 2014 and progressing to a more sustainable, effective and efficient model of care in the medium term.

   a. **Creating stability in the medical workforce within ED** at ARI ahead of August and agreeing and implementing the medium term workforce sustainability plan for the two ED’s is of crucial importance. Efforts continue to recruit to consultant and middle grade positions. Aligning hopes of fully recruiting, thereby avoiding the crisis position come August 2014 is a high-risk strategy and therefore workforce sustainability is being progressed alongside other actions aimed at improving the overall position. An interim rota to support senior decision making in the period beyond August is being agreed. Linked to this is the development and agreement of a single improvement/action plan that aligns ED service challenges in both ARI and Dr Grays.

   b. **Implementation of an intense 6-9 month ‘Flow Programme’ to address the barriers to effective and efficient whole-system flow.** Capacity has been created to lead and support a dedicated whole-system flow programme. A key focus within the programme is to re-invigorate the previously agreed emergency patient flow protocols. The transfer of patients from ED and AMIA to appropriate specialties is widely recognised as requiring improvement support. This will also include the redesign of current operational support systems and options for enhancing this model based upon learning from elsewhere such as the NHS Fife Hub Model. There is wide recognition that improvements in patient flows from ED and AMIA require support across the hospital. As part of the flow improvement effort, further detailed work involving services beyond ED and AMIA will be required to ensure predicted activity and capacity is being managed consistently and in the best interests of patients.

   c. **Sustainability of in and out of hours General Practice (GP).** Over recent years, there have been increasing challenges (workforce, increased workload, shifting balance of care etc) in relation to the sustainability of both in, and out of hours GP. The recent GP workforce survey and GMED GP survey has reaffirmed the increasing challenges regarding the general practitioner workforce. A key focus is to continue to work jointly with GP to develop joint advanced clinical practitioner posts, particularly in those General Practices which are at highest risk in terms of service sustainability. Work is underway to create career portfolio roles, which aim to attract and retain General Practitioners within Grampian. The review and redesign of GMED out of hour’s service is underway, with a number of changes being implemented to provide stability to out of hour provision.
d. **Redesign of workforce to provide integrated, responsive and flexible services in both the acute and primary/community care.** There are significant workforce challenges across the whole system, particularly in relation to recruitment and retention and unique factors (buoyant and competitive market, high cost of living, low unemployment) within Grampian. NHS Grampian and partners, have developed an integrated workforce model and, for the first time, a Grampian USC Workforce Plan to collectively tackle the shared workforce challenges. Key actions are outlined within Appendix 4.

NHS Grampian will actively promote the emergency services and develop a strategic plan linked to enhancing the reputation and strategic importance of Aberdeen in the context of the North of Scotland (NoS). This will be multi-factorial but aiming to make NHS Grampian an employer of choice, a valued and rewarding organisation to work with, capitalising on innovation and opportunities linked to the commercial sector e.g. Oil & Gas.

e. **Expansion of real time decision support** to enhance the delivery of high quality, person-centred care in the right place, at the right time and by the most appropriate team/professional. Appropriate and timely decision support is integral to the workforce model and achieving point “d” above. We aim to build upon phase one of decision support, which has shown considerable benefits by extending access to acute medical physicians and geriatricians, in addition to ED consultants. It is planned to make the service available to other healthcare professionals. In time, we will increase the operational hours of the service.

f. **Development of a Major Trauma Network within NoS.** As part of the national plans for the development of four major trauma centres across Scotland, NHS Grampian is working with NoS partners, and within Grampian, to develop clear plans in order to ensure responsive, high quality major trauma pathways are in place through a network approach by the end of 2016. Critical to the plan is ensuring the tertiary/specialist components of the network are sustainable e.g. ED, critical care, interventional radiology. The major trauma plan will be developed and agreed by 31st December 2014. This will be integrated within the proposed Grampian Clinical Services Strategy.

A key driver to the development of whole-system change is the integration of health and social care. A key focus in 2014/15 is the finalising of the scope of services to be set out in integration schemes and working towards frameworks for Joint Strategic Plans. This will influence many of the actions within this Plan and drive the planning of USC beyond March 2015. Critical to this is the development and redesign of integrated health and social care pathways being developed in each of the three partnership areas. This will support the delivery of appropriate local USC, consistent with the agreed Grampian USC model of care.
8. These actions have been prepared with reference to the “system check” and four hour self assessment, and link directly to the five key elements of NHS Grampian’s approach to USC. The actions are consistent with many of the priorities set out in the three local authorities Joint Strategic Commissioning Plans, third sector plans and the plans of NHS partner agencies.

9. The actions summarised in section 2 of this plan are supplemented by the:
   - Grampian USC Workforce/training plan – one page outline contained within Appendix 4.
   - agreed trajectory for the delivery of the four hour standard at Appendix 5.

Financial Investment Plan

10. The main focus of the financial plan is on providing stability to the ED in relation to workforce, addressing the flow issues within the whole-system and developing an integrated, responsive and flexible workforce for the future. This approach will continue to help us improve connectivity across the system, to optimise and enhance the organisation of resources.

11. Section 4, (pages 35-36) sets out NHS Grampian’s financial investment plan, which includes the USC national funding for 2014/15. There are a number of non-recurring funding streams (change fund, national funding), which have been allocated from various sources and are set out within section 4.

Monitoring/Performance Framework

12. Dr Roelf Dijkhuizen is the Executive Lead for USC and has a clear mandate to execute change within NHS Grampian and is supported by the Grampian USC Programme and the NHS Grampian USC Executive Group. The Programme Steering Group will review performance from a partnership perspective against the USC Plan, to ensure it supports an integrated, system-wide approach.

13. Within Grampian, there is an established performance framework in place. The USC Programme Steering Group provides assurance through bi-monthly performance reports to the Cross System Performance Review Group. That Group provides reports to the Performance Governance Committee, which is a subcommittee of the NHS Grampian Board. The Programme Steering Group submits reports to various operational and governance groups/committees, as appropriate. The NHS Grampian Board will receive reports regarding the development of USC and performance through the Performance Governance Committee.
14. NHS Grampian has in place daily, weekly and monthly monitoring and management systems. These are, consistent with the proposed Scottish Government measures.

15. NHS Grampian will continue to provide formal and informal reports and updates to the Scottish Government, as and when required. Formal progress updates will be submitted quarterly against the trajectory, agreed LUCAP actions and finance plan to reach and sustain the 95% 4 hour standard up to September 2014.

Endorsement of Plan

16. The draft Plan has been informed and supported by both the NHS Grampian USC Executive Group and the Grampian USC Steering Group. Formal endorsement of the plan is underway via these two Groups.

This Plan will be submitted to the Grampian NHS Board on the 6th June 2014 for approval.
2. Grampian Unscheduled Care Action Plan

NHS Grampian, with partners, have developed and agreed the Grampian USC Action Plan for 2014/15, which supports the delivery of the national USC Programme and the agreed Grampian Approach for USC. Appendix 3 outlines the USC challenges, key actions for 2014/15 and the strategic outcomes.

The actions below are set out within the context of the five national strategic themes and cross-referenced with the five key components of the Grampian USC approach, as colour coded below.

1. Self Care/Management  2. Integrated, Flexible & Responsive Workforce  3. Real Time Decision Support
4. Action/Follow Through  5. Re-enablement/Discharge

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

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<td>1.</td>
<td>Refresh and refocus self management and self care across Grampian to support the public in making the right choices.</td>
<td>i. Grampian Self Care/Management Framework implemented and reviewed. ii. Self management support within chronic pathways of care refreshed and implemented. iii. See KWTTT action no 2. iv. See action 6 re Respiratory Project. v. Roll-out phase one of Making Every Opportunity Count (MEOC) programme.</td>
<td>10%</td>
<td>• Framework published for consultation via CGI/No Delays and via key partner organisations, and consultation report produced. • Incorporated into CGI/No Delay’s platforms, and MCNs engaged.</td>
<td>31st Mar 2015</td>
<td>C Littlejohn</td>
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<td>1. cont.</td>
<td>• MEOC development strategy developed, cognisant of HPHS and Acute substance misuse strategies.</td>
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| 2. | Know Who To Turn To (KWTTT) refreshed and targeted at specific population groups. | i. Refresh and create more assertive messages through various opportunities.  
ii. Specifically focus on campaigns to support parents around appropriate paediatric ED attendances and the wider population on where to seek support for low grade mental health issues.  
iii. Evaluate the impact of the targeted KWTTT campaign on the high postcode users for ARI ED.  
iv. Raise awareness of the national KWTTT mobile platform.  
v. Reinforce KWTTT messages via redirection (see action 3.)  
vi. Include opportunities created by the Minor Ailments scheme (MAS) within the future refresh of KWTTT pharmacy strand. | 20% | | • Reduced paediatric attendances at ED/MIUs.  
• Hits on website.  
• Uptake of literature.  
• Clarity of what information/support is required by parents of young children.  
• Reduced activity for low grade mental health services.  
• Understand impact of targeted postcode campaign. | 31\textsuperscript{st} Mar 2015 | C Cameron |
### 3. Review and implement refreshed NHS Grampian redirection policy based on evaluation output.

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<td>10%</td>
<td>Reinforces agreed local KWTTT messages.</td>
<td>30&lt;sup&gt;th&lt;/sup&gt; Nov 2014</td>
<td>J Ferguson/L Harper/C Provan/S Dustan</td>
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- Based on evaluation and national guidance, agree any amendments required to current redirection policy.
- Implement revised policy within sites currently delivering redirection.
- Roll-out redirection to Dr Grays and remaining MIU’s across Grampian.
- Ensure recording of all outcomes of redirection is captured.
- Test principle of accessible in-hours GP appointments for appropriate patients.

### 4. Person-centred Anticipatory Care Plans (ACPs) are in place for the most vulnerable individuals, are reviewed and activated in a timely manner.

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<td>20%</td>
<td>15% of 5% was achieved by 31&lt;sup&gt;st&lt;/sup&gt; March 2014. Issues have been raised re quality, review, accessibility and impact of these.</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; Mar 2015</td>
<td>Leads in CHSCP’s</td>
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- 30% of 5% of practice population identified as high risk of USC have an up-to-date ACP in place.
- Ensure the ACP is easily accessible in and out of hours by health and care professionals – pilot in Kincardine/Lower Marr and national eKIS programme.
- Advanced Geriatric Nurses within Aberdeen support the development and implementation of quality ACPs.
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<td>iv. Appropriate capacity in place to respond to the activation of ACPs in a timely way. v. Audit undertaken to understand the quality and impact of ACPs to date in each of the three partnership areas.</td>
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<td></td>
<td></td>
<td>• Reduction in admissions of patients with ACP. • Clarity of quality and impact of ACPs and areas identified for improvement.</td>
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<td>5.</td>
<td>Roll-out and understand the impact of the Trigger Identification Tool (in conjunction with ACPs) within Aberdeen City.</td>
<td>i. Test the Trigger Tool for over 75’s in three General Practices within Aberdeen and compare results with Rubislaw findings. ii. Based on findings and learning’s, roll-out and evaluate impact of a further 10 General Practices. iii. Based on findings and learning’s, roll-out to remaining Aberdeen City General Practices by June 2015. iv. Share learning’s across Grampian.</td>
<td>10%</td>
<td>Rubislaw Practice piloted the trigger tool which initial data indicates a reduction in USC attendances/admissions of high risk patients.</td>
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<td>6.</td>
<td>Assess impact of supported self management package of care using telehealth tools for respiratory patients.</td>
<td>i. Test delivery of Pulmonary Rehabilitation (PR) using video conferencing and No Delays epackages across the region. ii. Based on findings and learning’s, roll out and evaluate impact across Grampian. iii. Evaluate impact of redesign.</td>
<td>30%</td>
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| 7  | Pilot and evaluate the concept and impact of redirection of non-complex UTI patients to community pharmacies. | i. Increase the number of pharmacies participating from 17 to approx 30.  
ii. Increase knowledge of pilot to increase uptake.  
iii. Model scalability based on evaluation/activity.  
iv. Review data and pathways to consider other UTI patient groups with/without decision support.  
v. Share findings with Scottish Government and discuss opportunities for inclusion within national Minor Ailments Scheme.  
v. Produce an evaluation report. | 30% | Focussed on delivering the right care, in the right place by the right professional, which has the potential to create capacity with USC services/in-hours GP. | • Good patient experience.  
• Care closer to home.  
• Numbers prevented from going to in and out of hours GP and ED.  
• Positive feedback from providers.  
• Full evaluation report with recommendations.  
• Potential impact of service at scale. | 31st Aug 2014 | C Hind                      |

**Creating Workforce Capacity within the Community**

| 8  | Increase the number of USC Advanced Clinical Practitioners across Grampian to support sustainable and responsive USC in primary/community care. | i. Increase the number of advanced clinical practitioners trained within Grampian by 12.  
ii. Increase the number of jointly employed advanced practitioners working in and out of hours GP by a minimum of 8.  
iii. Increase in advanced clinical practitioners to support the redesign of sustainable GMED services – see action 9.  
v. Creation of additional advanced practitioner capacity to provide support/sustainability to General Practices who have significant workforce challenges. | 25% | Building on the developments of increasing training capacity and creation of joint in/out of hours posts.  
Key to the development of a sustainable 24/7 USC workforce model. | • Additional 12 advanced clinical practitioners trained.  
• 11 paramedic practitioners delivering see and treat – reduced ED attendances/admissions.  
• 8-10 joint in/out of hours advanced practitioners.  
• Retention of practitioners within GMED. | 31st Mar 2015 | L Harper/M Weir |
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<td>8.</td>
<td>cont. v. Paramedic practitioners work with integrated H&amp;SC teams to manage patients appropriately in their own homes/local communities through see and treat and referral on to appropriate pathways of care.</td>
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<td></td>
<td>- Reduction in GP’s who have short term capacity issues.</td>
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| 9.  | Review and redesign current GMED model to ensure high quality, responsive and sustainable care. | i. Review original GMED modelling along with demand and capacity data.  
ii. Based on revised modelling, consult and agree alternative models of service delivery with key stakeholders including the three H&SCP’s.  
iii. Implement and evaluate agreed short and long term changes to the service.  
iv. Further develop links between GMED, ED and AMIA to develop USC approach and enhance sustainability. | 20%               | - Modelling complete.  
- GMED model of care reviewed and agreed.  
- Implemented model demonstrates delivery of agreed quality measures and standards. | 31<sup>st</sup> Mar 2015 | C Matthews /GMED Clinical Lead |                              |
| 10. | Explore and test a responsive and integrated community model for USC in Aberdeenshire. | i. Partners explore options for creating an optimal community model for USC.  
ii. Proposed service/workforce model is tested and impact evaluated within Banff and Buchan.  
iii. Continue to test the community paramedic role within Peterhead and Fraserburgh as part of the wider community model. |                   | - Understanding and agreement of principles and requirements for a responsive and integrated community model for USC. | 31<sup>st</sup> Mar 2015 | P Gowans/ J Hogg/ M Weir/ V Fox |                              |
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| 10. cont. | iv. Action is supported and linked to GMED redesign (no. 9), development of EMPs (no. 11), development of paramedic practitioners see and treat (no. 8), role of community hospital (no. 19) and H&SC Integration/Modernising Primary Care (no. 12). | 15% | • Clarity how various developments contribute to desired impact.  
• Share learning, and agree next steps. | | | |
| 11. | Support the sustainability of in and out of hours primary care and USC services through the development of GP roles which provide supported training and an attractive career portfolio:  
a. Emergency Medical Practitioners (EMPs)  
b. Acute GP Fellowships  
c. Careerstart | i. Work towards the development of a sustainable 24/7 rota of EMPs in Elgin, which provides senior cover for the local ED and the GMED cell. This will be part of a wider USC workforce redesign.  
ii. Work with NES to develop, test and evaluate a formal 1 Year EMP Fellowship Programme.  
iii. Develop joint in/out of hours EMP roles as part of the Banff and Buchan Community Model to create responsive and sustainable workforce within in and out of hours.  
iv. Host 2 NES Acute GP Fellows in Moray from August 2014.  
• Creation of attractive GP portfolio roles, which result in less vacant GP posts/sessions.  
• Test as part of Banff and Buchan Community Model.  
• EMP Fellowship Programme developed and evaluated by Sept 2015.  
• 2 Acute GP Fellows trained. |
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| 12 | Create integrated and responsive teams working within the community to maximise impact and use of resources. | i. Review and develop integrated person-centred pathways of care within each of the three H&SC partnerships.  
ii. Based on agreed pathways of care, reconfigure and integrate teams as appropriate within each of the local H&SC partnerships.  
iii. Integrate the modernising primary care workstream and outputs within H&SC integration.  
iv. Implementation of co-location of teams.  
v. Develop, agree and implement local H&SCP plans by 31st March 2015. | 10% | • Measures in place and in line with Governments outcome measures.  
• Local H&SCP pathways agreed.  
• Plans for integrated teams agreed.  
• Integrated Joint Boards go live in April 2015.  
• Co-location of teams. | 31st Mar 2015 | A Coldwells/ H Kelman/ L Taylor/ J Proctor/ J Mackie |
| 13 | Appropriate social care capacity is in place to support timely assessment and responsive care to maintain people within their own homes. | i. Maintain aggressive and continuous recruitment campaigns to maintain/exceed current capacity.  
ii. Work with partners to explore other opportunities for recruiting/retaining staff e.g. development of apprenticeships, part of career pathway, link to retirement programmes etc.  
iii. Link to action 12 re H&SC integration.  
v. Develop anticipatory care planning for carers of old people. | | • Recruitment activity.  
• Turnover.  
• % of full staff compliment met.  
• Waiting time for assessment.  
• Number of carers with an ACP.  
• Meeting standards for care package review. | 31st Mar 2015 | P Maclachlan/ J Mackie/ T Cowan |
### 14. Enhance the support available to unpaid carers.

- **i.** Increase availability of, and, access to short breaks.
- **ii.** Increase the provision and accessibility of direct and indirect support for carers.
- **iii.** Pilot a specific project in Moray in relation to supporting carers looking after someone with dementia.
- **iv.** Continue to provide moving and handling training and support to unpaid carers.

### 15. Mental Health redesign.

- **i.** To develop a 24/7 nurse practitioner service to compliment existing duty service.
- **ii.** Aim to reduce admissions and A&E breaches
- **iii.** Support for junior doctors to aid robust standardised assessment.
- **iv.** Explore CPN input/capacity within GMED.
- **v.** Secure funding to increase hours of service to 24/7

### Timely Decision Support to Ensure Where Clinically Appropriate Patients Remain within the Community Setting

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<tbody>
<tr>
<td>16</td>
<td>Improve patient care and enhance effective use of workforce capacity by creating timely access to real time patient information.</td>
<td>i. Enhance connectivity of patient information systems by developing and testing ‘Mobile Clinical Assistant II’. ii. Test the use of Pocket Vision in accessing patient information within the community setting in Aberdeenshire.</td>
<td></td>
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<td></td>
<td><strong>31</strong> December 2014</td>
<td>D Taylor/P Gowans/J Hogg/ A MacVinish</td>
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</table>
### 16. cont.

#### 17. Expand the Pre-Hospital Clinical Decision Support Service.

- i. Extend and evaluate the delivery of real-time decision support by Geriatric and acute medical consultants from May 2014.
- ii. Implement refined pathway for GP access to MIU appointments.
- iii. Extend operational hours to 8-6pm.
- iv. Evaluate impact to date and agree next stage of roll-out in summer.
- v. Review and enhance responsiveness of out of hours decision support.
- vi. Extend accessibility of decision support to care homes (with trained nurses), NHS 24 nurse advisors and pharmacists from summer 2014.
- vii. Explore and test a radiology decision support service. (no. 20).

On 2nd Sept 2013, a dedicated ED decision support service went live. Based on feedback, plans are in place to test mobile delivery of this service, along with expansion of services and access to professionals.

- Effective and efficient use of resources.
- Enhanced patient and staff experience.

#### 18. Test, evaluate and implement timely access to non-urgent advice, which links back to patient records.

- i. Encourage all specialities to move to evetting in preparation for use of electronic advice.
- ii. Test process developed using SCI Gateway with one speciality and small cohort of GP’s in June 2014.
- iii. Roll out programme and assess impact.


- Ease of access for non-urgent advice.
- Reduction in OP appointments.
- Improved OP waiting times.
- Reduction in admissions.
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<tr>
<td>19</td>
<td>Review and agree required capacity and use of intermediate beds, including community hospital beds.</td>
<td>Review, explore and agree role and remit and future functionality of community hospitals and resource utilisation as part of the Grampian Clinical Services Plan.</td>
<td>31</td>
<td>• Clarity on the role of community hospitals and other community bedded facilities. • Improved person-centred community health care provision.</td>
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<td>P Strachan/ G Smith</td>
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</table>
| 20 | Explore and test components to enhance timely access to diagnostics. | i. Explore and test enhanced local access to plain film x-ray in Aberdeenshire.  
   ii. Explore and test the provision of radiology advice/decision support.  
   iii. Develop and agree a community strategy for imaging expanding on direct access to imaging within agreed framework.  
   iv. Develop and agree an integrated strategy for point of care testing across primary and secondary care in Grampian.  
   v. Undertake a study to test the impact of troponin point of care testing in the community by SAS, supported by clinical teams within NHS Grampian. | 31st Mar 2015 | • Appropriate care provided closer to home. • Activity and outcomes. • Reduced impact on acute services. • Patient/Staff experience. • Advice service tested. • Agreed strategy for imaging and POCT implemented. | | | H&SCP Clinical Leads/ Radiology Clinical Lead/ Diagnostic Clinical Lead |
21. **Development of responsive same/next day assessment within the community and by specialities.**

   Work with high volume specialities to understand demand and capacity, with a view to identifying the opportunities and processes required to create ability to respond to same/next day assessment requests.

   Work begun with GI speciality, data shared with clinical/management team.

   - Improved outpatient waiting times.
   - Reduction in USC episodes.
   - Alternatives to USC attendance and admission.

22. **Implementation of the national minimum standards for Falls**

   i. Review and amend current plans as appropriate to support the implementation of the agreed national minimum standards for Falls.

   ii. Within the local partnerships, continue to progress the implementation of alternative pathways for people who have fallen, but who are uninjured.

   iii. Map CHP performance against national minimum standards in May/June 2014.

   iv. Develop and test a virtual fracture/fall liaison service.

   v. In Moray, test the use of decision support for care home staff, whose client has experienced a fall.

   vi. Test and implement falls education programme.

   vii. Continue the roll-out of the Falls Trigger Bundle to SAS colleagues.

   Standards are out for consultation. Meeting with National Falls Lead on 20th May to consider the recommendations of the pathway.

   - Performance against the standards.
   - Audit of the falls bundles work on a 6 monthly basis.
   - Impact of virtual fracture/liaison clinic.
   - Number of professionals who have undertaken the falls education programme.
   - Number of SAS colleagues using trigger bundle.

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<tr>
<td><strong>23. Timely access to local equipment services.</strong></td>
<td><strong>i. City</strong></td>
<td>9 month project to redesign the Aberdeen City Equipment Service and increase efficiency through improved stock control, equipment tracking, maintenance and cleaning, as well as streamline the pathway for ensuring patients who need appropriate domiciliary equipment.</td>
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<td><strong>ii. Moray</strong></td>
<td>Review criteria for provision of equipment and audit request forms.</td>
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<td><strong>iii. Aberdeenshire</strong></td>
<td>Demonstrate a more robust effective and efficient responsive collaborative single service that should impact positively on Delayed Discharges.</td>
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<td><strong>10%</strong></td>
<td>Has the potential to impact on improving quality and rapidity of City discharges Has the potential to support admission avoidance.</td>
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<td>Aberdeenshire have implemented a successful Joint Equipment Store, which has enhanced the stock management and more responsive delivery time to all Aberdeenshire Areas. Has created capacity in Health Visiting, OT and Physiotherapy by releasing time to care.</td>
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<td>• Stock identifiable and auditable on electronic management system.</td>
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<td>• Fewer steps in equipment pathway.</td>
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<td>• Fewer delays in patients accessing equipment.</td>
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<td>• Reduced spend through purchase of replacement equipment.</td>
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<td></td>
<td>• Community nursing staff ordering equipment through electronic live system.</td>
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<td>• Faster turnaround of pickups for patients.</td>
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<td>• Safer, better maintained equipment.</td>
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<td><strong>Estimated completion Dec 2014</strong></td>
<td>C Cameron/ G McLean/ L Boyd</td>
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### 2. Flow and the Acute Hospital
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| 24 | Enhance whole-system flow. | i. Agreement at Clinical Operational Management Team meeting with partners to focus on 6-9 month intensive improvement programme.  
ii. Project Team established and focus on key actions within acute hospital setting to:  
  - Embed EDD.  
  - Majority of discharges by mid-day.  
  - Fully implement operational policies across Acute Sector.  
  - Review and agree plan for the redesign of the Operational Support/Discharge Hub Model and commence implementation of this flow project during May 2014.  
  - Develop real-time time demand and capacity information.  
iii. Cross system core group (including H&SCP's) established to:  
  - Reduce discharges that are delayed.  
  - Enhance cross-system huddles.  
  - Fully embed IDLs to support quality of discharge.  
  - Explore and test methods to proactively manage flow (e.g. discharge to assess). | | | • Smooth discharge process.  
• Reduced discharges that are delayed.  
• Reduced impact on acute services.  
• Improved Patient/Carer/Staff experience.  
• Reduced non-random variation across services. | Initial phase 31st March 2015 | P Strachan A Croft G Smith |
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| 25 | Enhance flow within ED. | i. Develop and agree a single improvement/action plan that aligns ED service challenges in both ARI and Dr Grays.  
   ii. Enhance flow in ARI ED by:  
      • Reducing time to first assessment via physician associates.  
      • Exploring delegated authority for placement of patients by ED Consultants.  
      • Expanding decision support – see action 17.  
      • Exploring and testing alternatives to ED attendance where appropriate.  
      • Redirection – see action 3.  
      • Prompt assessment by mental health team – see action 15.  
      • Piloting senior nursing support in ED to ensure decision support and onward flow of patients to specialities.  
      • Linked to action 24 – whole-system flow programme.  
      • Supported by actions within workforce plan.  
      • See action 30 re MSK and Orthopaedic Quality Drive. | | | | | | A Croft/P Gent |
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| 25. cont. | iii. Enhance flow in Dr Grays ED by:  
• Enhancing triage skills and implementing redirection policy.  
• Reviewing of patient criteria determining suitability for CDU admission, including agreement of specialties allowed to admit to CDU.  
• Alternatives routes other than admission to DGH – further development of links and increased utilisation of social work and all other voluntary agencies.  
• Review of current AHP provision available within ED.  
• Increase redirection of appropriate patients meeting the criteria for AMAU and assess patient’s suitability for review in AMAU ‘next day clinics’.  
• Linked to action 24 – whole-system flow programme.  
• Develop and agree a shared escalation plan with NHS Highland for the Moray population. | | | | | | |
### 3. Assuring Effective And Safe Care 24/7 At The Hospital Front Door

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| 26. | Expand Ambulatory Care Service and monitoring capacity within AMIA to ensure patients receive the most appropriate care/management. | i. Increase monitoring kit/capacity for those with collapse/syncope/chest pain, which will reduce waiting time for holter monitoring and assessment resulting in reduced length of stay.  
ii. Expand current ambulatory care service to include syncope/collapse as of September 2014.  
iii. Consider, work up and test other potential options for expansion of ambulatory care during 2014/15. | | • Improved patient experience.  
• Appropriate /reduced length of stay.  
• Reduction in admissions.  
• Improved staff experience.  
• Improved capacity/flow via AMIA. | | | C Matthews/ S Close/J Wattie |
| 27. | Ensuring demand to ED is appropriate. | i. See KWTTT (action no. 2)  
ii. See Redirection (action no. 3)  
iii. See Decision Support (action no. 17)  
iv. Review activity and identify with colleagues alternatives for enhancing patient pathway and care.  
v. Consider the re-direction/location of medical patients to AMAU/AMIA or other services outwith ED flow. | | • Appropriate patients seen within ED.  
• Reduction in inappropriate ED attendance.  
• Enhanced patient and staff experience. | | 31st Mar 2015 | Leads for Various Actions |
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| 28 | Appropriate staffing in the short term to manage the significant reduction in the middle grades and resignation of 2.0 WTE ED consultants. | i. Dr Grays:  
- Recruit to vacant ED posts.  
- Identification of resource through redesign/reprioritisation to achieve sustainable EMP/medical cover.  
- Training minor illness nurses – funding yet to be secured.  

ii. ARI  
- Implement agreed short term medical workforce plan to manage staffing challenges whilst delivering safe ED service.  
  - Recruitment to vacant 3.0 WTE consultant posts.  
  - Locums as a contingency.  
  - Recruit to specialty doctor posts.  
  - Explore alternative staffing for middle grade.  
  - Agree contingency plan for ED focussing on staffing and flow.  

• Recruitment currently underway for both Consultant & Middle Grade staff. Staff Grade interviews being organised for week of 20th May 2014.  

Further work planned to assist the overall attractiveness of the department and raise the profile of ED services in the North East. | Safe and stable ED services.  
Adequate senior medical cover in place. | Recruitment currently underway for both Consultant & Middle Grade staff. Staff Grade interviews being organised for week of 20th May 2014.  
Further work planned to assist the overall attractiveness of the department and raise the profile of ED services in the North East. | 31st Jul 2014 | P Gent |
| 29 | Long term workforce model and workforce sustainability plans for ED’s in ARI and Dr Grays agreed and implemented. | i. Develop and agree the long term workforce model for ED in ARI and Dr Grays.  
ii. Agree and commence implementation plan. | • Model and implementation plan agreed and implementation commenced. | Model and implementation plan agreed and implementation commenced. | 31st Jul 2014 | P Gent/J Ferguson/P Hardy |
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| 30.| MSK Orthopaedic Quality Drive | i. NHS Grampian is currently working at pace on all five high impact work strands:  
- AHP MSK Redesign  
- Fracture Pathway Redesign  
- Enhanced Recovery  
- Hip Fracture Care Pathway  
- Demand and Capacity Planning and Management  
ii. Weekly operational huddle in place to review progress and agree actions. Executive Lead weekly huddle to support progress and unblock barriers. Fortnightly update with Government to support progress, signpost to additional help etc.  
iii. Rapid improvement event supported in May 2014 for clinical and managerial leads to identify service developments.  
iv. Explore increased use of telemedicine within the care pathway. | | | | March 31\(^{st}\) 2015 for all work strands except MSK work strand which is fully achievable by 31\(^{st}\) March 2016. | Clinical Leads/A Forrest |

- MSK redesign model fully implemented.  
- All non-operative fractures to be discharged directly by ED or referred to a virtual Orthopaedic clinic. Only patients with a clinical need receive a review.  
- All arthroplasty patients receive best practice interventions that enhance experience and optimise recovery.  
- Implementation of the Scottish Standard of Care for Hip Fracture Patients.  
- Optimised capacity utilisation.  
- Improved patient
## 4. Promoting Senior Decision Making

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<tr>
<td>31.</td>
<td>Ensure prompt access to senior decision maker in ED (ED and senior speciality doctor).</td>
<td>i. Creation of robust pathways for first assessment by speciality teams for across the acute sector. ii. Re-invigorating and improving where necessary, previously agreed emergency clinical pathways and policies. iii. Expansion of consultant presence in ED as part of future staffing model. iv. Share and apply principles developed as part of the move to the ECC to support timely clinical decision making.</td>
<td></td>
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<td>Senior decision maker access in ED within 2 hours of patient attendance.</td>
<td>31st Aug 2014</td>
<td>P Gent/J Ferguson</td>
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<td>32.</td>
<td>Patients reviewed by a senior decision maker within 14 hours of decision to admit.</td>
<td>Work with key specialities who do not currently meet this standard.</td>
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<td>33.</td>
<td>Minimum of daily access to senior decision makers within ward area.</td>
<td>Explore and enhance the role of senior staff to provide timely decision making and co-ordinate appropriate senior decision making as and when required on a daily basis.</td>
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5. Cross Cutting Themes

*Information Management; Leadership and Management & Workforce Development*

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<tr>
<td>34</td>
<td>Technology</td>
<td>i. Access to info&lt;br&gt;• Continue to expand and develop clinical guidance intranet (CGI).&lt;br&gt;• Work with e-health to identify ways of creating access to information systems for frontline and mobile staff (see action 16).&lt;br&gt;ii. Alternatives to face to face consultation&lt;br&gt;• Continue to expand use of No Delays as an alternative to face to face consultation in the context of a clearly defined pathway.&lt;br&gt;• Further test and implement telehealth solutions.</td>
<td>CGI: Third version released.&lt;br&gt;Links established with e-health led EPR group which covers all clinical systems.&lt;br&gt;Joint venture company being formed with digital life sciences. Funding being sought from various sources. Extensive programme of work lined up.</td>
<td>See actions 6, 16 &amp;18.</td>
<td>31st Mar 2015</td>
<td>J Hogg/D Taylor/A MacVinish/ C Provan</td>
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<td></td>
<td>Development and implementation of the Grampian USC Partnership Workforce Plan</td>
<td>i. Agree and implement a Grampian Partnership USC Workforce Plan.&lt;br&gt;ii. See Appendix 4 and the various specific actions flagged in dark blue within this plan.</td>
<td>10%</td>
<td>First Grampian USC Partnership Workforce Plan to be developed.</td>
<td>Outcomes within the workforce plan delivered.</td>
<td>31st Mar 2015</td>
<td>G Lawrie/C Cameron</td>
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| 36. | Enhance delivery of high quality person-centred care via the CONNECT Leadership Programme | i. Launch CONNECT - Medical Leadership Programme on 2nd April 2014.  
ii. Commission short life action groups to focus on improving:  
- Advice/referrals  
- Admission/Discharges  
- Leadership/relationships with management  
- Recruitment and continuity.  
iii. Enhance understanding of clinical roles across primary and acute care and build upon relationships via the medical shadowing programme. | 20% | • Programme launched.  
• Agreed areas for medical leadership focus.  
• Short life groups deliver against agreed measures.  
• Shadowing programme assessed against agreed success measures. | During 2014/15 | C Provan |
| 37. | Dedicated USC Project Management | Provide dedicated USC Project Management to support whole-system partnership developments. | In place. | Dedicated support and co-ordination for partnership actions. | 1st April 2014 | G Smith |
| 38. | Developing real-time demand and capacity information. | Develop, test and implement access to real-time demand and capacity information. | 70% | • User friendly system in place.  
• System actively used to support flow and manage capacity across the system in real-time. | 31st Dec 2014 | P Gent |
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| 39 | Develop, agree and implement a plan to create a high quality, responsive Major Trauma Network within the North of Scotland (NoS) to deliver standards set out in the National Trauma Quality Framework. | *i. North of Scotland*  
- Establish a NoS Programme to oversee the development, agreement and implementation of a NoS Trauma Network as per national standards.  
- Recruit to NoS Clinical Lead.  
- Create management capacity to co-ordinate the NoS Programme.  
- Develop and agree a NoS Major Trauma Network Action Plan.  
- Agree NoS performance framework to assess impact of Programme Plan.  
- Participate, inform and provide reports as appropriate to the National Major Trauma Workstream.  

   *ii. Grampian*  
- Establish a Grampian Major Trauma Group to inform and oversee implementation of local plans which supports the NoS Plan.  
- Develop a Grampian Major Trauma Plan as part of the Clinical Services Strategy which specifically addresses local requirements and ensures sustainability of the various Programme structure in place.  
- Clinical Lead in post.  
- Agreed Grampian Major Trauma Plan with commenced implementation.  
- NoS Major Trauma Action Plan agreed and implementation underway. |                  | 31st Dec 2014  
G Smith/L Scott
Assistant: | No | Action | Description/ Output | Status % Complete | Commentary | Measurable outcome | Timescale | Lead |
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<tr>
<td>40</td>
<td>Independent Evaluation of Grampian USC Approach</td>
<td>i. Seek views of patients, carers and professionals across partners via:&lt;br&gt; - Surveys&lt;br&gt; - Seeking patient/staff experience&lt;br&gt; - Independent focus groups led by Aberdeen University&lt;br&gt; - Independent in depth interviews with patients/carers and professionals from NHS/partner organisations.&lt;br&gt; ii. Aberdeen University reviews and reports on quantitative data/impact within the independent evaluation report.&lt;br&gt; iii. Seek independent challenge from Aberdeen University on local evaluation findings on an ongoing basis.&lt;br&gt; iv. Produce an interim evaluation report in October 2014 and a full evaluation report in April 2015.</td>
<td>20%</td>
<td>Aberdeen University have been commissioned to provide independent challenge and produce an independent report on the qualitative and quantitative impact of Grampians agreed USC Approach.</td>
<td>• Independent Evaluation Report produced highlighting impact of the USC approach. • Quantitative and qualitative output continues to inform implementation of USC Approach.</td>
<td>30&quot; April 2015</td>
<td>J Evans/ C Cameron</td>
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### 3. Key Risks

There are a number of key risks identified as outlined below.

- Inability to recruit to key roles such as ED consultants, speciality doctors, GP’s, speciality consultants and care workers.
- Continued attrition of advanced nurse practitioners from GMED to in-hours GP.
- Messages to the public relating to self care/management and support are not adhered to.
- Increased workload/pressures and increased sickness absence.
- Delayed discharges do not reduce, or further increase, restricting bed capacity and flow and resulting in reduced performance in relation to 4 hour standard and boarders with resultant increase of in hospital mortality and morbidity.
- Professionals do not fully utilise Decision Support service/network.
- Delays in implementing appropriate technology.
- Restrictions on availability of resource will hamper the desire to train and develop a sustainable workforce for the future.
- Delivery of some of the actions contained within the Plan will require cultural and behaviour changes which may take time to evolve.
4. Financial Planning

The table below sets out the financial projections for 2014/15, and is line with the data submitted earlier this year in relation to planned investment over the three year period to 2015/16. It sets out the projected expenditure, breakdown of funding source and confirms if this is recurring or non-recurring funding. The completion of the finance plan has been overseen by NHS Grampian’s Director of Finance.

<table>
<thead>
<tr>
<th>Funding Source e.g. Local LUCAP Funding</th>
<th>Narrative/Description of Expenditure</th>
<th>Projected Expenditure 2014/15 £000s</th>
<th>Recurring/non-recurring costs 2014/15 £000s</th>
<th>Total Costs £000s</th>
</tr>
</thead>
</table>
| LUCAP Funding                           | Funding for the following items:  
- ED Consultant posts  
- Funding for decision support  
- Triage Nurses for ED  
- Physician Associate roles in ED  
- Training of Advanced Clinical Practitioner roles  
- Mental Health Practitioners  
- Support to ED Consultant rota  
- Acute GP Fellow posts  
- Project Management & Evaluation | £1,034k Recurring - £250k  
Non Recurring - £784k | £1,034k |
| Core NHSG Funding                       | Additional nursing posts for  
Emergency Care Centre Wards at ARI | £800k Recurring £800k | £800k |
<table>
<thead>
<tr>
<th>Funding Source e.g. Local LUCAP Funding</th>
<th>Narrative/Description of Expenditure</th>
<th>Projected Expenditure 2014/15 £000s</th>
<th>Recurring/non-recurring costs 2014/15 £000s</th>
<th>Total Costs £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core NHSG Funding</td>
<td>Additional investment in Diagnostics for Emergency Care Centre</td>
<td>£800k</td>
<td>Recurring £800k</td>
<td>£800k</td>
</tr>
<tr>
<td>Core NHSG Funding</td>
<td>Contribution to ScotSTAR Emergency Retrieval System</td>
<td>£150k</td>
<td>Recurring £150k</td>
<td>£150k</td>
</tr>
<tr>
<td>Core NHSG Funding</td>
<td>Additional investment in costs of sessional Doctors for GMED OOH service</td>
<td>£200k</td>
<td>Recurring £200k</td>
<td>£200k</td>
</tr>
<tr>
<td>Change Fund / Core NHSG Funding</td>
<td>Continued development of Anticipatory Care Plans</td>
<td>TBC</td>
<td>Non recurring</td>
<td>TBC</td>
</tr>
<tr>
<td>Core NHSG Funding</td>
<td>Investment in continued development of Clinical Guidance Intranet</td>
<td>£80k</td>
<td>Recurring - £80k</td>
<td>£80k</td>
</tr>
<tr>
<td>NHSG Endowments</td>
<td>Pre hospital primary response / retrieval service</td>
<td>£100k</td>
<td>Recurring - £10k</td>
<td>£100k</td>
</tr>
<tr>
<td>Existing Integrated Care Funding</td>
<td>Implementation of partnership plans to support the delivery of the 2 week standard for delayed discharges</td>
<td>£3396k</td>
<td>Non Recurring - £3396k</td>
<td>£3396k</td>
</tr>
</tbody>
</table>

**Additional Note**

The Finance Plan above supports the short, medium and long term priorities set out within the LUCAP for 2014/15. This has been based on the initially indicated Scottish Government non-recurrent USC allocation for 2014/15 of £784k, in addition to specific additional funding from the Grampian NHS Board and other partnership funding. Given the challenges currently experienced within Grampian, we wish to enter into a dialogue for further support from the Scottish Government regarding the intensive flow programme (circa £200k) and a contingency plan for the continued high volume and potentially realistic increase in delayed discharges (circa £1.5m). In addition, flexibility is required subject to arrangements being put in place to deliver staffing requirements for ED post August 2014.
Some Of The Progress So Far…

- KWTITT:
  - targeted campaign in Nov 2013
  - antibiotic campaign
  - reinforce KWTITT messages in Adult and Children's ED and MIUs by streaming patients to the appropriate service

- Anticipatory Care Plans
  - over 90% of General Practices using eKIS
  - increased focus on quality and input from patient/family and multi-agency teams

- Framework to support staff to promote self management to patients/public is underdevelopment

- 17 pharmacies in 15 locations delivering UTI treatment

- Implementation of Falls Programme

- No Delays evaluation commenced Oct 2013

- Respiratory Project to assess planned interventions, self management and rehabilitation to prevent admissions underway

- Decision Support Service live on 2nd Sept 2013

- Continued enhancement of local decision support networks e.g. eye care network, Moray, palliative care

- Automated Vehicle Location System piloted in Aberdeen

- Increase in the number of alternatives to admission e.g. ongoing development of acute medicine assessment clinic

- Moray district nursing role redesign underway

- Intelligent Bed Placement Model used in all hospitals since May 2013

- Pre-Hospital Response Service operational

- Near Patient Troponin Testing Pilot commenced

- Dr Grays Surgical Assessment Unit opened Jan 2014

- Implementing partnership plans to reduce the number of delayed discharges

- Increasing the number of staff with re-enablement skills

- Increasing the support available to unpaid carers

- Geriatric Assessment Unit – 30-40% patients being discharged within 24 hours

- Intelligence gathering re ‘hospital at home’ model

- Development of a ‘Flow’ programme

- eBooking of appointments – MIU & others in development

- Decision Support Service live on 2nd Sept 2013

- Increased nurse capacity in ED to ensure timely triage/redirection achieved Jan 2014

- Increase in A&E Consultants

- 4 Physician Associates had 6 month of intern year in A&E

- NHS 24 moved into the ECC Hub in Nov 2013

- Improved recruitment/retention of paid carers across Grampian.

- eBooking of appointments – MIU & others in development

- Automated Vehicle Location System piloted in Aberdeen

- Increase in the number of alternatives to admission e.g. ongoing development of acute medicine assessment clinic

- Moray district nursing role redesign underway

- Intelligent Bed Placement Model used in all hospitals since May 2013

- Pre-Hospital Response Service operational

- Near Patient Troponin Testing Pilot commenced

- Dr Grays Surgical Assessment Unit opened Jan 2014

- Decision Support Service live on 2nd Sept 2013

- Continued enhancement of local decision support networks e.g. eye care network, Moray, palliative care

- Progressing electronic access to non-urgent clinical advice including electronic update of clinical record

- Clinical Guidance Intranet (CGI) launched Sept 2013 - circa 90 sites active

- ‘System-Check Huddle’ established. Opportunities for expansion under consideration
Appendix 2

Please see separate document for Grampian Self Assessment
Aim: Delivering excellence by organising our resources around the person’s needs

Outcomes

B. Proactive services across the care pathway are available & utilised to support care at home or as close to home as possible.

C. Avoidable unscheduled care attendances across the system & admissions to hospitals are reduced.

Key Actions

1. Making the Community Right Place & Developing The Primary Care Response
   - Refresh the self management support within chronic pathways via Framework.
   - 30% of high risk population have a personally owned action plan. The person’s needs are evaluated in a timely manner.
   - Refresh KWT for focus on reducing paediatric and low grade mental health attendances.
   - Review and amend redirect policy and roll-out to Dr Grays and MIUs.
   - Evaluate/agree next steps of redirect of uncomplicated UTI to pharmacy.
   - Increase the number of advanced clinical practitioners within the community.
   - Develop connectivity of systems to create real-time access to patient information e.g. Pocket Vision in Aberdeenshire and Mobile Clinical Assistant.
   - Timely access to non-urgent decision support.
   - Expand Decision Support to include AMIA and GAU Clinicians and to cover 8am – 6pm.
   - Roll-out to other professionals e.g. NHS24, care homes, pharmacy.
   - Enhance local access to plain film x-ray and radiology advice/decision support.
   - Agree strategy and plan for developing point of care testing in Grampian.
   - Increase same day next day assessment by the community and specialties.
   - Timely access to community & HSC teams.
   - Implementation of local H&SC partnership plans to create greater integration & potential capacity to respond to need.
   - Review capacity for intermediate beds which includes community hospitals.
   - Implement local plans for meeting the 2 week delayed discharge standard.
   - Review and redesign GMED to create greater sustainability.
   - Explore with partners a community model for USC in Banff and Buchan.
   - Implement and evaluate the redesign of mental health.
   - Falls – greater focus on SAS role, care homes and linked to decision support.
   - Test alternative services/care delivery for carers and people with dementia.

Expected Impact

A. Proactive population who take responsibility for their own communities health through self care & self management which reduces the need for unscheduled contact.

B. Patients receive discharge care which responds to their needs & supports the transition into planned care & self management which reduces the risk of further unscheduled care contacts.

C. Proactive services across the care pathway are available & utilised to support care at home or as close to home as possible.

D. Patients presenting to hospital are assessed, treated & subsequently discharged by the appropriate clinical & multi-agency team.

E. Patients receiving discharge care which responds to their needs & supports the transition into planned care & staff management which reduces the risk of further unscheduled care contacts.

F. Sustainable health and social care workforce across primary, secondary & community settings, including rural areas.

Pressure Points/Challenges

Population Changes
- Projected increase of 6.2% by 2020.
- Population 65 and over is projected to increase to 19% by 2020.
- Increased co-morbidities/complexity/ dementia

Workforce Capacity & Sustainability
- Recruitment, retention & availability of specific professional groups e.g. GP, ED consultants, some specialty consultants, advanced practitioner & care worker roles.
- Continued challenges particularly in Aberdeen and parts of Aberdeenshire re recruitment and retention of carers.
- Changes to medical training numbers, supply & recruitment of middle grade doctors.
- Increased risk of sickness absence due to increasing pressure/workload.

Appendix 3

Final - Grampian Local Unscheduled Care Action Plan (LUCAP) for 2014/15

Page 39 of 41
Overview of Grampian Unscheduled Care (USC) Workforce Plan for 2014/15

Key Actions for Recruitment & Retention
1. Increase recruitment and retention of Emergency Medicine workforce. Specifically agreed 3.0 wte consultant vacancies and specialty doctors via proactive and creative recruitment.
2. Increase the recruitment of GP’s in Grampian by providing opportunities for career portfolios (see action 21).
3. Continue to increase the number of paid carers through creative recruitment via job fairs, on the day appointments, campaigns, apprenticeships and review of pay and conditions.
4. Explore opportunities for joint working in relation to the recruitment and retention of paid carers e.g. career framework, apprenticeships, link to retiral programmes etc.
5. Create proactive and innovative generic and specific (radiology, nurses) recruitment campaigns for wider workforce e.g. films, radio, creation of marketing materials, careers fairs, business breakfasts, BMJ/RCN career fairs.
6. Explore opportunities for retaining NHS 24 Advanced Nurse Practitioners through joint working with NHS Grampian e.g. development of joint posts and/or rotational posts.

Key Actions for Workforce/Role Development & Redesign
7. Create integrated multi-professional/agency teams within each of the three health and social care partnerships.
8. Implement short term plans within Emergency Medicine at ARI due to changes in the middle grade rota.
9. Implement three year workforce development plan for Emergency Medicine within ARI.
10. Agree and commence redesign of Dr Grays Emergency Department (ED) workforce to create greater sustainability.
11. Agree and commence implementation of GMED redesign by late summer 2014.
12. Review the workforce model for acute medicine in relation to service redesign and long term sustainability.
13. Enhance development of the Community Geriatric Services in Grampian by redesigning the workforce based on agreed model.
14. Agree and implement workforce plans for the delivery of a North of Scotland Major Trauma Network.
15. Redesign of mental health workforce.
16. Expand the development of the Decision Support Network e.g. USC Decision Support Unit, local networks, specialty urgent/non-urgent advice etc. Training in place for kit, skills and competencies for individual service requirements.
17. Paramedic practitioners work with local integrated teams to manage patients appropriately within their own homes/local communities through see and treat and referral on to appropriate pathways of care.
18. Increase the number of non-medical prescribers by a further 6 in 2014/15.
19. Roll out of community pharmacy non-complex UTI pilot to additional 15 Pharmacies in May/June 2014.
20. Review the role of AHPs to ensure skills/expertise add maximum value to the USC patient pathway.
21. Improve GP workforce sustainability:
   - develop, test and formalise EMP Fellowship Programme with NES
   - 8 Careerstart GP posts across Grampian (in-hours with 1 session out of hours)
   - host 2 Acute GP Fellows in Moray (placements in Dr Grays/GP)
   - develop ‘joint’ in/out of hours advanced clinical practitioner roles in 8-10 General Practices.

Key Actions for Education & Training
22. Increase support for unpaid carers through identification, provision of basic information packs, named person who can signpost/support and co-ordinate practical support/training.
23. Provision of training needs analysis for care home staff and co-ordinate training/updates consistent with required competencies for health and social care. Enhance access to decision support.
24. Develop joint education and learning plan to enhance relationships, shared culture and maximise existing resource. Priority areas are enablement, technology, dementia, anticipatory care planning, falls and Every Opportunity Counts.
25. Train additional 12 Advanced Nurse Practitioners (GMED and joint in/out of hours GP).
26. Formalise workforce training changes with higher/further education providers.
27. 8 Physician Associates undergo 6 month intern year placements in ED.
29. Staff in Dr Grays ED and Minor Injury Units trained in the delivery of assessment tools and redirection.