Borders NHS Board

LOCAL UNSCHEDULED CARE ACTION PLAN – 2014/15

Aim

NHS Borders is required to submit a Local Unscheduled Care Plan on an annual basis. The Guidance documentation issued in March 2014 asked Boards to submit draft action plans in May, ahead of final submissions being agreed by respective Boards and submitted by the end of June 2014.

The central requirement is for NHS Boards to demonstrate a systematic, co-ordinated and managed approach to capacity planning, flow management and service development to ensure we are delivering against key service standards, and in particular the emergency access standard.

Background

NHS Borders is required to submit a Local Unscheduled Care Plan on an annual basis. The Guidance documentation issued in March 2014 asked Boards to submit draft action plans in May, ahead of final submissions being agreed by respective Boards and submitted by the end of June 2014.

The central requirement is for NHS Boards to demonstrate a systematic, co-ordinated and managed approach to capacity planning, flow management and service development to ensure we are delivering against key service standards, and in particular the emergency access standard.

Summary

Issues associated with unscheduled care planning for 2014-15 are being addressed with reference to three specific programmes, and the operational management arrangements made in respect of flow management on a day to day basis. Each programme is in the process of developing action plans, and these have been brought together within the body of our LUCAP return (attached).

- Unscheduled Care (Out of Hours and Unscheduled Care/Front Door Service Delivery and redesign).
- Proof of Concept (Operational/Capacity Management and Planning)
- Connected Care (Flow Management).

The guidance issued has asked that LUCAP's have a focus wider than acute and need to demonstrate a clear emphasis on key themes identified nationally, but specifically the development of community and primary care solutions that support delivery of unscheduled care.

The guidance required NHS Boards to complete a Heath Check against key objective and themes and include with LUCAP submissions (attached – annex B).

Finally the LUCAP must detail planned investment on a recurring and non-recurring basis. This included the use of SG funding provided specifically in support of LUCAP provided on a three year basis, initiated during 2014-15 (attached). This will be subject to regular and ongoing review, specifically in terms of return on investment and improvement (outcome) gains.

Consultation

In developing the LUCAP for 2014-15 the project teams associated with each of the Programmes of work have been consulted, Programme Boards include representation from all of the primary stakeholder groups associated with delivery against the key objectives associated with this important work, particularly Local Authority and Scottish Ambulance Colleagues.

Recommendation

The Board is asked to **note**:

- the trajectory against national access standard for unscheduled care.
- the overall application of funds supporting delivery of 2014-15 LUCAP.

The Board is asked to **agree**:

- the Local Unscheduled Care Action Plan.

Policy/Strategy Implications	As detailed in the report.
Consultation	Key Stake Holder Groups via Programme Boards detailed in the paper.
Consultation with Professional Committees	Not Applicable
Risk Assessment	Delivery against the 4 hour standard
Compliance with Board Policy requirements on Equality and Diversity	Yes
Resource/Staffing Implications	As detailed within the report, and action plans associated with individual Programme Boards.

Approved by

Name	Designation	Name	Designation
Jane Davidson	Chief Operating Officer		

Author(s)

Name	Designation	Name	Designation
Kirk Lakie	Service Manager, Unscheduled Care		

NHS Borders – DRAFT 16-5-14
Local Unscheduled Care Action Plan (LUCAP) Year 2 - 2014/2015

1. Overview & Key Issues

Performance Overview

In line with a number of Health Boards, NHS Borders LUCAP for 2013/14 had an immediate and short term focus aimed at ensuring sufficient capacity and service resilience moving into what was anticipated to be a busy winter period. Moving forward there is a general recognition that our LUCAP for 2014/15 while learning the lessons from 2013/14, and building on our successes in relation to capacity planning and service resilience, needs to widen it's focus to ensure sustainability within the context of whole systems working including key partner organisations.

Table 1. Emergency Access Standard Performance

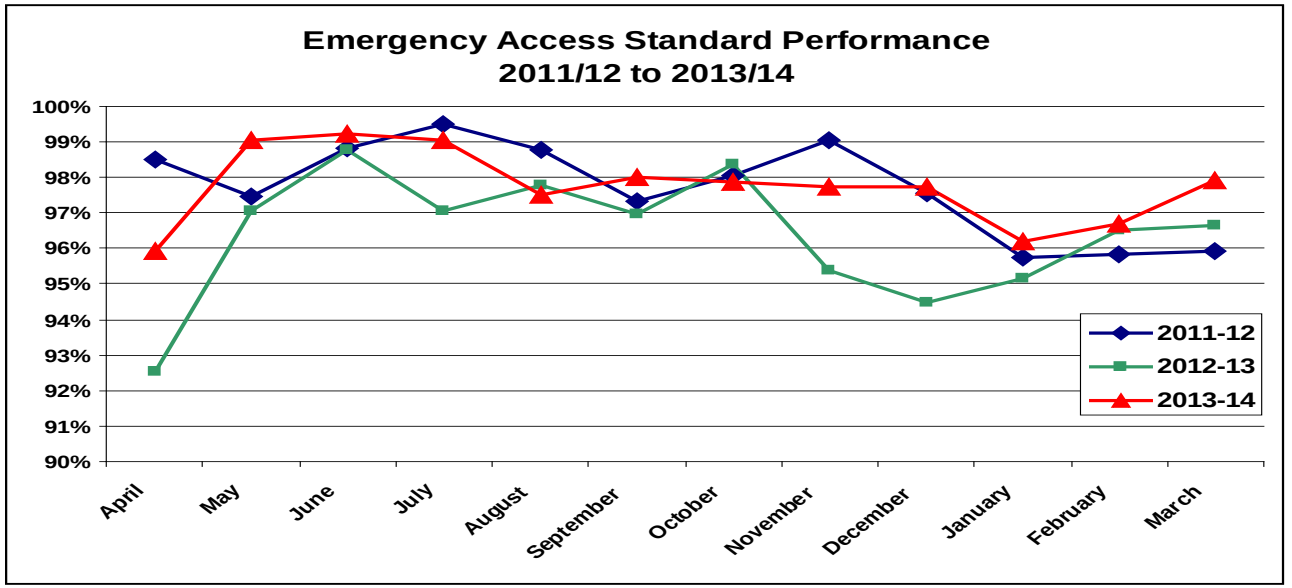

Table 1 above shows that our overall emergency access standard performance for 2013/14 was above the national target of 95% but fell below our locally agreed standard of 98% in 3 of the 12 months. Again during April and May 2014 we are seeing significant pressure associated with activity surge pulling performance against the standard below 98%.

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Key Issues:

Analysis of performance against the standard would suggest that while we are making progress in addressing issues related to flow there are still a number of fundamentals that need attention and that should be our focus moving forward.

- Breach analysis over the course of 2013/14 demonstrated a reduction in breaches in all flow categories (Minor Flow, Majors, and Medical and Surgical admissions) but particularly in delivery against Minor Flow breaches in ED where the significant performance improvement has been sustained over the winter. However, we retain specific vulnerabilities within minor flow activity associated with two issues, no physical separation of minor from major activity flow, and transitioning from evening to overnight cover and activity volumes during this period. We will move to address these issues during 2014/15.
- The dip in performance noted during January to March can largely be attributed to delays associated with bed availability within the hospital, this pattern has continued into April. While winter planning and provision for surge capacity within our bed footprint has insulated us to some extent, we still experience issues with flow right across our care system and performance variability in all aspect of flow management will again need to be a key focus for NHS Borders. Central to this will be our Day of Care Audit work which demonstrates that we have a significant number (20%-30%) of patients retained within acute beds that are otherwise medically fit for discharge. Unlocking this issue through discharge planning and flex across our care system would move us significantly towards sustainable improvement consistent with 98% performance against the emergency access standard.
- Pathway development for the frail elderly is also highlighted as an area with potential for significant impact and improvement. This group represent a significant proportion of our unscheduled emergency admissions, and ensuring we have appropriate pathways as alternatives to ED assessment and admission for this patient group, particularly during the out of hours period and at the weekends, will be a area for particular focus working closely with GP's, Social Work Departments, and our Scottish Ambulance Service partners.
- Reviewing arrangements for capacity planning as part of normal operational management process has also been identified as a key area for focus. While we identified surge capacity to support unscheduled flow, this did impact on our ability to maintain elective flows and it is recognised that we need to focus efforts at ensuring we are capacity planning right across and not scheduling elective admissions peaks to coincide with unscheduled activity peaks. This will be incorporated into our normal operational planning cycles.
- Capacity within our Medical Assessment Unit can also be identified as a potential bottleneck. This is our largest unscheduled activity area and is often responsible for congestion issues within our Emergency Department as it becomes the waiting room for our assessment unit. Addressing these issues will be a key focus for our Acute Medical Service during the coming year. This will primarily be focused on rapid assessment and ambulatory care pathways, supported by operational management aimed at improving flow supporting across our bed holding areas,
- A significant risk to resilience and sustainability are workforce challenges within unscheduled care services, particularly within our medical workforce. A focused programme of work has been initiated within NHS Borders aimed at identifying and implementing more sustainable models of service delivery that address this vulnerability. This will deliver within the next 12 – 18 months.

NHS Borders has established 3 Programmes of work aimed at addressing the key issues noted above :

1. **Unscheduled Care Programme Board** – Changing models of care within our ED and our Out of Hours Services, and dealing with issues of sustainability and service resilience. Working Closely with the Scottish Ambulance Service and NHS24. This will also address issues associated with Acute Medicine, hospital at night, and a number of other associated and related issues with a core common theme.

2. **Connected Care Programme Board** – Addressing Issues associated with flow management right across the NHS Borders care community and working between Health, Social Work and the Third/Voluntary Sector.

3. **Proof Of Concept** – Addressing issues associated with Capacity Planning and links with Operational Management Theory/Winter/Capacity Planning in general.

The actions listed below are picked up within the work plans associated with these Programmes of work. It is anticipated that this will be co-ordinated through an overarching Board ensuring synergy between these stands of work.

2. Action Plan

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

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

Improvement → Transformation → Sustainability

No	Action	Description/ Output	Status %	Commentary	Measurable outcome	Completion Date	Lead
1.1	Hospital Readmission & Prevention.	Audit and evaluation of hospital readmission data at 7 and them 28 days. Include daily readmission notification and early input from anticipatory care coordinator/social work START where appropriate.	50 25	Initial process has been established and weekly review meetings are now in process. Individual work stream/areas for improvement being identified.	Readmission rates at 7 and 28 days.	Jun 14	Pauline Burns
1.2	Reducing unnecessary ED attendance.	Audit and evaluation of repeat ED attendance through an MDT approach for anticipatory and intervention planning.	50	Establishing information reporting and MDT review team structures.	Attendance & repeat attendance rates reported monthly.	Aug 14	Ed Witkowski
1.3	Key Information Summary (KIS), Anticipatory, and Palliative Care Planning.	Appropriate identification of at risk patients, development of key information summaries, and ensuring access to information at key points in the care system (BECS, ED and MAU).	50	Establishing how often 2450 KIS's held within EMIS are being accessed by	Number KIS Summaries Number Accessed at point of care.	Sept 14	Jonathan Kirk

		Establishing that KIS is effective at influencing future care planning and decision making.		unscheduled care teams, and impact on subsequent decisions.	Impacts assessment Audit		
1.4	Rehabilitation to reablement programme for developing AHP services.	Development of specific pathways aimed at shifting the balance of care toward community focused and community based rehabilitation and reablement.	40	 Project Plan - Improving and Integr	Hospital LoS for key rehabilitation pathways Stroke & #NoF pathways). % Conversion for inpatient to an alternative reablement plan	Dec 2014	Lynne Morgan Hastie
1.5	Community Hospital Redesign	Developing a service model that supports early supported discharge via hospital at home type arrangements – closely related to resign around GP support into community hospital & rehab/reablement programme.	30	Project Initiation	Early Supported Discharge	Aug 2015	Jonathan Kirk
1.6	Unscheduled Care Redesign Project.	Revising the service delivery model for unscheduled care recognising the current workforce issues. This is predicated on a number of principles consistent with the draft clinical strategy, and national delivery standards Central to this strategy is to develop services that maintain patients in their home where safe and appropriate.	25	Project Initiation	National Out of Hour Performance Standards. % Home Visits Admissions Avoidance.	Sept 2015	Kirk Lakie
1.7	Joint working – Ambulance Service	Working with the ambulance service to develop capability around three aspects of service delivery: - Competency assessment and training around identification and management of common conditions for paramedics. - Arrangement for prof to prof referrals/advise during day time/out of hour's period. - Supporting the development of Advance Practitioners to support community based paramedic assessment.	30	Project Initiation	% Ambulance attends where patient is assessed, treated and left at home. Number contacts for advice, and outcome.		Kirk Lakie

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2. Flow and the Acute Hospital

Improvement → Transformation → Sustainability

No	Action	Description/ Output	Status %	Commentary	Measurable outcome	Timescale	Lead
2.1	Developing capability and capacity for flex across the care system that is responsive to identify need (Systems Elastic principles).	Early, timely and continuous feedback on bed utilisation, with a focus on patients delayed in the wrong place, waiting for assessment, reablement or rehabilitation that does not require an acute hospital bed. Development of flexible Intermediate beds, assessment beds, direct access 'step up' beds for community services across 7 days.	35	Undertaking weekly Day of Care audit to establish themes in terms of systems bottlenecks to support targeted pdsa actions aimed at improving flow across our heath system. Developing 'step down' and 'step up' pathways.  Day of Care Audit Report 7th May 2014	Bed Occupancy rates at or below 80% Reduction in % patients at the wrong place of care on Day of Care Audit data. Reduction in Bed Boarding. Reduction Delayed Discharges Associated LoS improvements across all Clinical Specialties.	Mar 2015	Simon Watkin Jane Douglas
2.2	Frailty Service + Older Peoples Liaison	Supporting three principles : - Telephone access for community teams to a Geriatrician for advice in relation to management of frailty issues. - Rapid access to comprehensive geriatric assessment from community teams on an ambulatory basis. Included referrals from Emergency and OOH services. - Comprehensive geriatric assessment on admission to support day 1 discharge planning principles for the frail elderly patients.	40	This project is established and the team are working through development of appropriate frailty pathways. Data gathering to establish demand and impact assessment.	Admissions Avoidance LoS for Frail Elderly % Frail Elderly Assessed on Admission.	Mar 2015	Janet Bennison

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2.3	Seamless and Simple Discharge Planning.	Introducing an evidenced based approach to discharge co-ordination and planning that is embedded as part of business as usual. Ensuring that this works right across the care systems and isn't sector specific and disjointed.	15	Project Initiation	Discharge Profile Average LoS % Over 14 days LoS	Nov 2014	Pauline Burns
2.4	'No Delay' waiting for equipment to facilitate discharge.	Ensuring that we have sufficient capacity to ensure that timely access to equipment never delays a patient who is medically fit for discharge.		Project Initiation	Delays related to Equipment/Adaptations.	Nov 2014	Pauline Burns
2.5	Post Discharge follow up/transitional care	Development of virtual 'follow up' clinics, supported by the third sector that are planned and organised at the point of discharge		Project Initiation	Hospital Readmission Patient satisfaction	Mar 2016	Pauline Burns
2.6	Rapid Access Home Care development	Development of rapid reaction services reflecting the geography of the Borders, and are responsive to the needs of patients. Aimed at supporting patients at home and responding to requests that promote early supported discharge arrangements.		Project Initiation	Delayed Discharges Admissions avoidance	Mar 2015	Jane Douglas
3. Assuring Effective And Safe Care 24/7 At The Hospital Front Door							
							
No	**Action**	**Description/ Output**	**Status %**	**Commentary**	**Measurable outcome**	**Timescale**	**Lead**
3.1	Workforce Sustainability & Alternative Delivery Models – Unscheduled Care	A programme of work to develop, agree and deliver service delivery models for Unscheduled care that are sustainable based on the current workforce challenges faced by services. Expectation that these will be based around key principles that these will need to be repeatable and resilient long term.	30	Developing models of that address underlying service challenges	Performance Framework across Unscheduled Care	Sept 2015	Kirk Lakie
3.2	Ambulatory	Continuing the development of pathways for the ambulatory	40	Currently Developing	Same Day Discharge rates	Sept 2014	Kirk Lakie

	Assessment Capacity.	assessment and treatment of urgent and acute general medical referrals from community services without reference to the Emergency Department or an assessment/admission bed.		relevant clinical pathways.	Admission avoidance Reduction in overnight stays.		
3.3	MDT Assessment and Care Management.	Supporting rapid assessment and admissions avoidance at the front door across 7 days. Based on principles of rapid/immediate MDT assessment for medically fit patients who may need a supported discharge or a intermediate/reablement placement (linked to flex beds).	50	Project Initiation	Admissions Avoidance	Mar 2015	Pauline Burns
3.4	Flow Management & Urgent Care Centre development	Improvement work with ED has established significant benefit in the physical separation of Minor flow from majors. The unit will move to separate flows during 201-15, and aim for an Urgent Care Centre approach to minors working across ED and the Out of Hours service.	20	Project Initiation	4 Hours Access Standard Minor Flow Activity.	Oct 2014	Jacques Kerr

4. Promoting Senior Decision Making

No	Action	Description/ Output	Status %	Commentary	Measurable outcome	Timescale	Lead
4.1	Increasing number of Scheduled Consultant Ward Rounds	Revisiting scheduled ward round as part of job planning process for all clinical staff. Specific aim is to increase the spread of ward work to increase the frequency of senior decision making on wards, not necessarily the overall quantity of ward work.	30	Ongoing with Job planning reviews.	Frequency of senior consultant reviews. Impact on daily discharge No delays pending senior review.	Nov 2014	Kirk Lakie
4.2	Increasing Consultant at presence at weekends (Pilot)	Alteration to arrangements for acute medical assessment and weekend working to deliver split weekend on call (level loading) and increase consultant weekend presence by time	60	To be delivered via reorganisation of consultant on-call rota's	Weekend Discharge Rates Reduction is Delays	Jul 2014	Janet Bennison

		shifting to the weekend.		and as part of job planning reviews.	Increase senior reviews at weekends.		
4.3	Acute Assessment	Development of an acute assessment model for GP referrals based on a principle that acute referrals should see a senior decision maker as early as possible in their assessment to avoid unnecessary work or admission where this could be avoided.	60	Commencing arrangements for pdsa'ing new assessment models from June 2015	Same Day Discharge rates Admission avoidance Reduction in overnight stays. Time to First Assessment	Sept 2014	Peter Leslie
4.4	AHP working across 7 Days.	AHP capacity planning across 7 days to ensure that resources match demand, linked to the principles that no patient should be delayed in our system waiting for service not available consistently across 7 days. This includes Rapid and comprehensive MDT assessment at the front door of the hospital across 7 days.	40	Pdsa'd during December – March 2013/14. Proposal for 2014/15 being developed between relevant services.	Patients Delayed Admission avoidance Interventions and outcomes assessments.	Oct 2014	Karen McNicol
4.5	Capacity/Demand resource profiling – Emergency Department.	Reviewing at deployment of resources within Unscheduled Care service to ensure that staff are deployed to the best advantage to meet available demand	30		Response Times OOH Emergency Access Standard	De 2014	Jacques Kerr Craig Wheelans

5. Cross Cutting Themes

Information Management; Leadership and Management & Workforce Development

Improvement → Transformation → Sustainability

No	Action	Description/ Output	Status %	Commentary	Measurable outcome	Timescale	Lead
5.1	Clinical Engagement & Leadership	It is recognised that the significant change in current practice being suggested will require significant levels of clinical engagement, and crucially key programmes will need to be			Evident Clinician Engagement	Oct 2014	Sheena McDonald

		clinically led. Each of the programme Boards are scrutinising all programmes of work in order to satisfy themselves that there is evidence of both a clinical engagement and that clear clinical leadership is evidenced.					
5.2	Capacity/Winter Planning	A requirement to ensure that we are planning elective and unscheduled capacity as part of business as usual activities. This should include ensure we are adjusting elective plans to recognise anticipated activity peaks in our unscheduled flow where possible.		Proof of concept work is scheduled to see how Operational Management Theory might support these objectives.	Elective Cancelations reduced Flow 3 and 4 Breaches Reduced Bed Occupancy Levels	Oct 2014	Pauline Burns
5.3	Data Collection, Performance Reporting, and Technology	NHS Borders has invested in systems that support real time, reliable data to enable operational management/decision support systems within our Site and Flow Management functions. We have also recognised that the right systems performance data can drive performance where this coincides with good clinical leadership and a desire to improve. We will continue to use technology and data to support our improvement work		Continue to develop our White Board technology and electronic systems in support of real time data, and decision making.	Evidence based improvement.	Mar 2015	Laura Jones Dawn Carmicheal
5.4	Improvement methodology.	Ensuring that this is applied consistently within projects and that we are making changes that demonstrate improvement through the use of data and that change is evidence based. Increase the organisational capability to support appropriate improvement methodology at all levels.		A focus on ensuring appropriate project management structure, and the use of data supporting improvement in a targeted way.	Evidence based improvement.	Mar 2015	Laura Jones
5.5	Clinical Practice Development Framework for Unscheduled Care.	Establishing a clinical development framework that supports our ambitions to develop nursing roles within Unscheduled Care, and Acute/Community hospitals. Support our aspirations to build resilience and sustainability going forward given the recognised work force challenges faced in this area.		Working in conjunction with partners to ensure we have roles defined and support with appropriate skills and competences.	New patterns of working.	Sept 2015	Helen Clinkscale

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3. Key Risks

Clinical Engagement/Leadership – It is recognised that the ambition and scale of the changes we are required to make in the next 18months are significant and will need managed carefully. NHS Borders will ensure that a focused project management approached is adopted, that has key clinical leader at the centre of the changes we are making, employing recognised improvement techniques.

Workforce readiness for Service Redesign – A number of the changes we are working towards require changes in our workforce profiles. Development, Recruitment and retention of key groups of staff will be an important component part of a number of the projects identified. Workforce planning has been identified within each of the programmes identified as critical and proposals that will address identified issues are required support by detailed project plans.

Financial risks – Costs within the programmes will need to be managed carefully and effectively, and strategies that require disinvestment to support reinvestment to deliver sustainability longer term changes will need careful monitoring and appropriate financial rigour applied. Finance engagement within each programme and project will be required and robust financial planning will need to be demonstrated.

Service Capacity – Continuing to deliver a safe and effective service, while ensuring we are developing in line with required actions outlined in the plan, and maintaining clinical leadership and engagement will need specific focus given the size of the change agenda associated with this Programme.

Activity growth – We are seeing increasing activity levels within unscheduled care which may not be linear. If growth is sustained at current levels we may need to revisit timescales in order to bring forward to meet demand.

Internal/External Communication – Effective and proactive communication, describing goals and aspirations to our staff and our local population will be required in order to reassure, and manage expectation moving forward.

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4. Financial Planning

Your financial projections for 2014/15 should be in line with the data submitted earlier this year in relation to planned investment over the three year period to 2015/16, and should complement the action plan. The section requires you to complete projected expenditure, breakdown of funding source (i.e SG allocation / Change Fund / Board funding, including your planned level of additional local investment in the programme) and confirmation of recurring or non-recurring funding. This should be completed in partnership with your Director of Finance.

Funding Source e.g. Local LUCAP Funding	Narrative/Description of Expenditure	Projected Expenditure 2014/15 £000s	Recurring/non-recurring costs 2014/15 £000s	Total Costs £000s
LUCAP (non-recurring)	ED Consultant Appointment	6,500		6,500
	AHP W/End Capacity Unscheduled Care	50,000		50,000
	Paramedic Development/Jointly Funded Scottish Ambulance Service	80,000		80,000
	ENP Capacity Emergency Department	46,000		46,000
Local (Recurring)	ED Consultant Appointment	53,500		53,500
	Bed Busters	20,000		20,000
	Additional DME Consultant	100,000		100,000
Local (Non-recurring)	Weekend Site/Flow Management	16,000		16,000
	Acute Physicians	210,000		210,000

**** It is anticipated that a further significant investment will be made in transitional arrangements supported from the Change Fund (circa (£1.7m over two years). At this stage the detail of specific investment is being finalised as part of the project initiation phase associated with this project and detail will be available as our LUCAP position is finalised.***

Annex B

LUCAP 2013/14 Health Check

Please assess your progress against each action by using the traffic light system - Red, Amber and Green. For actions you have classed as Amber or Red an explanation / narrative is required along with progress/timescales for completion where applicable.

Key

G	Implemented on a sustained basis on all sites/systems
A	Partailly implemented/Plans to implement - progress/timescale for completion?
R	Not Implemented - if not, why not?

Unscheduled Care Self Assessment

Improvement Transformation Sustainability	Board Actions									
	Whole system approach, including all stakeholders	Site Management Capacity Focus rather than cross/multi site	Agree Care Residential / Home care package budget phasing to avoid annual winter delayed discharge backlog evident in some Health Boards	Medical & Nursing Directors promoting early in day discharges as key quality measures	Enhanced at Home Care Service	Local ED Acute Med & GP OOHs medical recruitment & retention strategy	Signposting/ redirection and Anticipatory Care Planning	Clinical and Managerial Information Management 'Dashboard'	Review Administrative Processes to ensure the Admin burden on ward staff is reduced	Unscheduled Care Management Board Established
NHS Borders										
Borders General Hospital	G	G	A	G	A	G	G	G	A	A
Comments	There is evidence of clear enagagement within individual Projects and the overarching Programmes that demonmstrates that NHS Borders is very much adopting a whole systems approach to Unscheduled Care Planning, Redesign and Improvement. There is particular evident in respect of winter and capacity planning, and flow management discussions. There is senior local authority representation on our Connected Care Programme Board and Scottish Amubulance representation on our Unscheduled Care Programme Board. A number of projects are dependant upon joint improvement work.	There is a site specific operational focus on Flow management within NHS Borders that operates across 7 days.	Thre was provision made during 2013-14 for additional flex capacity within Residential/Care homes. This did not always work as effectively as necessary and lessons will be carried into planning for 2014-15 as part of 'Stup up' and 'step down' capacity planning included within our Connected Care programme (Project 2.1). This will be Amber until plans are firmed up and agreed with Local Authority colleagues.	There has been a specific focus during 2013-14 on effective discharge planning, and avoiding unnecessary delays associated with a failure to plan accordingly. This has focused on drugs management, discharge letters and transport, but will be continued during 2014-15 bringing in criteria led discharge in support of these objectives (Project 2.3).	NHS Borders successfully piloted a number of initiatives aimed at improving access to home care, and developing seamless access points that make home care the easiest thing to do where appropriate. This will be extended and developed during 2014-15 (Project 1.4 and 2.6)	NHS Borders has initiated a focused project aimed at addressing specific work force challenges identified within current service models. This work will aim to address specific points of weakness and risk moving forward in our Out of Hours service specifically, but and unscheduled care services in general (project 3.1).	We are moving forward with proposals for the development of Acute assessment and ambulatory care provision. This will be supported by arrangements to ensure that there is access to anticipatory plans at key points of contact right across our care system (Projects 1.1, 1.2, 1.3, 1.4).	NHS Borders has daily updated information focused on Flow Management, ED performance, and improvement. This information is discussed at a number of Daily and weekly forums aimed at addressing current issues, and proactively looking for issues in advance. This will be enhanced during 2014-15 to include planning between Scheduled and Unscheduled care Projects 5.3 and 5.4).	This has been identified as part of arrangement looking at Acute admission/assessment processes (Project 4.3 - Acute Assessment and Admission Process).	While NHS Borders have established robust governance arrangement in relation to each of our identified Programmes, there is a need to establish an overarching Board to ensure consistency, coordination and delivery. It has been agreed that this will be support via a sub group of the excecutive management team, and Programme overview reports during 2014/15.

Annex B

LUCAP 2013/14 Health Check

Please assess your progress against each action by using the traffic light system - Red, Amber and Green.
For actions you have classed as Amber or Red an explanation / narrative is required along with progress/timescales for completion where applicable.

Key

G	Implemented on a sustained basis on all sites/systems
A	Partailly implemented/Plans to implement - progress/timescale for completion?
R	Not Implemented - if not, why not?

Improvement Transformation Sustainability	Local/Site Actions											
	Site Capacity Management review of current processes by clear site leadership *Ref Annex C	Appropriate Ambulatory Care adopted	Set challenging discharge targets (Time of Day and Weekend)	Protect Minors Performance at 100%	Reduce 4-5hr Breaches	Eliminate 8 & 12hr non-clinically justified patients waits/breaches	Flow Co-ordinators & Flow performance focus	GP Direct Admission to beds	Frail Elderly process agreed across sectors	Discharge Hub and Partnership Processes	Effective ward/ board rounds supported by use of Electronic Whiteboard	Clear and agreed strategy to eliminate boarding & non-clinically driven transfers between sites
NHS Borders												
Borders General Hospital	G	A	G	G	G	G	G	G	A	A	G	G
Comments	NHS Borders has significant focus on ensuring site based capacity management is in place across 7 days.	Ambulatory care pathways have been developed and specific physical capacity identified to start working toward established ambulatory care pathways from June 2014 (Project 3.2).	This is undertaken daily, and audited weekly (Project 2.1).	Specific arrangement have been identified to protect minor flow, there will be enhanced during 2014 (Project 3.4)	We have seen the overall number of 4hr breeches reduced by 30% in 2013-14 compared to the previous 12 month period. However, during the winter months performance was consistent with previous years despite a 10% increase in attendance. This suggests additional focus, particularly on flow 3 (Medical Assessment) is required. (Projects 3.3, 4.3, and 4.5)	NHS Borders had no 12 breeches during 2013-14. All 8 and any 12 hour breeches to be treated as a clinical incident and be subject to a significant adverse event review.	There is a daily focus on flow management and co-ordination that has a senior management leadership.	GP's have admission rights to Community Beds and acute assessment beds as appropriate (Projects 2.1 and 4.3).	NHS Border has invested in capacity in Older peoples services and developed direct access clinics for frailty assessment, during 2014-15 capacity within all aspect of older peoples services will continue to be developed (Projects 2.1 and 2.2).	NHS Borders is looking at local arrangements for transitional care and care co-ordination associated with discharge and anticipatory care planning (Project 2.3 and 2.5).	NHS Borders will continue to enhance process associated with electronic whiteboards and real time data availability and management. During 2014-15 this will include electronic IDL capability and task management.	Boarding and non-clinical transfers are clearly identified as performance and quality indicators within flow management arrangements (Projects 3.3, 4.1 and 4.2).