REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 26 September 2024

BY: Chief Officer

SUBJECT: Unscheduled Care Lothian Strategic Development Framework

---

1 PURPOSE

1.1 To provide an update to the East Lothian Integrated Joint Board on the implementation of, and revisions to the Unscheduled Care pillar of the (USC) Lothian Strategic Development Framework (LSDF).

2 RECOMMENDATIONS

2.1 The IJB is asked to:

i. Note the progress made in the implementation of the USC pillar of the LSDF

ii. Note the continuing challenging financial landscape and support the revisions made to the programme to maximise effective delivery of key objectives within the USC LSDF pillar.

iii. Consider the IJBs role as commissioners of USC delivery and where and how this role and function can be best utilised to deliver improved outcomes for patients.

3 BACKGROUND

3.1 The LSDF implementation book has been revised for 2024/2025 for several reasons. These include a changed and challenging financial landscape, a series of recommendations that were received by the Board since the original development of the LSDF, and new projects and programmes that have emerged, which were not sufficiently captured within the LSDF, nor in the LSDF reporting systems and governance structures.

3.2 Additionally, an annual review was conducted, and the LSDF book (attached as Appendix 1) outlines the key impacts the programme achieved in 2023/2024. The USC Tactical Committee reviewed this and developed proposals to revise the strategy. This included the development of new strategic groups to drive priority workstreams, consolidating existing workstreams into more strategic groups, and proposing revised outcome objectives and associated timelines.

3.3 The USC LSDF book has been revised according to the proposals approved by the USC Tactical Committee. It now aims to consolidate all the key workstreams under the Unscheduled Care pillar of the LSDF into one comprehensive master document. Where possible, the USC LSDF book includes links to workstream documentation, with the goal of becoming a single source of truth when seeking information on the progress of the USC programme.

Changed Financial Landscape

3.4 On 19th December, a significant budget impact was revealed. NHS in Lothian faced an increased financial gap, which had initially been 3%, but this has now risen to 7%. Comparisons across different Boards indicate a gap ranging from 7% to 14%. The budget has prioritised pay over all other pressures, leaving zero uplift for inflation, demographic pressures, drugs, supplies, and other developments.

3.5 Additionally, impact of this is expected to stretch over the next three years, which will likely create further tension between finance and performance. Despite these pressures, there remains a statutory responsibility to break even financially.

3.6 The pan-Lothian USC portfolio receives an allocation of approximately £280 million, and within that includes historic recurring investments of around £13 million to support improvement activities, and an additional £5 million from Scottish Government funding for a similar purpose.

3.7 Recovery plans have been required within 24/25 financial year in order to achieve financial balance. Key actions to achieve this include a review of the 2023/24 programme releasing around £2.1 million (predominately from slippage in projects), pausing the Flow Centre expansion (£0.5 million) and RACU expansion (£1.3 million), and reviewing historic USC investments (£0.72 million).

3.8 Currently the USC portfolio is forecast to be around £10m (~3%) overspend by the end of the 24/25 financial year.

3.9 The USC Tactical Committee agreed that focus needs to shift from delivery of “easier” savings programmes including the likes of identifying non-recurring savings, or pausing plans for expansion of specific services, into a space where the entire portfolio is reviewed, and models of care and service delivery are evaluated across the entire system with an aim to deliver improved or similar levels of care with the same of less funding. Appendix 2 details this proposed approach.

3.10 This approach is based upon the assumption that through a whole-system redesign of our models of care, with a particular view to improve care closer to home and reduce reliance on acute hospitals, efficiencies can be identified whilst improving patient care.

3.11 The Integrated Joint Board is encouraged to consider their role in shaping this process.

Changes to Programme Structure

3.12 As described in 3.2, the programme structure has been revised to ensure focus on the key USC objectives. A list of the revised programme boards/working groups is detailed below with their agreed objectives;

STRATEGIC GROUP	OBJECTIVES	CHAIR
Navigation Programme Board	• To develop and define key principles, pathways & required model(s) for the Lothian Flow Navigation Centre and each HSCP Single Point of Contact to collaboratively ensure effective navigation to the appropriate support for patients in both community or acute hospital • To provide overarching leadership to ensure alignment is maintained with the organisations wider strategic direction	Jenny Long
OT // PT Working Group	• To review current arrangements for managing and directing OT & PT resources across the health and social care system and implement the set of recommendations emerging from the working group. • To ensure adherence to HF Principles, where patients are assessed and rehabilitated at home as a default option • To define a system wide approach to risk management with a clear framework for the best place for assessment and by whom,	Jenny Long
DwD Pan-Lothian Group	• Drive forward the local and national DwD agenda (i.e.: Hospital Occupancy Action Plan/Whole System Self-Assessments) • Responsible for the oversight and assurance of key DwD workstreams across Lothian and formally capture what work is being done to support effective discharge planning across the whole system. • Provide a forum to provide the sharing/learning of effective discharge planning processes.	Grace Cowan
Pan-Lothian RACU Group	• Maximise current capacity at RACU and review pathways to enable this. • Ensure pan-Lothian equity of utilisation of this service • Refine case for further expansion of RACU at WGH and development of SJH RACU acknowledging that further work is required to identify what could be deprioritised to fund this (+ prep for 4hr EAS compliance)	David Walker
Interface Care Programme Board	• Provide leadership to enhance and embed delivery of “Interface care” services (ie H@H and other standalone interface services) to optimise and streamline access to care closer to home equitably throughout the Lothian system • To determine right sizing model for Lothian Interface Care Services to meet current and future requirements	David Hood

Frailty Programme Board	• Develop comprehensive, patient-centred care pathways integrating medical, social, and community services for frail patients across various settings, including care homes, acute hospitals, and community services. • Ensure standardised measurement, assessment, and data recording of frailty to drive a preventative approach and improve patient outcomes. • Provide leadership and direction to create consistent service models and pathways (both on acute sites & in community), ensuring equitable access and seamless transitions of care for frail patients across all geographic areas.	Pat Wynne
Early Supported Discharge	• To develop a whole-system approach to delivering the required models of care outlined in the Buchan Bed modelling exercise. These include; • 50% of general medicine and frailty patients discharged in 48 hours and 60% of surgical patients discharged within 24 hours. (Note link to frailty programme)	Oli Campbell

3.13 To complement this revision, a measurement framework has been agreed and an interactive dashboard is is under development and will shortly be available for use. This will aim to capture all the key metrics that will measure the success of the programme as well as each individual programme board. This can be found within the LSDF Implementation book (appendix 1).

4 ENGAGEMENT

4.1 The revisions to the implementation book have been presented at the USC Tactical Committee, the USC Programme Board as well as NHS Lothians Corporate Management Team. All these forums have representation from Acute, HSCPs, Clinical Leaders as well as partnership leads.

5 POLICY IMPLICATIONS

5.1 None.

6 INTEGRATED IMPACT ASSESSMENT

6.1 This is report is detailing revisions to the USC LSDF pillar, and it is acknowledged that impact assessments must be conducted through each programme board where changes are proposed.

7 DIRECTIONS

7.1 None.

8 RESOURCE IMPLICATIONS

8.1 Detailed in paragraphs 3.4 to 3.11 in this report.

9 BACKGROUND PAPERS

9.1 None

Appendices:

Appendix 1: LSDF Implementation Book

Appendix 2: USC Medium Term Financial Framework

AUTHOR'S NAME	Oliver Campbell
DESIGNATION	Programme Director, USC, NHS Lothian
CONTACT INFO	07411 548 902, oliver.campbell@nhs.scot
DATE	19/09/24

Unscheduled Care Update

LSDF – Implementation Plan

2024 // 25 →

Everything you need to know in 3 slides

USC LSDF implementation Book Update

Everything you need to know in 2 slides

(1) Context

- The LSDF implementation book has been revised for 24/25 for a series of reasons. These include;
  - A changed and challenging financial landscape
  - A series of recommendations that were received by the Board since the original development of the LSDF
  - New projects and programmes that had resultantly emerged and were not sufficiently captured within the LSDF and therefore the LSDF reporting systems and governance structures.

- In addition, the annual review was undertaken and the LSDF book outlines the key impacts the programme achieved in 23/24.
- The USC Tactical Committee reviewed all the information detailed above and developed proposals around revising the strategy.
- This included the development of new strategic groups to drive priority workstreams, consolidating existing workstreams into more strategic groups, and proposing revised outcome objectives and associated timelines.
- The USC LSDF book has been revised in line with the proposals approved by USC Tactical Committee, and now aims to bring together all the key workstreams under the Unscheduled Care pillar of the LSDF into one overarching master document.
- The USC LSDF book uses links where possible to workstream documentation, with the aim of becoming a single source of truth when seeking information on USC programme progress.

USC LSDF implementation Book Update

Everything you need to know in 2 slides

(2) Index

- The USC LSDF book seeks to tell the story of;
  - How the programme was previously structured
  - What's already been delivered
  - Changes to the financial landscape
  - What else has changed
  - The process of pulling all this above together
  - The proposed structural revisions
  - The Acute Divisions role in delivering elements of this
  - The proposed new step diagrams
  - Progress against 24/25 (tbc)

Unscheduled Care

LSDF – Implementation Book

2024 // 25 →

Lothian Strategic Development Framework

The Lothian Strategic Development Framework sets out what we want to happen over the next five years across the system, to help us to achieve our vision

The outcomes we aim to achieve through the LSDF are delivered by our five-year plans . These plans are separated into **6 Pillars**

Mental Health, Illness & Wellbeing	**Children & Young People**	**Anchor Institutions**
Primary Care	**Unscheduled Care**	**Scheduled Care**

Supported by **5 Parameters**

- **Workforce Availability**
- **Environmental Sustainability**
- **Digital**
- **Revenue Availability**
- **Capital Availability**

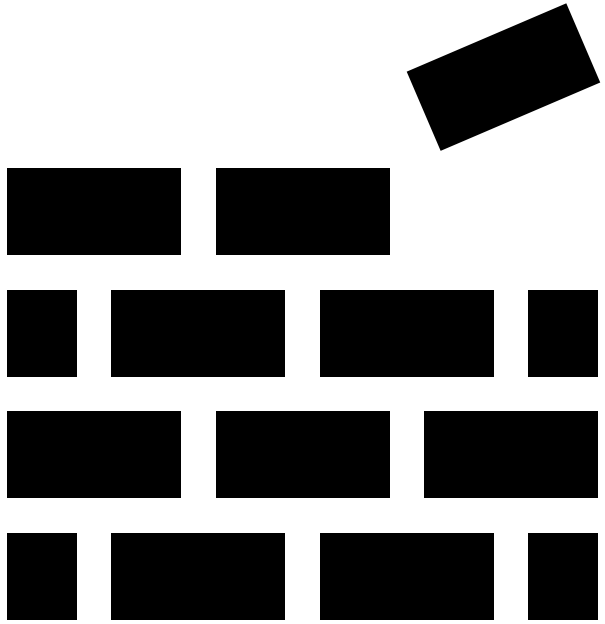
Unscheduled Care Priorities

Priority 1: **Reduce ED Attendances**

Priority 2: **Reduce Length of Stay**

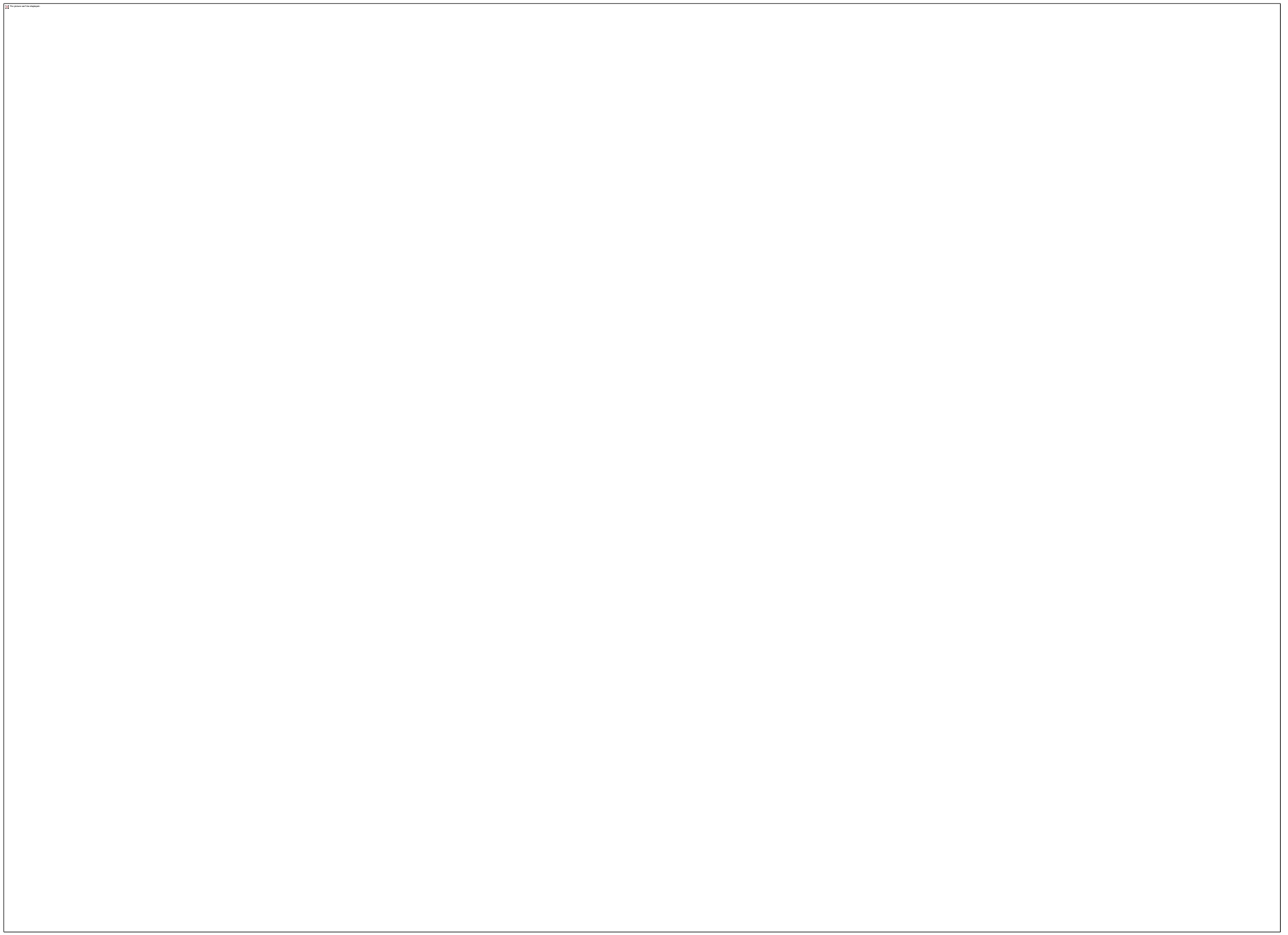
Priority 3: **Reduce Admissions**

Previous Structures



Previous Driver Diagram

Note items in italics are programmes that came online since the original development of the diagram/strategy



Previous Programme Structure

Unscheduled Care Programme Board
(Chair: Fiona Wilson and Vice Chair: Colin Briggs - Quarterly)

Unscheduled Care Tactical Committee
(Chair: Yvonne Lawton - 6 weekly)

Scheduling of Minor Injuries SLWG (Chair: V Mulholland)

FNC Programme Board (Chair: G Cunningham)

Clinical Pathway Review Board (Chair: R Cheesbrough)

ED Frequent Attenders SLWG (Chair: A Tyrothoulakis)

Front Door – Early Supported Discharge (ESD) (Chair: O Campbell)

DwD Pan Lothian Group (Chair: G Cowan)

Pan Lothian SDEC Dev. Group (Chair: L Cameron)

H@H Oversight Group (B Flynn & A Coull)

Respiratory SLWG (Chair: G Choudhury)

OPAT SLWG (Chair: C Mackintosh)

LSDF THEMES

REDUCE ED ATTENDANCES

REDUCE LoS

REDUCE ADMISSIONS

RIE Emergency Access Standard Project Board (Chair: Aris Tyrothoulakis)

WGH Emergency Access Group (Chair: Lyndsay Cameron)

SJH Emergency Access and Quality Performance (Chair: Shirley Douglas Keogh)

4 HSCPs Home First Delivery Programmes (Chaired by Heads of Health)

Where we got to 23/24

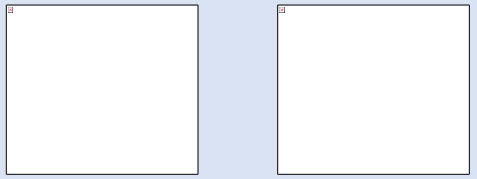
Annual Plan 2023-24 Priority 1: Reducing ED Attendance

High Level of Assurance	Medium level of Assurance	Low Level of Assurance
Currently on track to meet objectives and measurements of success No interventions required at this stage.	Some interventions required for objectives to remain on track, i.e. input and oversight from SMT, additional resourcing, etc.	Objectives and/or success measurements at risk of not being completed within the timescales and/or allocated resources. External influence impacting success.

Project	Project Brief	Assurance Level
Scheduling Minor Injuries		
Implementing sign posting and redirection at our acute front doors		
Enhancing the FNC		
Clinical pathway review and monitoring		
Single point of contact in HSCP		
Support ED frequent attenders		

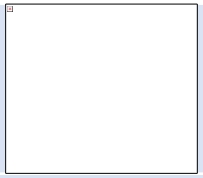
Annual Plan 2023-24
Priority 2: Reduce Length of Stay

High Level of Assurance	Medium level of Assurance	Low Level of Assurance
Currently on track to meet objectives and measurements of success No interventions required at this stage.	Some interventions required for objectives to remain on track, i.e. input and oversight from SMT, additional resourcing, etc.	Objectives and/or success measurements at risk of not being completed within the timescales and/or allocated resources. External influence impacting success.

Project	Project Brief	Assurance Level
Implementing Discharge without Delay Programme - Planned Date of Discharge (phase 2) - Early Supported Discharge (ESD)		

Annual Plan 2023-24 Priority 3: Reducing Admissions

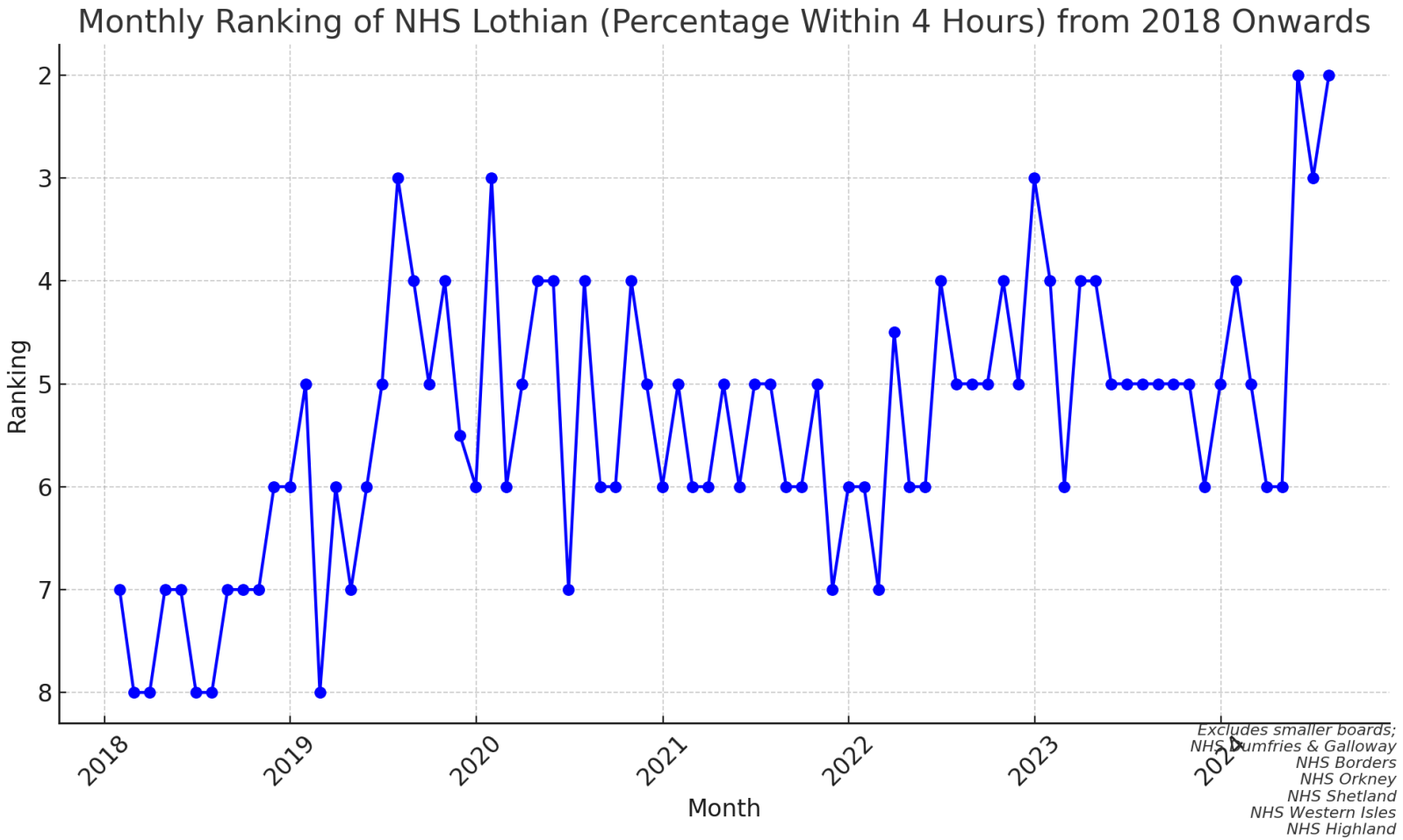
High Level of Assurance	Medium level of Assurance	Low Level of Assurance
Currently on track to meet objectives and measurements of success No interventions required at this stage.	Some interventions required for objectives to remain on track, i.e. input and oversight from SMT, additional resourcing, etc.	Objectives and/or success measurements at risk of not being completed within the timescales and/or allocated resources. External influence impacting success.

Project	Project Brief	Assurance Level
Develop Pan Lothian Rapid Assessment and Care Unit (RACU) (Previously SDEC)		
Hospital @Home (H@H)		
Enhancing OPAT Services Pan Lothian		
Enhancing Respiratory Services Pan Lothian		

LSDF Programmes // Impact to date

Continue to optimise Public **111 pathway**	**28.8%** of referrals are re-directed to alternative pathway Reduced the number of patients attending a Lothian front door setting
Implement Signposting and **Redirection**	Current re-direction rate from ED is **5.5%** of attendances.
Minor Injuries Scheduled Appointments	RIE: 25%, WGH: 40%, SJH 100%
RUC Phase 2 – Prof to Prof Pathways	**19%** of referrals flow to alternative pathway
Transition of FC to **Flow Navigation Centre**	Improved GP referrals to alternatives **19%** of patients are referred to an alternative pathway such as H@H, OPAT. CRT etc.
Augment **Single Point of Contacts (SPOC)**	
Implement DwD Pan Lothian **Spreading PDD** across Acute and Community Hospitals Patient identification through **Early Supported Discharge (ESD)**	**WLHSCP** has seen a **30% ALOS** reduction on discharge hub tracker from Dec '22 to Dec '23 **SJH:** improved discharge coordination, boosting discharge numbers and flow coordination. PDD implemented to date across 5 wards to date. **WGH:** 50% fewer delayed patient bed occupancy across PDD wards 9-day LOS reduction and 35% discharge rate increase from Phase one end to previous year Decrease in 48-hour validation rule for local RFS data PDD implemented to date across 4 wards **RIE:** PDD implemented across 3 MoE wards Discharge Forum leads on the re-launch of PDD programme Strong collaboration with LACAS site leads. Regular meetings with service leads encourage engagement, accountability for facilitation and learning opportunities **ESD:** Work commenced in December 2023 to support the early identification of patients who could be aligned to a specific ESD pathway from within AMU at the RIE. Throughout the period to date there has been a significant reduction in OBDs with EHSCP however the rationale for this is still to be fully determined. Co-location of the RIE Acute/HSCP ESD Team will commence in June 2024 which will further strengthen the daily communication to support this workstream.
Expand Rapid Assessment Care Unit @ WGH and develop one at SJH (RACU)	Around **1800 patients per month** are now seen via RACU
Develop a consistent model and expand delivery of **Hospital at Home** across each HSCP	The number of new patients admitted to the service / month has increased from a baseline average of 238 new patients / month in 2021 to **460 new patients / month on 2024 (93% increase).**
Increasing the number of patients managed on short-stay admitted pathways - Implement and strengthen **Early Supported Discharge**, and implement pan-Lothian.	EHSCP have achieved a significant reduction in total occupied bed days from the start of January 2024 saving of **31 beds per day** which is roughly equal to an acute hospital ward
Enhance alternatives to hospital admission – initial focus **Respiratory and OPAT**	The number of OPAT and Respiratory patients managed has **increased by 38% and 20%,** respectively.

Comparative National Performance for Larger Boards (excludes boards ≤25% smaller than Lothian)

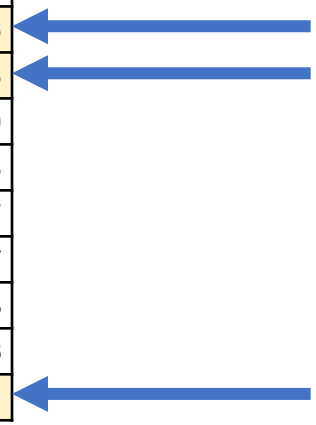


Excludes smaller boards;

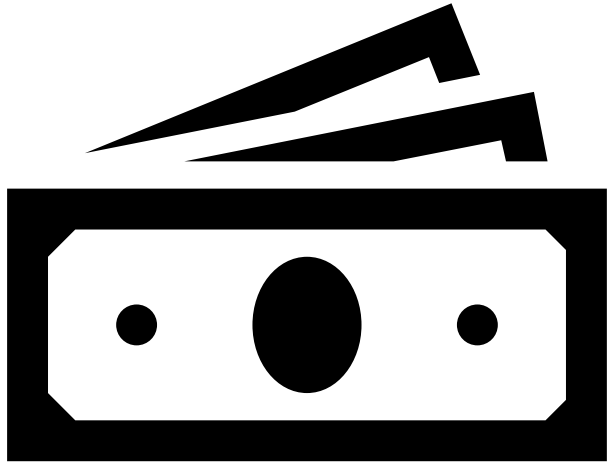
(Combined weekly attendances for the boards listed above, are still less than NHS Lothian weekly attendances)

Improved comparative performance over winter

Site Admitted Pathway Performance between January and March Relative to Other Large Mainland Sites 2022-2024 (Excludes Children's Hospitals)			
	League Table		
	2022	2023	2024
ABERDEEN ROYAL INFIRMARY	17	18	19
BORDERS GENERAL HOSPITAL	14	11	10
DUMFRIES & GALLOWAY ROYAL INFIRMARY	3	6	4
FORTH VALLEY ROYAL HOSPITAL	4	15	15
GLASGOW ROYAL INFIRMARY	12	14	14
INVERCLYDE ROYAL HOSPITAL	5	3	5
NINEWELLS HOSPITAL	2	1	1
QUEEN ELIZABETH UNIVERSITY HOSPITAL	15	12	12
RAIGMORE HOSPITAL	10	8	9
ROYAL ABERDEEN CHILDREN'S HOSPITAL	1	2	2
ROYAL ALEXANDRA HOSPITAL	18	10	18
ROYAL INFIRMARY OF EDINBURGH AT LITTLE FRANCE	19	17	16
ST JOHN'S HOSPITAL	13	13	13
UNIVERSITY HOSPITAL AYR	20	20	20
UNIVERSITY HOSPITAL CROSSHOUSE	8	7	8
UNIVERSITY HOSPITAL HAIRMYRES	11	16	17
UNIVERSITY HOSPITAL MONKLANDS	9	5	7
UNIVERSITY HOSPITAL WISHAW	7	4	3
VICTORIA HOSPITAL	6	9	6
WESTERN GENERAL HOSPITAL	16	19	11



Changed Financial Landscape



Changed Fiscal Parameters

- 19th December Budget Impact
  - NHSiL 3% gap increased to 7%
  - Board comparisons 7% to 14%
- Pay prioritised above all other pressures
- Zero uplift for inflation, demographic pressures, drugs, supplies, developments, etc
- Non-Pay deal impact over next 3 years
- Resulting tension between finance and performance
- Statutory responsibility to break even

USC Finances

Governance Overview

NHSL & IJBs

Pan Lothian Funding
Circa £280m

USC Programme Board

USC Recurring Investment
Circa £13m

SG Funding
Circa £5m

Recovery Plans Required:

- 23/24 Programme review - **£2.1m**
- Pause Flow Centre expansion - **£0.5m**
- Pause RACU expansion **- £1.3m**
- Review of USC Historic Investments **£0.72**

- **Requirement to focus on £280m portfolio in coming years**

Analysis of Pillars

Front Door

Services Included:

- Accident & Emergency (A&E)
- Medical Assessment Units
- Major Trauma
- Minor Injuries

Interface Care

Services Included:

- Respiratory Services
- Flow Centre
- Ambulatory Care
- Same Day Emergency Care (SDEC)
- OPAT
- Hospital At Home
- Hospital to Home

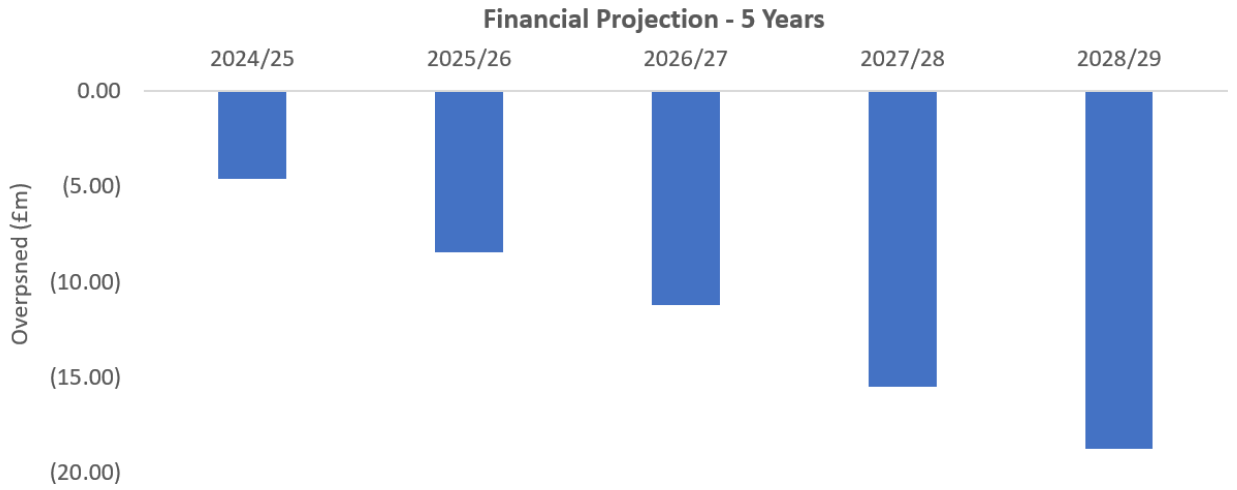
Hospital Based

Services Included:

- **Acute** – Geriatric Medicine, Cardiology, Critical Care, Infectious Diseases & General Medicine.
- **Primary Care** – Community Hospitals (excluding Mental Health wards).

Medium Term Financial Framework

The MTFF for Unscheduled care is derived from the overall NHS Lothian Financial Plan. The output from the modelling is shown →

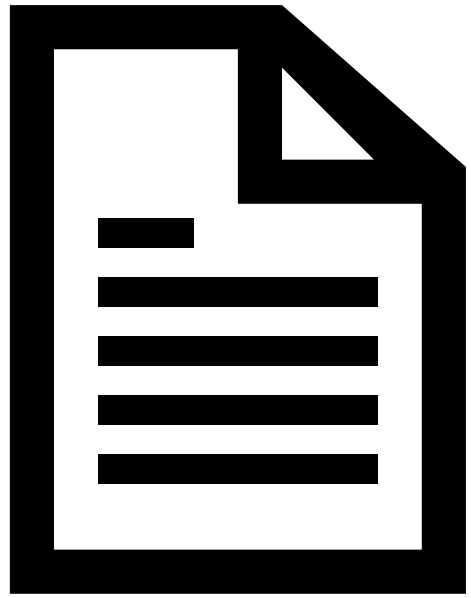


Financial Modelling Assumptions

- The baseline budget, expenditure and variance has been taken from the NHS Lothian operational financial plan.
- Pay uplift impact has not been modelled into the MTFF for 2024/25 onwards.
- After factoring in all the financial recovery actions, the results indicate that unscheduled care **will achieve a balanced financial position for 2024/25**. This projection relies on the implementation and full delivery of the recovery actions and is supported by one-off benefits from the stop and assess initiative.
- *Population growth has not been included in the model*

External Recommendations & New Workstreams

(received/developed since original development of LSDF)



RIE Emergency Access Standard Programme Board
Diagnostic review recommendations

Diagnostic review in 2023/24 within **RIE** identified **29 recommendations** across six themes - **25 have been implemented**

Five high priority recommendations

1. Relocate Interface Service - outstanding environmental issues
2. Review and revise ED operating model - further work required to ensure the model is fully implemented
3. Review and refine escalation model, including roles and responsibilities of the site capacity team - further work required to ensure the site & capacity model is fit for purpose
4. Clinical Leadership Forum in place - complete
5. Enhanced performance and improvement reporting in place - complete

RIE Emergency Access Standard Programme Board
Outstanding RIE EAS recommendations

- Ensure Trak is completed in a timely manner across all wards and services - significant work required

- Revised surgical pathways to be completed - June 2024

- ED, AMU and SOU operating models - 14th June

- Rollout eObs to ED - requires further changes to Trak - implementation plan required

Centre for Sustainable Delivery (CfSD) Outputs (1)

Recommendations to NHS Lothian from CfSD Discovery Debrief Session ;

Benchmarking Link Here

- Increasing primary care access to alternatives to the emergency department such as H@H, RAAC/Ambulatory Care/SDEC and hot clinics
- Optimising the use of clinical spaces in ED, through early access to decision makers, rapid assessment and streaming
- ‘Rightsizing’ the assessment function and developing an ‘in reach’ model to support early ownership and ward moves
- Enabling direct admissions to specialties where appropriate (bypassing ED)
- Increasing the number of patients managed on short-stay admitted pathways
- Reducing the number of long-stay patients in hospital (particularly non-delayed patients)
- Focus on reducing LOS for key high volume pathways by increasing community capacity, particularly for rehabilitation and re-ablement services.

CfSD Outputs (2) - Leverage Points

Aim	Methodology
1	Local impact if your organisation matched the mainland Scotland average (calculated excluding your board)
2	Local impact if your organisation matched the average for the top 75 percentile performing mainland boards.
3	Local impact if your organisation matched the average for the upper quartile performing mainland boards.
4	Local impact if your organisation matched the top performing mainland board in this area.

NHS Lothian CFSD Leverage Points	Current Typical Day	Aim1	Aim2	Aim3	Aim4	% req'd to next point
Reduce the **average LOS** in the Emergency Department for patients that **get admitted** to hospital after arriving between the hours of 5pm to 5am (Overnight)	492	424	387	279	204	-14%
Reduce the **average LOS** in the Emergency Department for patients that **get admitted** to hospital after arriving between the hours of 5am to 5pm (Day Time)	437	361	326	265	180	-17%
Reduce the **average LOS** in the Emergency Department for patients that **do not get admitted** to hospital after arriving between the hours of 5pm to 5am (Overnight Time).	223		206	150	144	-8%
Reduce the **average LOS** in the Emergency Department for patients that **do not get admitted** to hospital after arriving between the hours of 5am to 5pm (Day Time)	184	181	168	125	117	-2%
Reduce the average **time to first assessment** in Emergency Department for patients that **get admitted** to hospital after arriving between the hours of 5pm to 5am (Overnight)	102			70	41	-31%
Reduce the average **time to first assessment** in Emergency Department for patients that **get admitted** to hospital after arriving between the hours of 5am to 5pm (Day Time)	89		71	62	30	-20%
Reduce the average time to **first assessment** in Emergency Department for patients that **do not get admitted** to hospital after arriving between the hours of 5pm to 5am (Overnight Time)	91		87	71	45	-4%
Reduce the average time to **first assessment** in Emergency Department for patients that **do not get admitted** to hospital after arriving between the hours of 5am to 5pm (Day Time)	67		60	50	34	-10%
Reduce the number of patients in Acute & Community hospital beds with a **LOS >14 days**	1,270		1,140	1,007	835	-10%
Reduce the number of non-delayed patients in Acute & Community hospital beds with a **LOS >14 days**	1014		852	766	578	-16%
Reduce the number of patients in acute and community hospital beds affected by **standard delays**	166			162	135	-2%
Reduce the number of patients in acute and community hospital beds affected by **AWI delays**	50			34	26	-32%

Buchan Bed Modelling

a) Demographic Growth

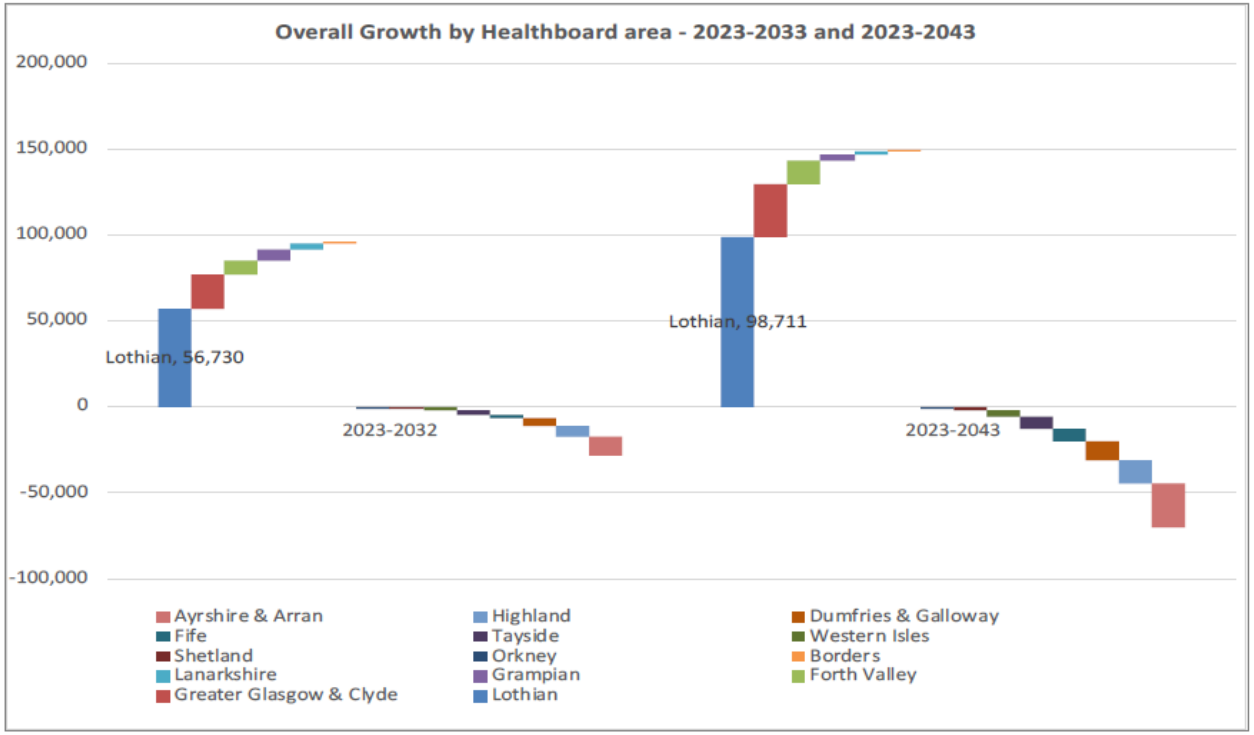
Demographic growth

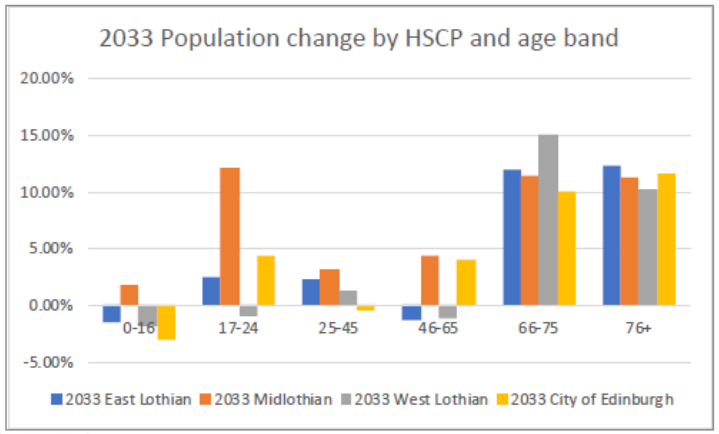
National Records of Scotland (NRS) sub-national projections by age, gender and local authority.

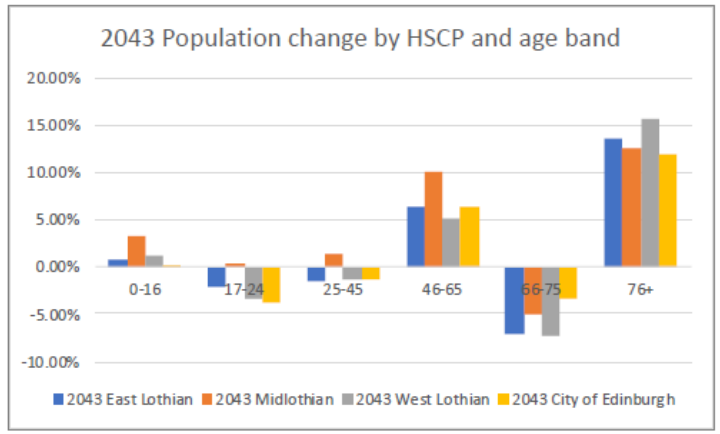
Source:https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/sub-national-population-projections/2018-based

~10% growth every 5 years

84% of all growth in Scotland 2023-33 within NHS Lothian (125% 2023-2043)

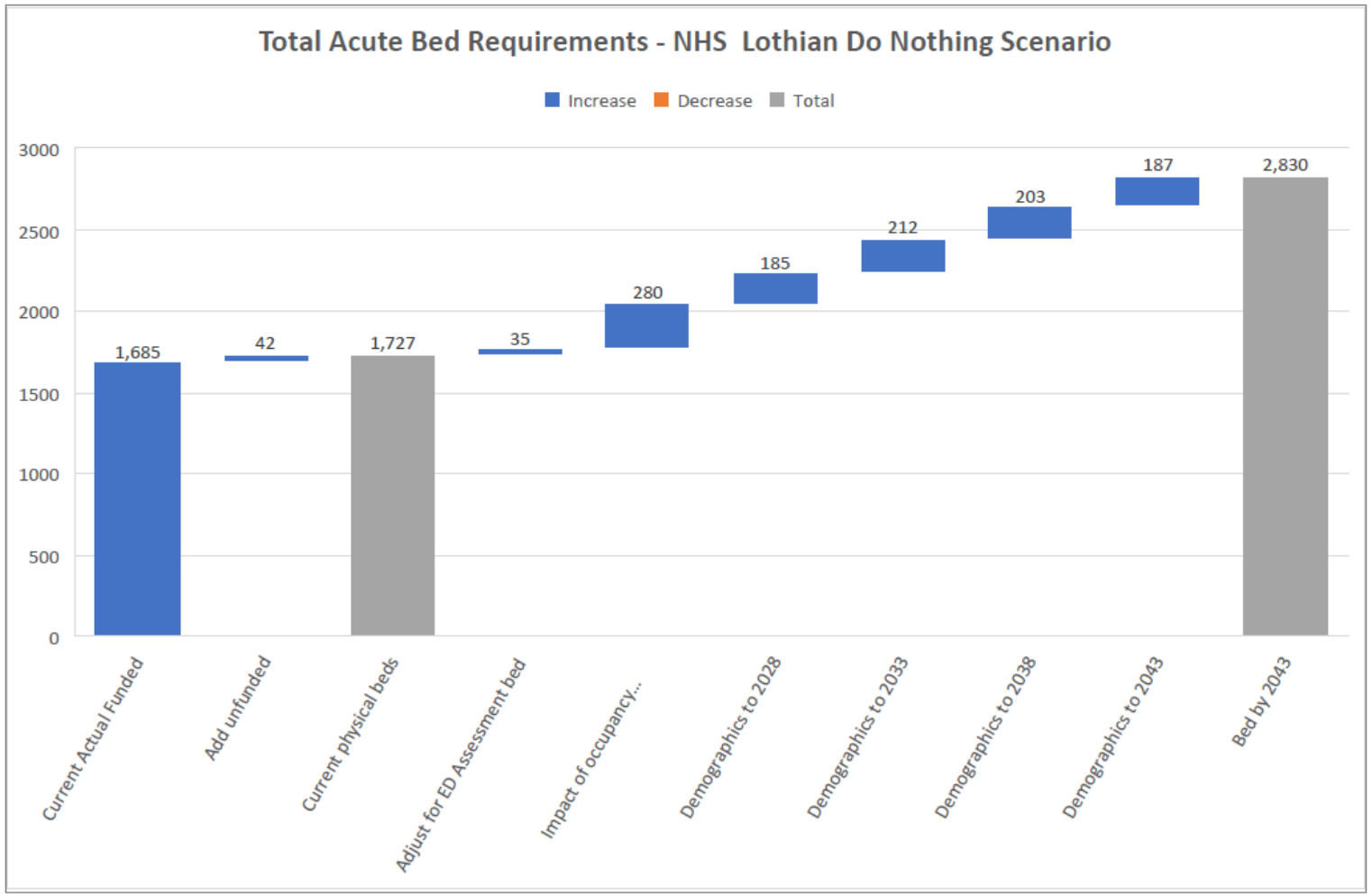






Buchan Bed Modelling

a) Demographic Change – bed impact all acute sites

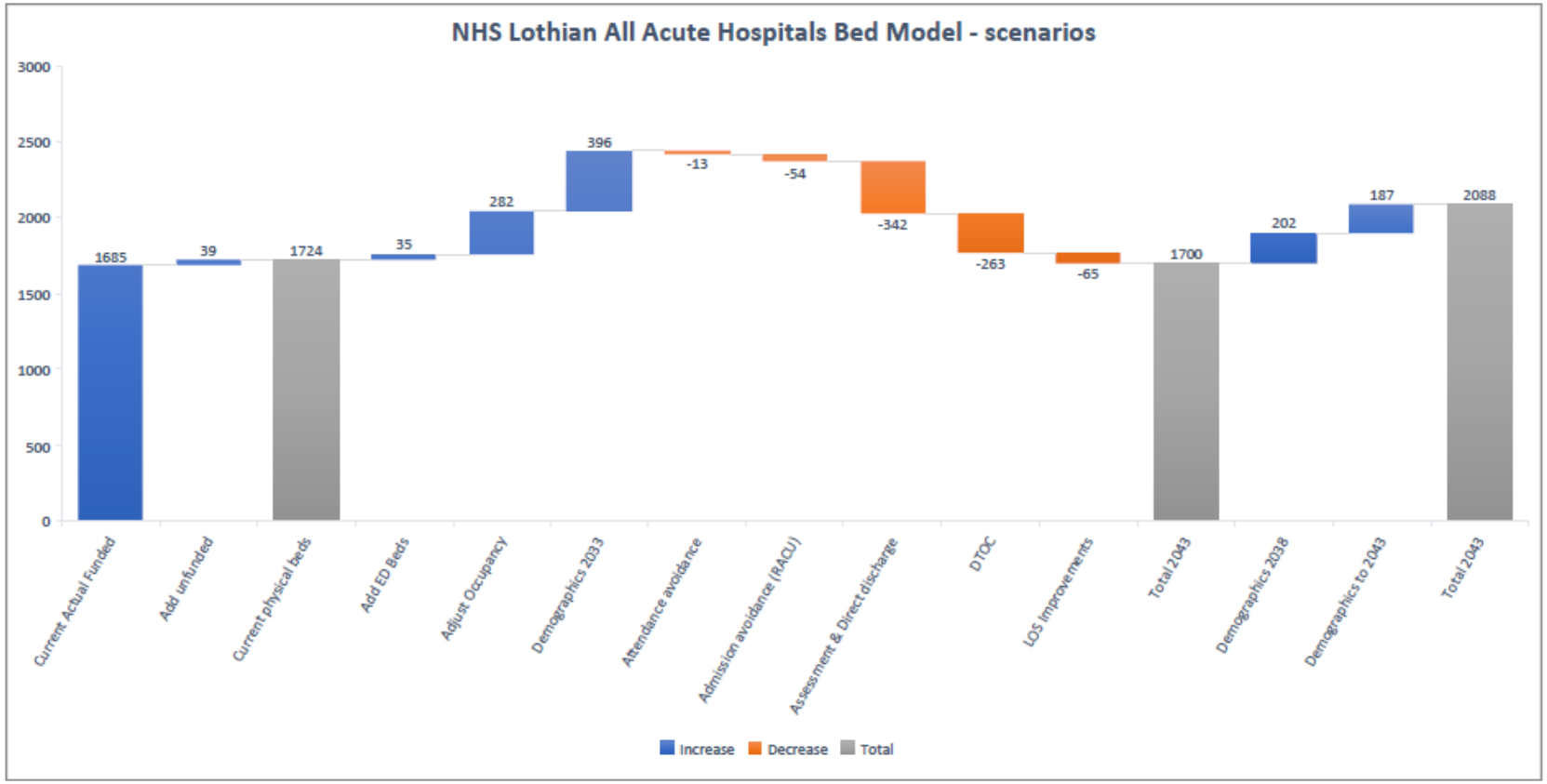


Significant growth across all sites due to:

- current over occupancy, both within ED (42 beds) and inpatient areas (273 beds). Including adjusting for the current use of non-inpatient areas for overnight care.
- demographic growth, equating to an average of ~200 additional beds every 5 years.

Buchan Bed Modelling – Mitigating Actions

Scenarios b-e) bed impact all acute sites



Significant change needed to implement scenarios.
By 2033, the improvements will mitigate the growth and occupancy; however, additional capacity is required by 2043.

New Workstreams

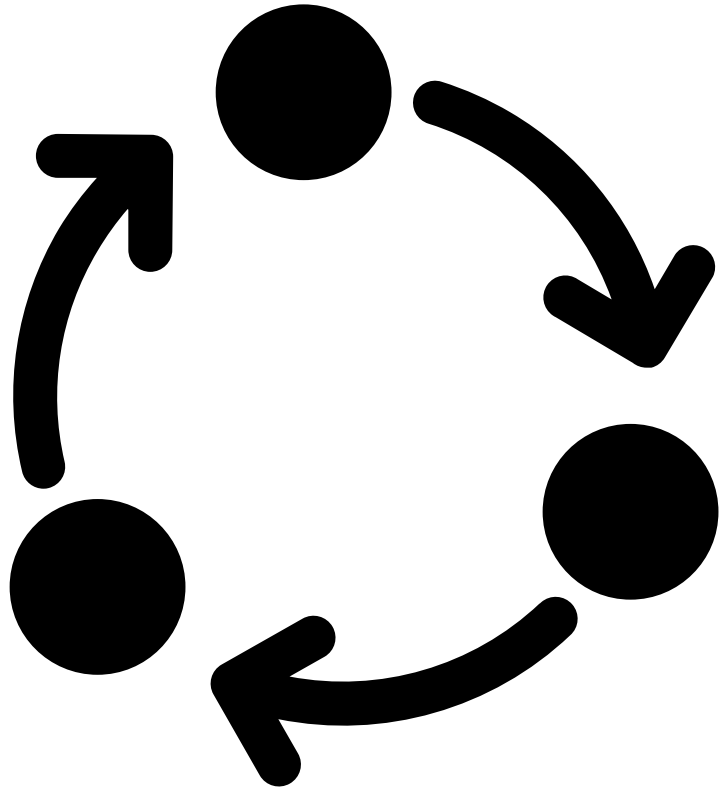
programmes/developments that came online since the original development of the diagram/strategy

- ***Specialty by Specialty LoS*** *programme in Acute*
- *Implementation of* ***Discharge Framework***
- *Review and further implementation of* ***Flowthian***
- *Review of AHP* ***(OT/PT) models of care*** *to improve flow*
- *Implement and strengthen* ***Early Supported Discharge*** *and implement pan-Lothian*
- ***Buchan Bed Modelling*** *outputs*
- *Whole System Responsiveness* ***(consistent implementation of escalation framework)***
- *Partnership* ***Bed Occupancy Report / Ownership***
- *Implementation of* ***RIE External Review Recommendations***

Women's Health Plan - TBC

- No explicit recommendations for USC
- However, work required to ensure all principles found in WHP are reflected in the USC programmes

Pulling it all together



LSDF, CfSD & Buchan Outputs: Thematical Mapping

				LSDF										
Generalised Theme	**CFSD Executive Recommendations**	**Buchan Bed Modelling Scenarios**	**Buchan Modelled Impact**	**Reduce ED Attendance**	**Reduce Length of Stay**	**Reduce Admissions**	**NHS Lothian CFSD Leverage Points**	**Current Typical Day**	**Aim1**	**Aim2**	**Aim3**	**Aim4**	**% req'd to next point**
ADMITTED FLOW	**'Rightsizing' the assessment function and developing an 'in reach' model to support early ownership and ward moves**	**Assessment bedpool Target discharge/ flow interval Target discharge rate within this interval General Medicine 48hrs 50% Frailty 48hrs 50% Surgery 24hrs 60%**	**342 beds released**	✓	✓	✓	Reduce the **average LOS** in the Emergency Department for patients that **get admitted** to hospital after arriving between the hours of 5pm to 5am (Overnight)	492	424	387	279	204	-14%
	Increasing primary care access to alternatives to the emergency department such as H@H, RAAC/Ambulatory Care/SDEC and hot clinics	**The modelled impact of other HSCPs achieving the same reduction in ED attendances over 10 years as West Lothian has achieved in the last 4 years, with West Lothian reducing by a further 1% per year Expand RACU/SDEC to the full range of pathways across all sites over the next 10 years. 274 diagnosis codes; ~131 pathways**	**67 Beds released**				Reduce the **average LOS** in the Emergency Department for patients that **get admitted** to hospital after arriving between the hours of 5am to 5pm (Day Time)	437	361	326	265	180	-17%
NON-ADMITTED FLOW	**Optimising the use of clinical spaces in ED, through early access to decision makers, rapid assessment and streaming Enabling direct admissions to specialties where appropriate (bypassing ED)**			✓			Reduce the **average LOS** in the Emergency Department for patients that **do not get admitted** to hospital after arriving between the hours of 5pm to 5am (Overnight Time).	223		206	150	144	-8%
				✓			Reduce the **average LOS** in the Emergency Department for patients that **do not get admitted** to hospital after arriving between the hours of 5am to 5pm (Day Time)	184	181	168	125	117	-2%
ED PROCESSES - ADMITTED				✓		✓	Reduce the average **time to first assessment** in Emergency Department for patients that **get admitted** to hospital after arriving between the hours of 5pm to 5am (Overnight)	102			70	41	-31%
				✓		✓	Reduce the average **time to first assessment** in Emergency Department for patients that **get admitted** to hospital after arriving between the hours of 5am to 5pm (Day Time)	89		71	62	30	-20%
ED PROCESSES - NON-ADMITTED				✓			Reduce the average time to **first assessment** in Emergency Department for patients that **do not get admitted** to hospital after arriving between the hours of 5pm to 5am (Overnight Time)	91		87	71	45	-4%
				✓			Reduce the average time to **first assessment** in Emergency Department for patients that **do not get admitted** to hospital after arriving between the hours of 5am to 5pm (Day Time)	67		60	50	34	-10%
LENGTH OF STAY	**Focus on reducing LOS for key high volume pathways by increasing community capacity, particularly for rehabilitation and re-ablement services.**	**An opportunity to improve length of stay (LOS) through specialty benchmarking**	**120 beds released**		✓	✓	Reduce the number of patients in Acute & Community hospital beds with a **LOS >14 days**	1,270		1,140	1,007	835	-10%
	Reducing the number of long-stay patients in hospital (particularly non-delayed patients)				✓	✓	Reduce the number of non-delayed patients in Acute & Community hospital beds with a **LOS >14 days**	1014		852	766	578	-16%
DELAYS		**Acute delays removed by site and HSCP based on Delayed Transfers of Care (DToC)**	**263 beds released**		✓	✓	Reduce the number of patients in acute and community hospital beds affected by **standard delays**	166			162	135	-2%
							Reduce the number of patients in acute and community hospital beds affected by **AWI delays**	50			34	26	-32%

Outputs from USC Tactical Committee Prioritisation Workshop (April 24)

New broader aim
(a key output from USCTC workshop)

To enable people who need urgent care, to access it in a timely manner, in a setting best suited to their needs

- KPIs
  - Trend of attendance and admission rates/1000 population into ED by HSCP, split by SIMD
    - Target = reducing trend on baseline tbc
  - 4hrEAS
    - Admitted
    - Non-admitted (target = 85%)
  - Bed Occupancy
    - Target = 85%

Outputs from USC Tactical Committee Prioritisation Workshop (April 24)

- **Emerging programmes**;
  - Focus on reducing LOS for key high-volume pathways by increasing **community capacity, particularly for rehabilitation and reablement services**.
  - Reducing the number of **long-stay patients in hospital** (particularly non-delayed patients)
  - Develop strategy around **Realistic Medicine** in USC
  - System **Frailty** / **Co-morbidity** workstream
  - 'Rightsizing' the acute **assessment function** and developing an 'in reach' model to support early ownership and ward moves

- **Consolidating Programmes**
  - **FNC & SPOCS under 1x navigation programme board**;
    - Implement Signposting and Redirection
    - Develop enhanced Prof 2 Prof Pathways
    - Schedule Minor Injuries Appointments & GP Flow
  - **Hospital at Home and Interface Care** workstreams consolidated under one oversight group
  - **DwD / PDD / Discharge Framework / ESD** to be overseen by Lothian DwD Programme Board

2024/25 Corporate Objective
Actions to achieve

"Review the Implementation Book and implement the revised 24-25 step, with a **focus on non-admitted performance to be at least 85% across the system**."

Current non-admitted performance = 79%

Initial actions proposed at the Senior Leadership event 23/05/24 to achieve this aim;

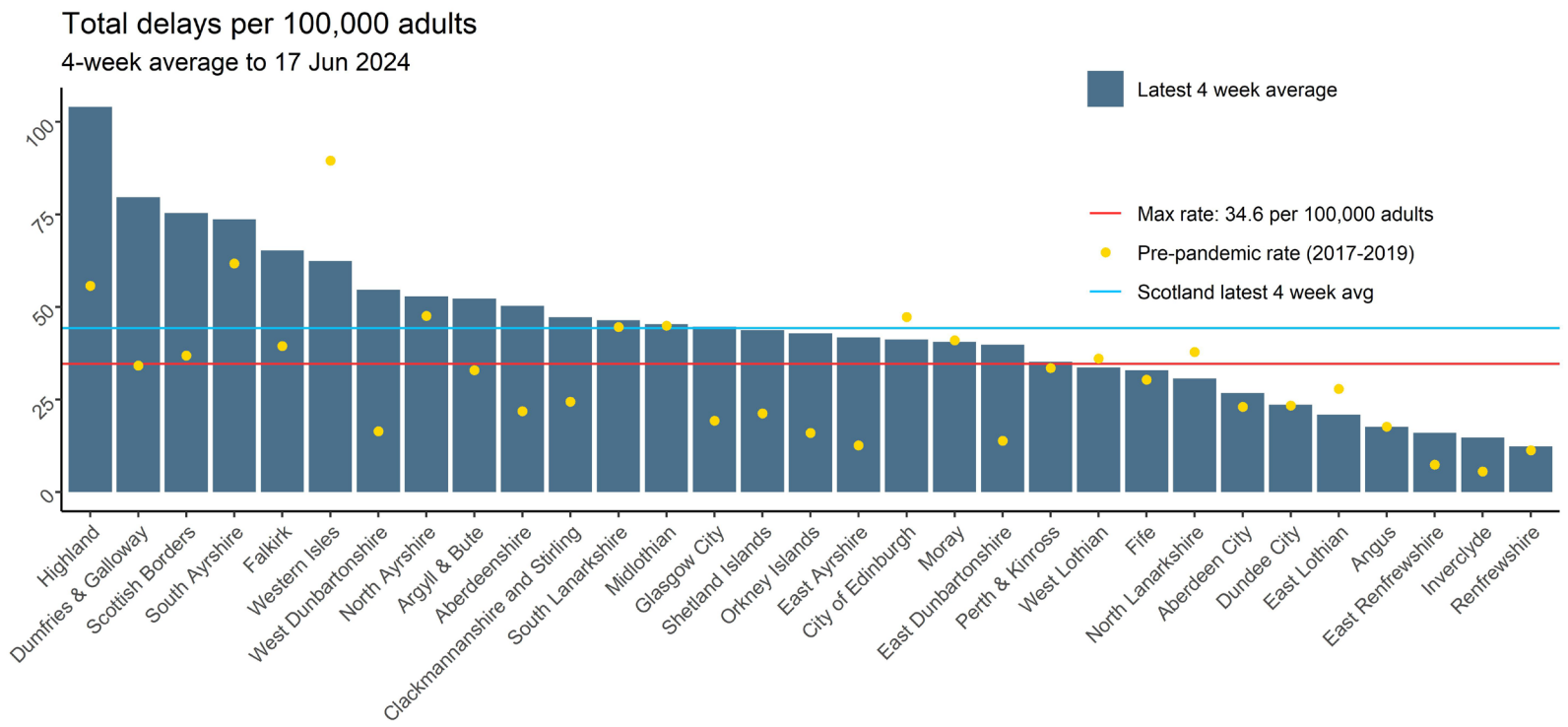
- → Increased development of, and utilisation of hot clinics
- → Work with FNC/SAS to reduce no. of care home attendances
- → Review "thresholds" for EDs, align with realistic medicine
- → Evaluate current use of RACU with view to maximising available capacity and resource
- → Review diagnostic pathways with view to improve flow and reduce number undertaken within an urgent ED context

New focus on DWD

To reduce the total number of delays in Scotland to the national pre-pandemic levels (1,410) with a “rate cap” approach, it is necessary for Partnerships to reduce delayed discharges to a **maximum of 34.6 delays per 100,000 resident adults** in any area.

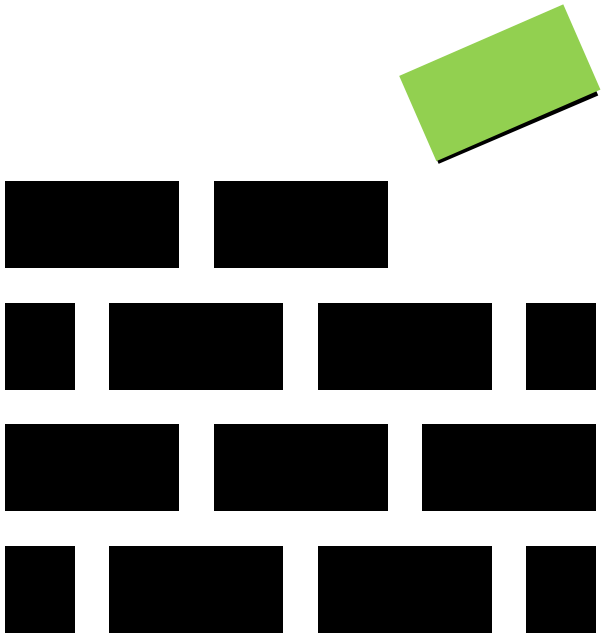
For some areas, this means reducing to below the regional pre-pandemic rate.

Partnerships with delays below 34.6 per 100,000 should remain at or below their baseline rate (4-week average to 13 May)



Revised & Proposed Structures

To deliver identified priorities

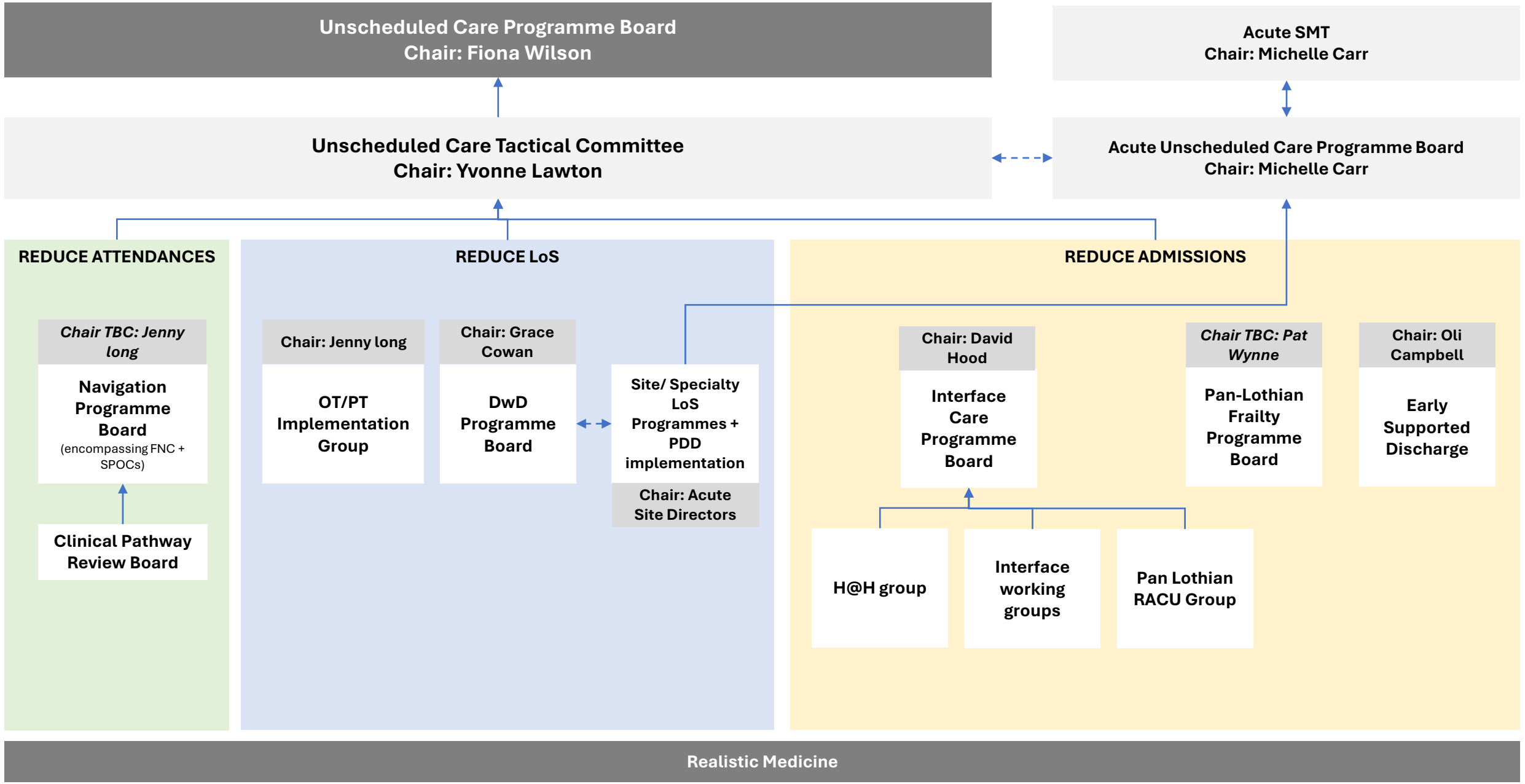


Proposed // Revised Driver Diagram

(Based on USCTC prioritisation exercise)

Proposed // Revised Programme Structure

(Based on USCTC prioritisation exercise)



Proposed // Revised USC Measurement Framework WORK IN PROGRESS

- Attendance rates/1000 population into ED by HSCP (total population and >75s)
- Unplanned Admission rates/1000 population by HSCP (total population and >75s)
  - Target = reducing trend on baseline tbc
- 4hrEAS
  - Admitted
  - Non-admitted (target = 85%)
- Bed Occupancy
  - Target = 85%
  - Emergency bed day rate for adults (per 1000 population)

- Attendance rates/1000 population at ED by HSCP (total population and >75s)

REDUCE ATTENDANCES

Navigation Programme Board (encompassing FNC + SPOCs)

% redirection

% Utilisation of alternative capacity

Clinical Pathway Review Board

- Total occupied bed days for all patients, and patients in delay
- Actual LoS vs PDD LoS vs Target LoS
- % Bed Occupancy

REDUCE LoS

OT/PT Implementation Group

TOBDs for patients not in / and in delay

DwD Programme Board

Site/ Specialty LoS Programmes + PDD implementation

Actual & Planned (PDD) LoS for each specialty against targets

% PDD set within 48 hours of entering ward

- Admission rates/1000 population by HSCP (total population and >75s)
- Proportion of last 6 months of life spent on acute site
- % of frailty patients discharged within 48hours
- % of General Medicine patients discharged within 48hours
- % of Surgical patients discharged within 24hours

REDUCE ADMISSIONS

Interface Care Programme Board

Number of appointments that would have been ED attendances and admissions#
Trend in admission rates by relevant condition

Pan-Lothian Frailty Programme Board

Trend in admission rates for those categorised as frail

TOBD for those categorised as frail

ESD Project Board

TOBD for unplanned patients

% discharged from AMUs within selected timescales

H@H group

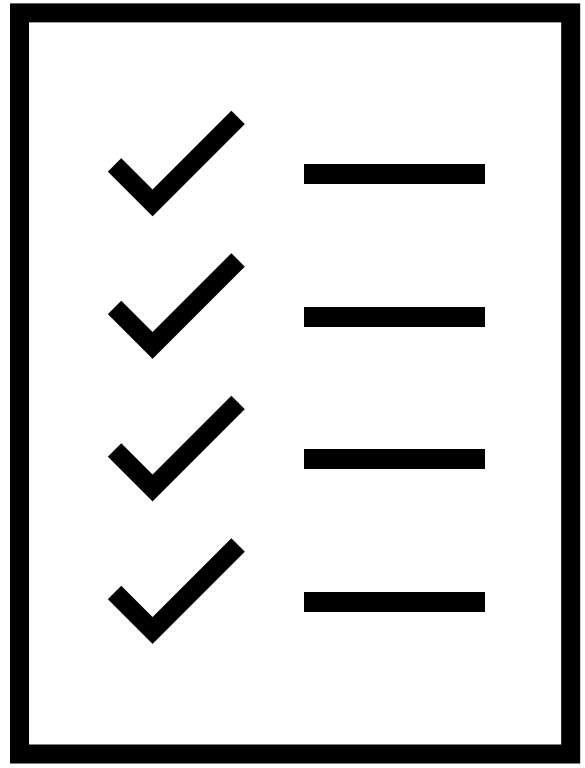
Interface working groups

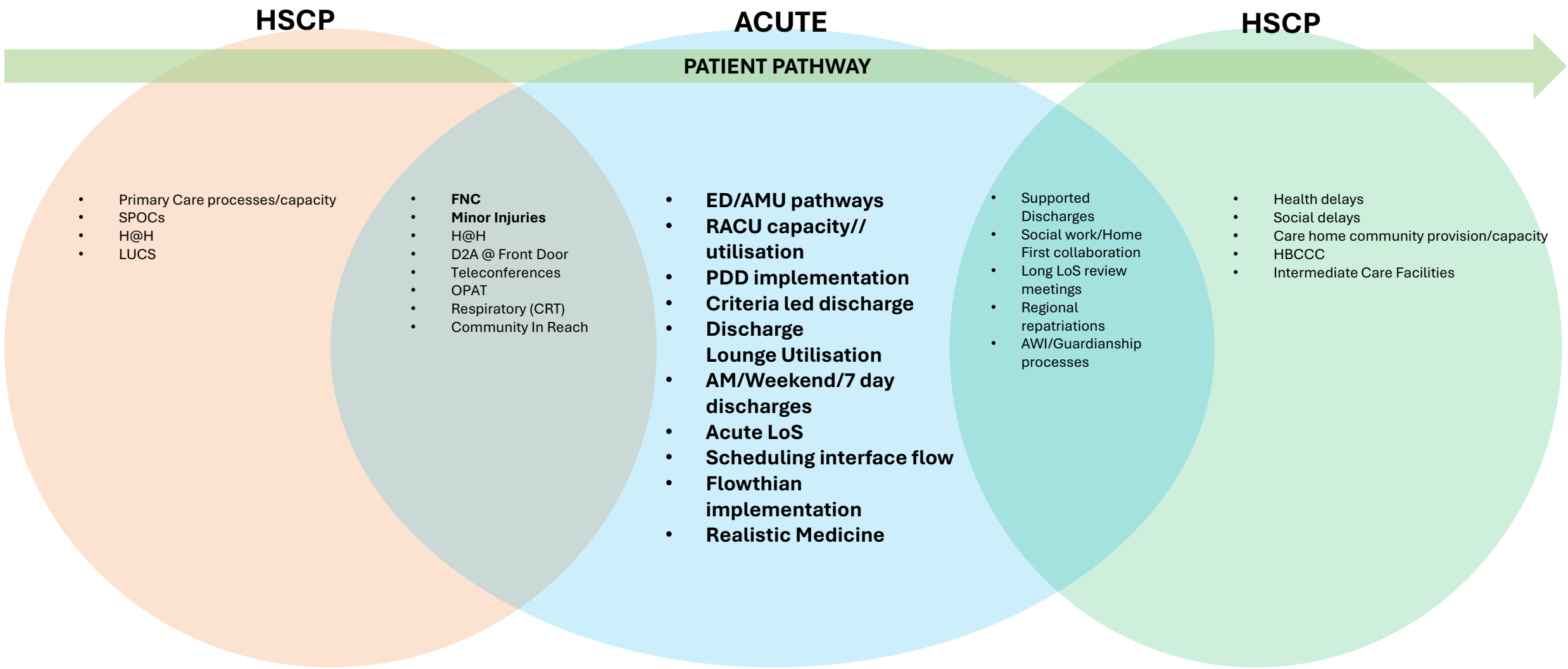
Pan Lothian\ RACU Group

Realistic Medicine

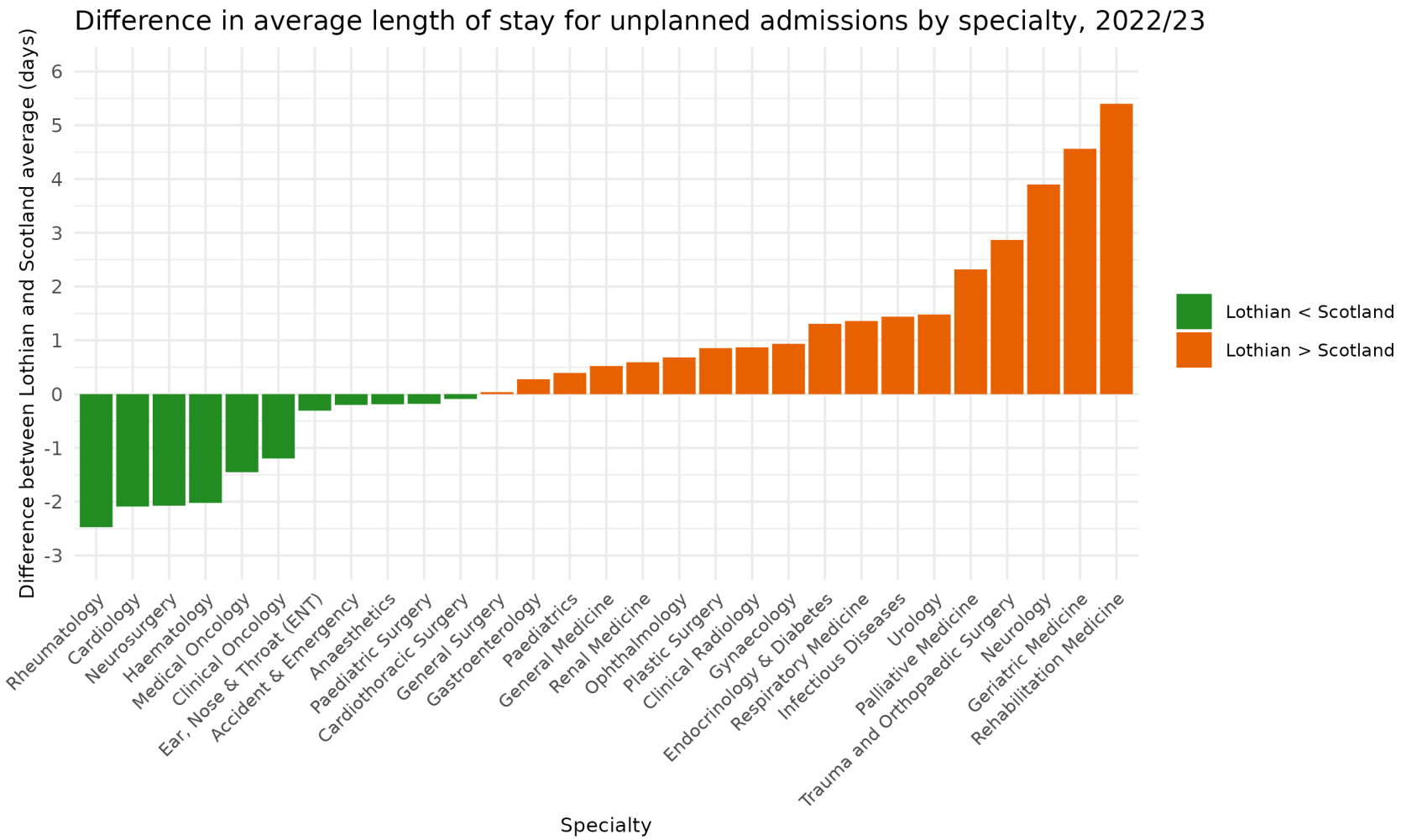
STRATEGIC GROUP	DRAFT PROPOSED PURPOSE	CHAIR
Navigation Programme Board	• To develop and define key principles, pathways & required model(s) for the Lothian Flow Navigation Centre and each HSCP Single Point of Contact to collaboratively ensure effective navigation to the appropriate support for patients in both community or acute hospital • To provide overarching leadership to ensure alignment is maintained with the organisations wider strategic direction	Jenny Long
OT // PT Working Group	• To review current arrangements for managing and directing OT & PT resources across the health and social care system and implement the set of recommendations emerging from the working group. • To ensure adherence to HF Principles, where patients are assessed and rehabilitated at home as a default option • To define a system wide approach to risk management with a clear framework for the best place for assessment and by whom,	Jenny Long
DwD Pan-Lothian Group	• Drive forward the local and national DwD agenda (i.e.: Hospital Occupancy Action Plan/Whole System Self-Assessments) • Responsible for the oversight and assurance of key DwD workstreams across Lothian and formally capture what work is being done to support effective discharge planning across the whole system. • Provide a forum to provide the sharing/learning of effective discharge planning processes.	Grace Cowan
Pan-Lothian RACU Group	• Maximise current capacity at RACU and review pathways to enable this. • Ensure pan-Lothian equity of utilisation of this service • Refine case for further expansion of RACU at WGH and development of SJH RACU acknowledging that further work is required to identify what could be deprioritised to fund this (+ prep for 4hr EAS compliance)	David Walker
Virtual Capacity Group	• Provide leadership to enhance and embed delivery of virtual capacity services (ie H@H and interface services) to optimise and streamline access to care closer to home equitably throughout the Lothian system • To determine right sizing model for Lothian Virtual Capacity Services to meet current and future requirements	David Hood
Frailty Programme Board	• Develop comprehensive, patient-centred care pathways integrating medical, social, and community services for frail patients across various settings, including care homes, acute hospitals, and community services. • Ensure standardised measurement, assessment, and data recording of frailty to drive a preventative approach and improve patient outcomes. • Provide leadership and direction to create consistent service models and pathways (both on acute sites & in community), ensuring equitable access and seamless transitions of care for frail patients across all geographic areas.	Pat Wynne
Early Supported Discharge	• To develop a whole-system approach to delivering the required models of care outlined in the Buchan Bed modelling exercise. These include; • 50% of general medicine and frailty patients discharged in 48 hours and 60% of surgical patients discharged within 24 hours. (Note link to frailty programme)	Oli Campbell

Acute USC Programme Board




HSCP
ACUTE
HSCP
PATIENT PATHWAY
Primary Care processes/capacity
SPOCs
H@H
LUCS
FNC
Minor Injuries
H@H
D2A @ Front Door
Teleconferences
OPAT
Respiratory (CRT)
Community In Reach
ED/AMU pathways
RACU capacity// utilisation
PDD implementation
Criteria led discharge
Discharge Lounge Utilisation
AM/Weekend/7 day discharges
Acute LoS
Scheduling interface flow
Flowthian implementation
Realistic Medicine
Supported Discharges
Social work/Home First collaboration
Long LoS review meetings
Regional repatriations
AWI/Guardianship processes
Health delays
Social delays
Care home community provision/capacity
HBCCC
Intermediate Care Facilities

Reducing Length of Stay – Key Acute Programme



Latest Emergency length of stay

BY NHS BOARD

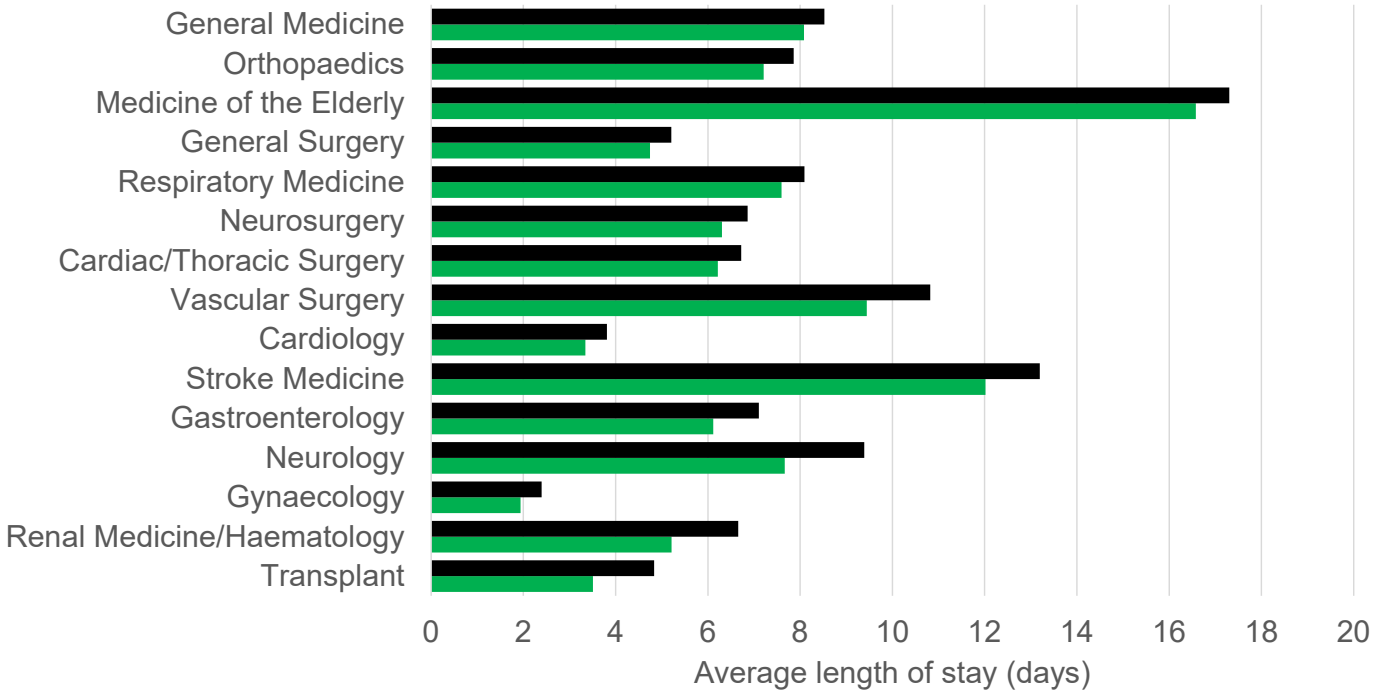
NHS Board	Latest Emergency length of stay
NHS Lothian	8.7
NHS Greater Glasgow and Clyde	7.8
NHS Ayrshire and Arran	7.6
NHS Lanarkshire	7.4
Scotland	7.3
NHS Grampian	7.3
NHS Western Isles	7.3
NHS Borders	6.9
NHS Highland	6.4
NHS Tayside	6.4
NHS Fife	5.8
NHS Golden Jubilee	5.5
NHS Forth Valley	5.2
NHS Orkney	5.2
NHS Dumfries and Galloway	4.6
NHS Shetland	3.7

RIE: Proposed changes in length of stay

NHS LOTHIAN | ROYAL INFIRMARY OF EDINBURGH

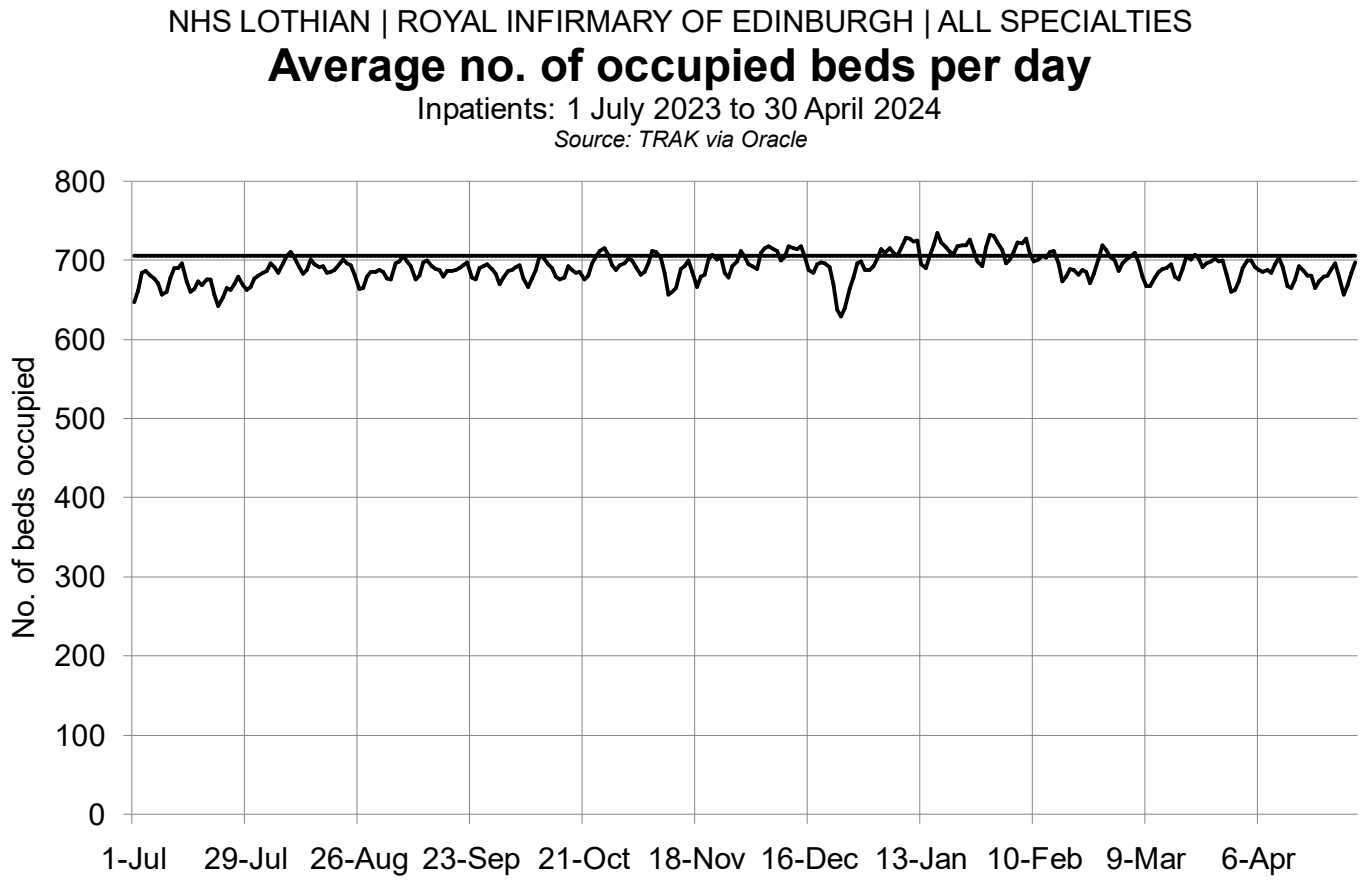
Actual average length of stay Jul-23 to Apr-24 and proposed average length of stay

Source: TRAK via Oracle

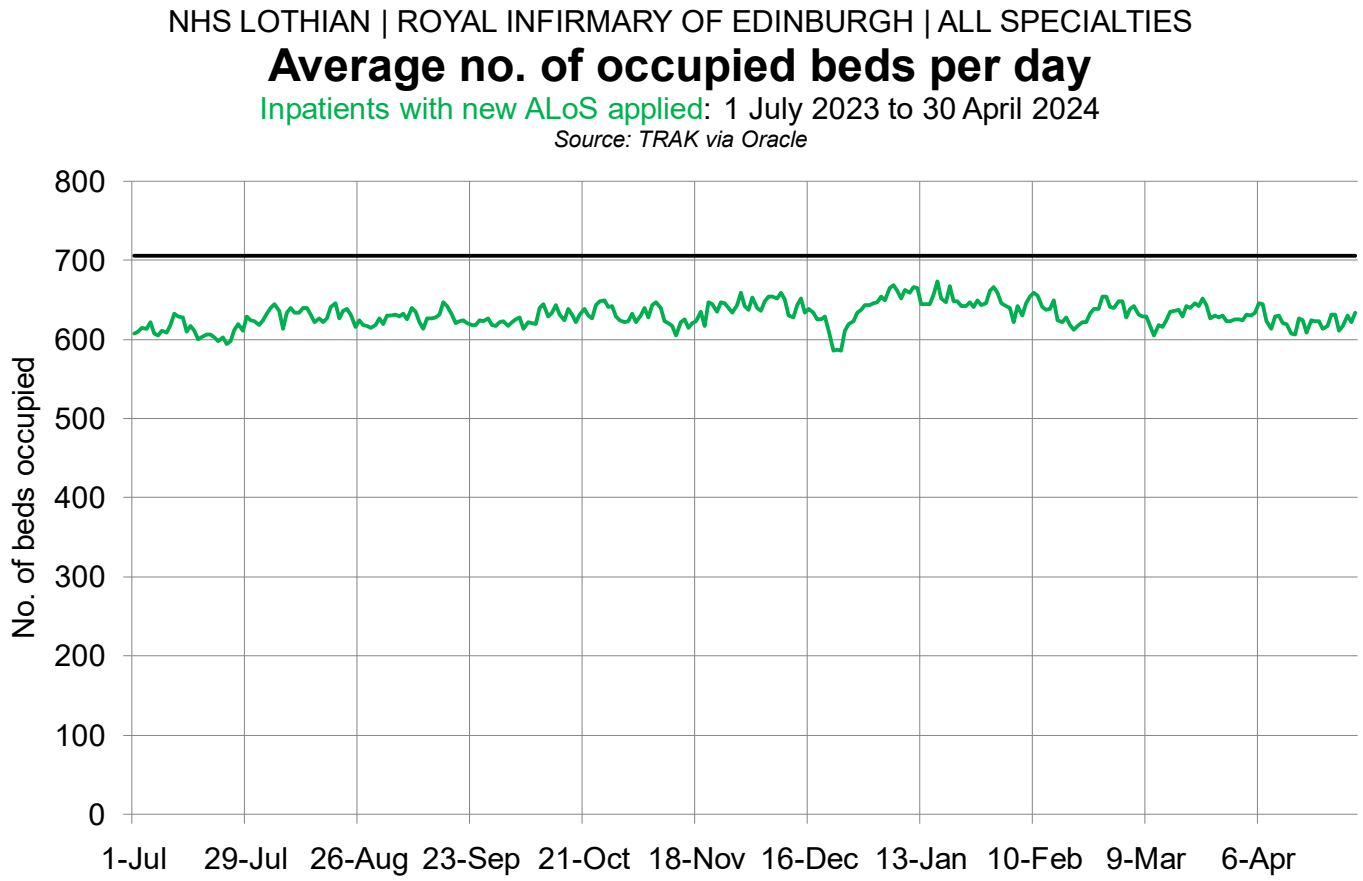


Specialty	ALoS (days)	Proposed ALoS (days)
General Medicine	8.53	8.08
Orthopaedics	7.86	7.21
Medicine of the Elderly	17.30	16.58
General Surgery	5.21	4.75
Respiratory Medicine	8.10	7.60
Neurosurgery	6.86	6.30
Cardiac/Thoracic Surgery	6.72	6.22
Vascular Surgery	10.82	9.45
Cardiology	3.81	3.35
Stroke Medicine	13.20	12.02
Gastroenterology	7.11	6.11
Neurology	9.39	7.66
Gynaecology	2.40	1.94
Renal Medicine/Haematology	6.66	5.21
Transplant	4.83	3.51
Total	**7.34**	**6.65**

What if..? (all specialties)



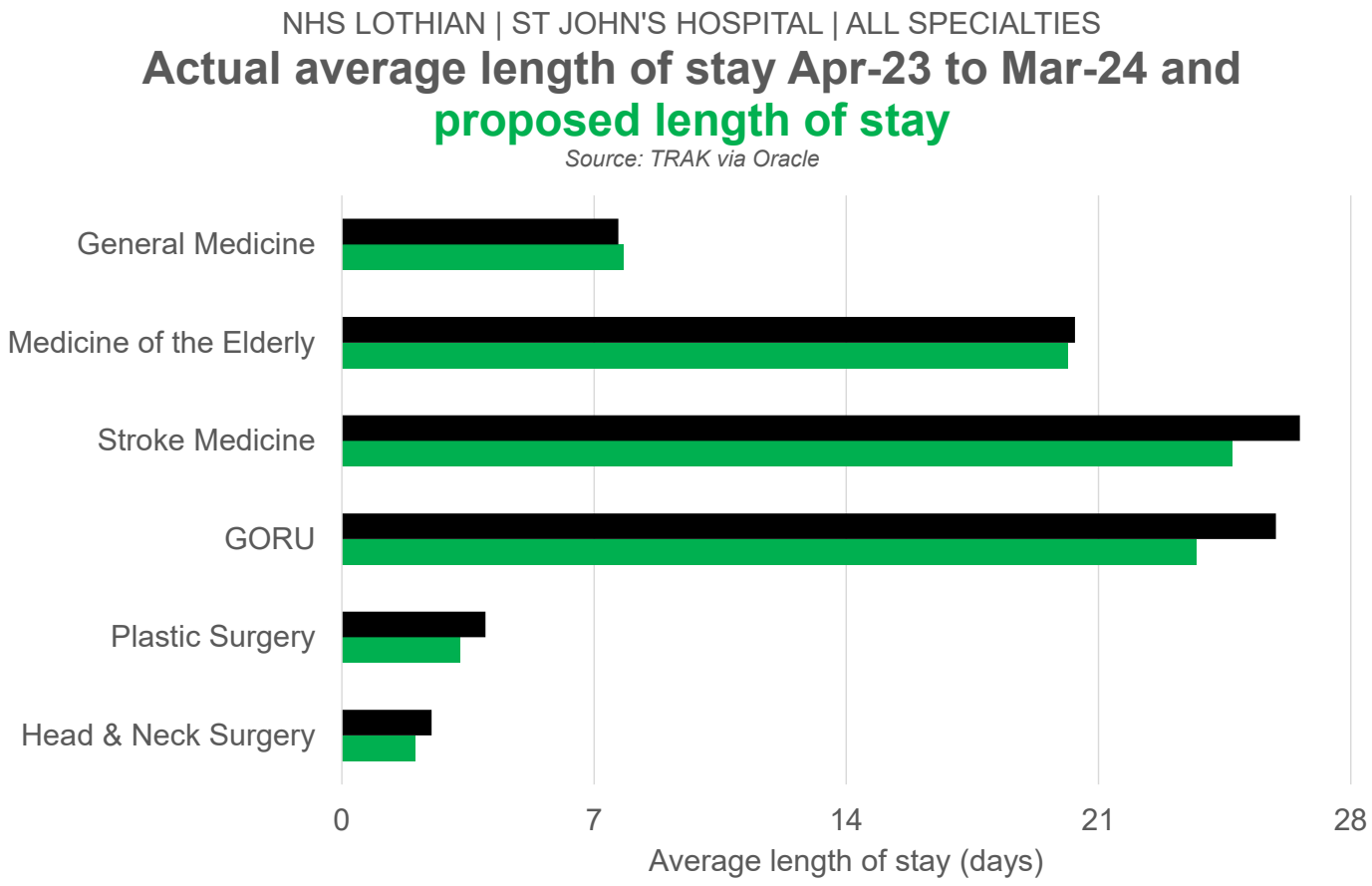
What if..? (all specialties)



The big summary table

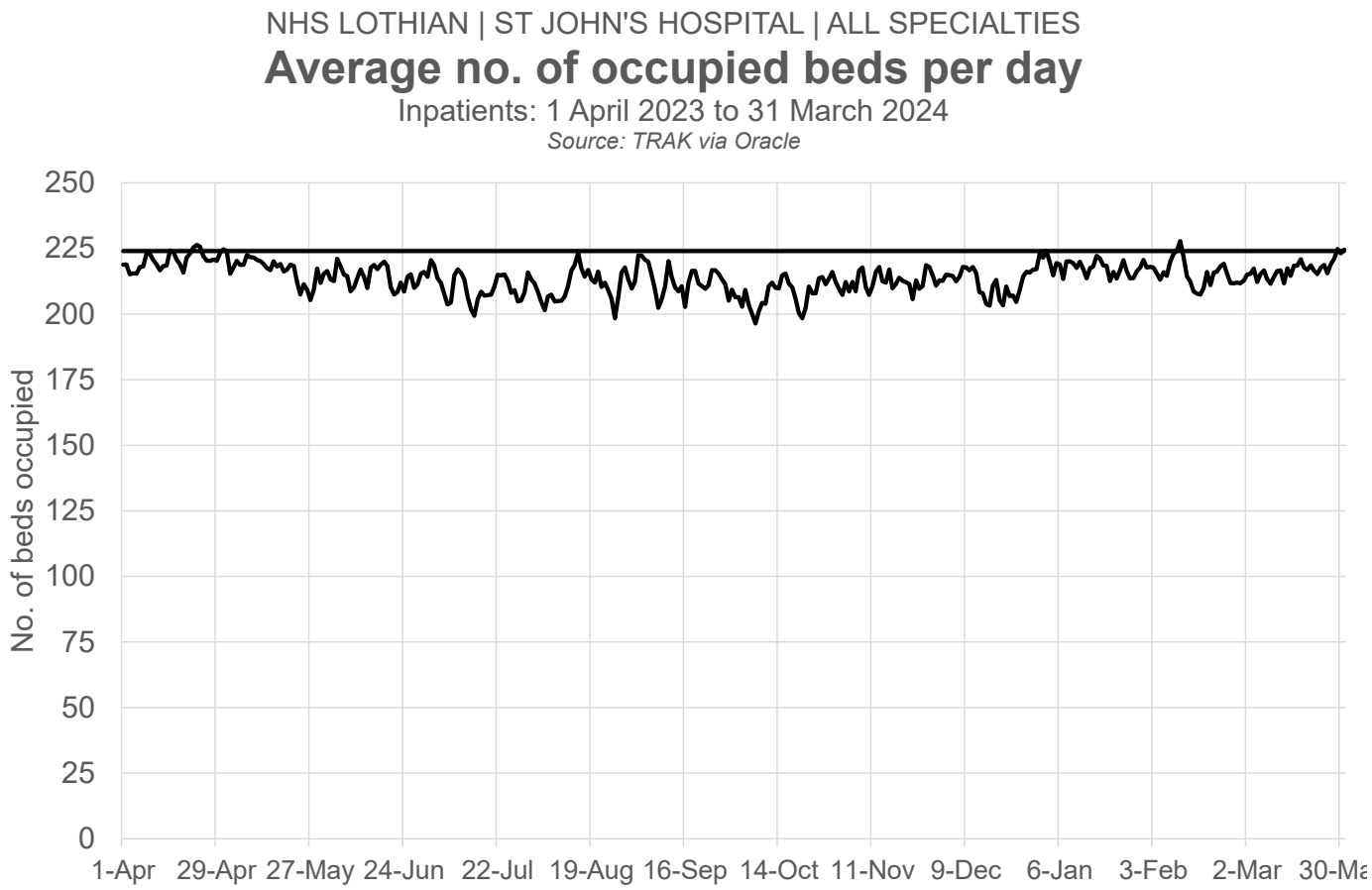
SPECIALTY CODE	BED ALLOCATION	NO.OF STAYS	MEAN LENGTH OF STAY (DAYS)	OCCUPIED BED DAYS	OCCUPIED BED DAY SHARE (%)	NEW BED ALLOCATION	NEW OCCUPIED BED DAYS	NEW MEAN LENGTH OF STAY (DAYS)
DELAY-OLOGY	0	2,563	10.80	27,680	13.4%	94	25,174	9.82
GM	72	4,104	7.13	29,244	14.1%	100	25,062	6.11
OR	127	4,372	6.44	28,153	13.6%	96	24,180	5.53
MoE	80	1,569	12.69	19,907	9.6%	68	14,271	9.10
GS	73	3,495	4.99	17,448	8.4%	59	16,089	4.60
RESP	46	1,765	7.52	13,274	6.4%	45	12,297	6.97
NS	49	2,027	6.51	13,199	6.4%	45	12,085	5.96
CS_TS	42	1,788	6.50	11,623	5.6%	40	10,561	5.91
VS	36	924	9.61	8,877	4.3%	30	7,728	8.36
STROKEM	36	734	9.98	7,326	3.5%	25	6,345	8.64
CA	36	2,548	3.75	9,546	4.6%	33	8,548	3.35
GI	30	964	6.30	6,077	2.9%	21	5,189	5.38
NEURO	19	376	11.02	4,142	2.0%	14	3,397	9.03
GY	18	1,633	2.37	3,868	1.9%	13	3,278	2.01
RM_HA	22	548	6.06	3,322	1.6%	11	2,547	4.65
TP	20	700	4.81	3,364	1.6%	11	2,587	3.70
Grand Total	**706**	**30,110**	**6.88**	**207,050**	**100.0%**	**706**	**179,339**	**5.96**

SJH: Proposed changes in length of stay

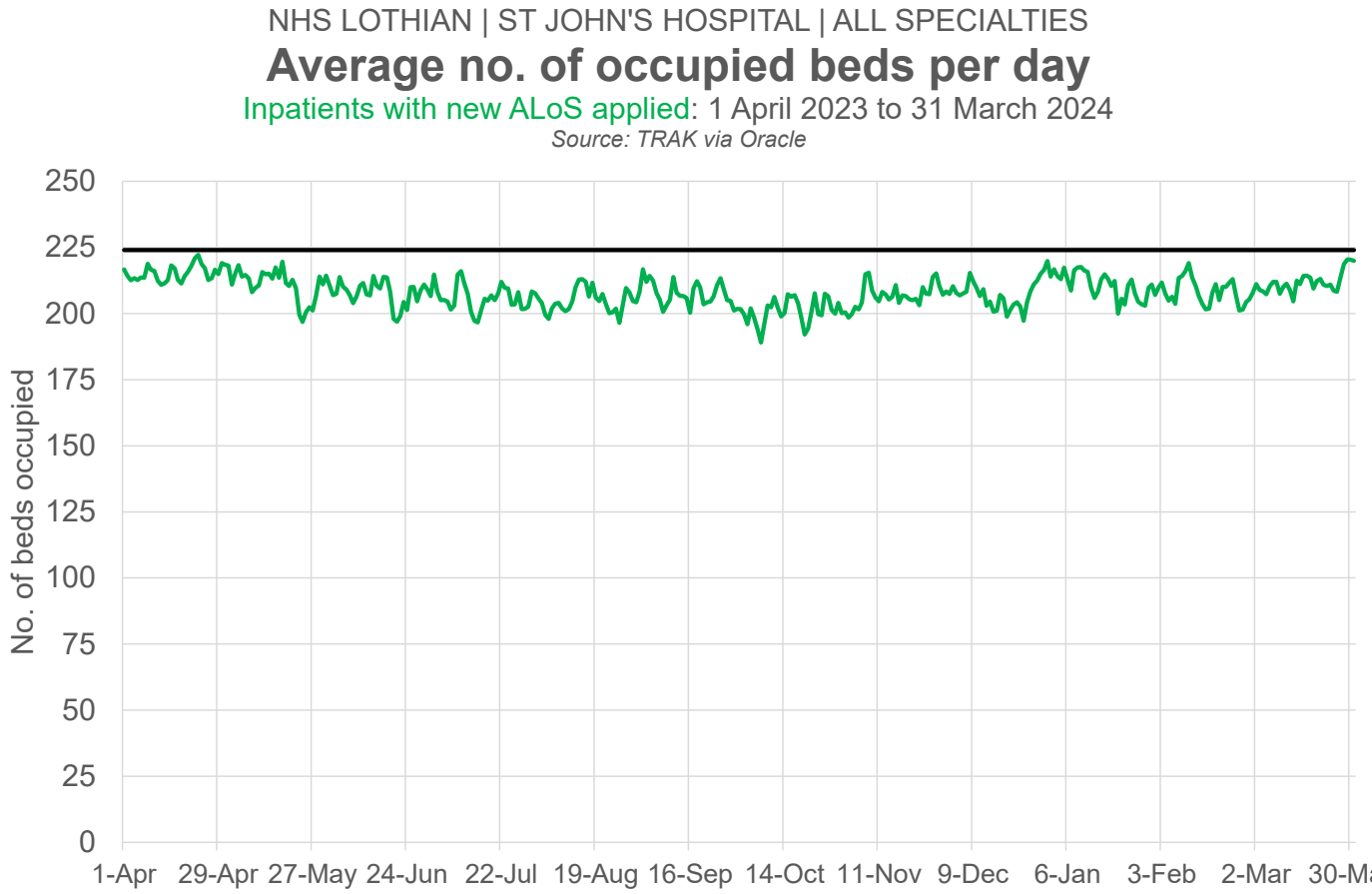


SPECIALTY	AVERAGE LENGTH OF STAY (DAYS)	PROPOSED AVERAGE LENGTH OF STAY (DAYS)
General Medicine	7.68	7.82
Medicine of the Elderly	20.35	20.16
Stroke Medicine	26.59	24.70
GORU	25.92	23.72
Plastic Surgery	3.99	3.26
Head & Neck Surgery	2.49	2.02
TOTAL	**8.16**	**7.93**

What if..? (all specialties)



What if..? (all specialties)

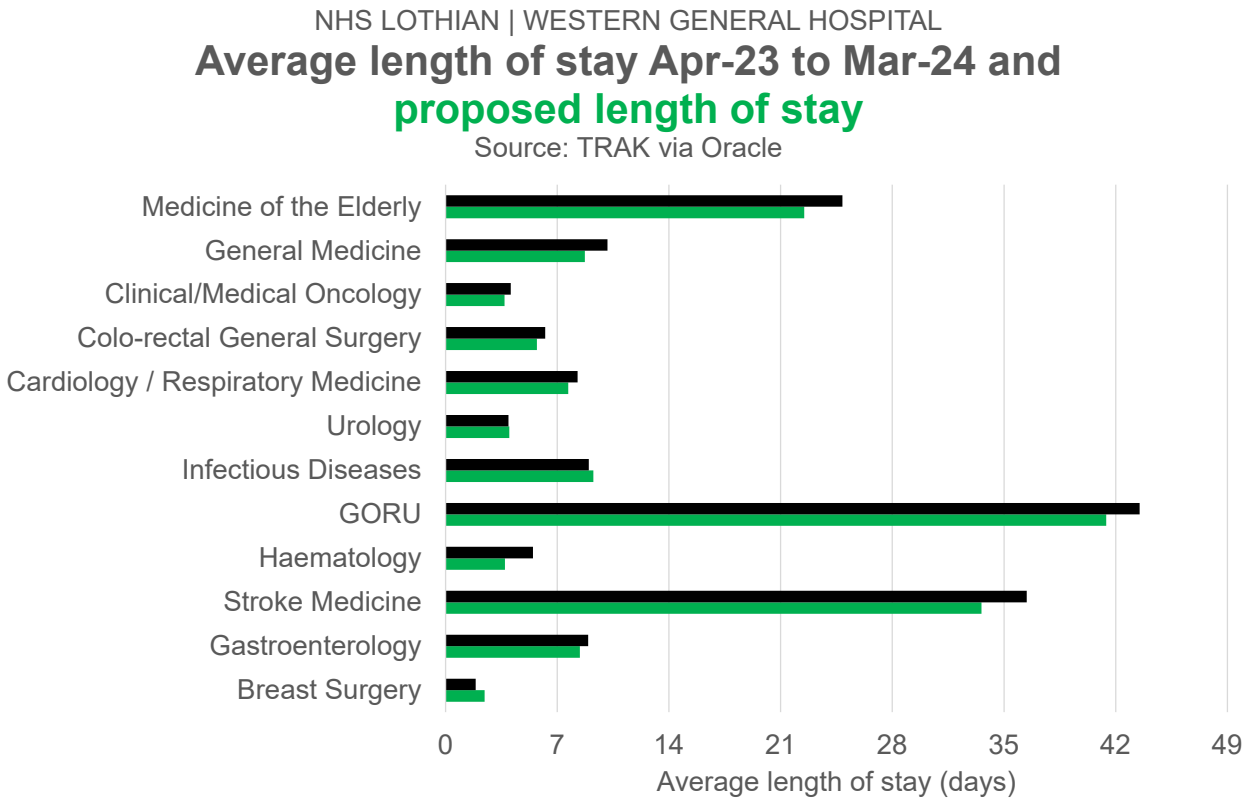


The big summary table

SPECIALTY/FIRM	BED ALLOCATION	NO. OF STAYS	MEAN LENGTH OF STAY (DAYS)	OCCUPIED BED DAYS	% SHARE OF OCCUPIED BED DAYS	NEW BED ALLOCATION	NEW OCCUPIED BED DAYS	NEW MEAN LENGTH OF STAY (DAYS
DELAY-OLOGY	0	659	20.82	13,720	18.0%	40	13,062	19.82
FIRM_21	30	2,341	5.39	12,618	16.6%	37	11,571	4.94
FIRM_09	30	1,412	7.22	10,191	13.4%	30	9,425	6.67
FIRM_08	29	888	9.99	8,870	11.7%	26	8,046	9.06
FIRM_25	30	1,259	7.03	8,852	11.6%	26	7,141	5.67
FIRM_14	30	455	16.62	7,562	9.9%	22	6,684	14.69
STROKEM	22	239	22.44	5,362	7.1%	16	4,521	18.92
PLAS	30	1,275	3.76	4,796	6.3%	14	3,775	2.96
H&N	23	1,670	2.44	4,082	5.4%	12	3,215	1.93
TOTAL	**224**	**10,198**	**7.46**	**76,055**	**100.0%**	**224**	**67,440**	**6.61**

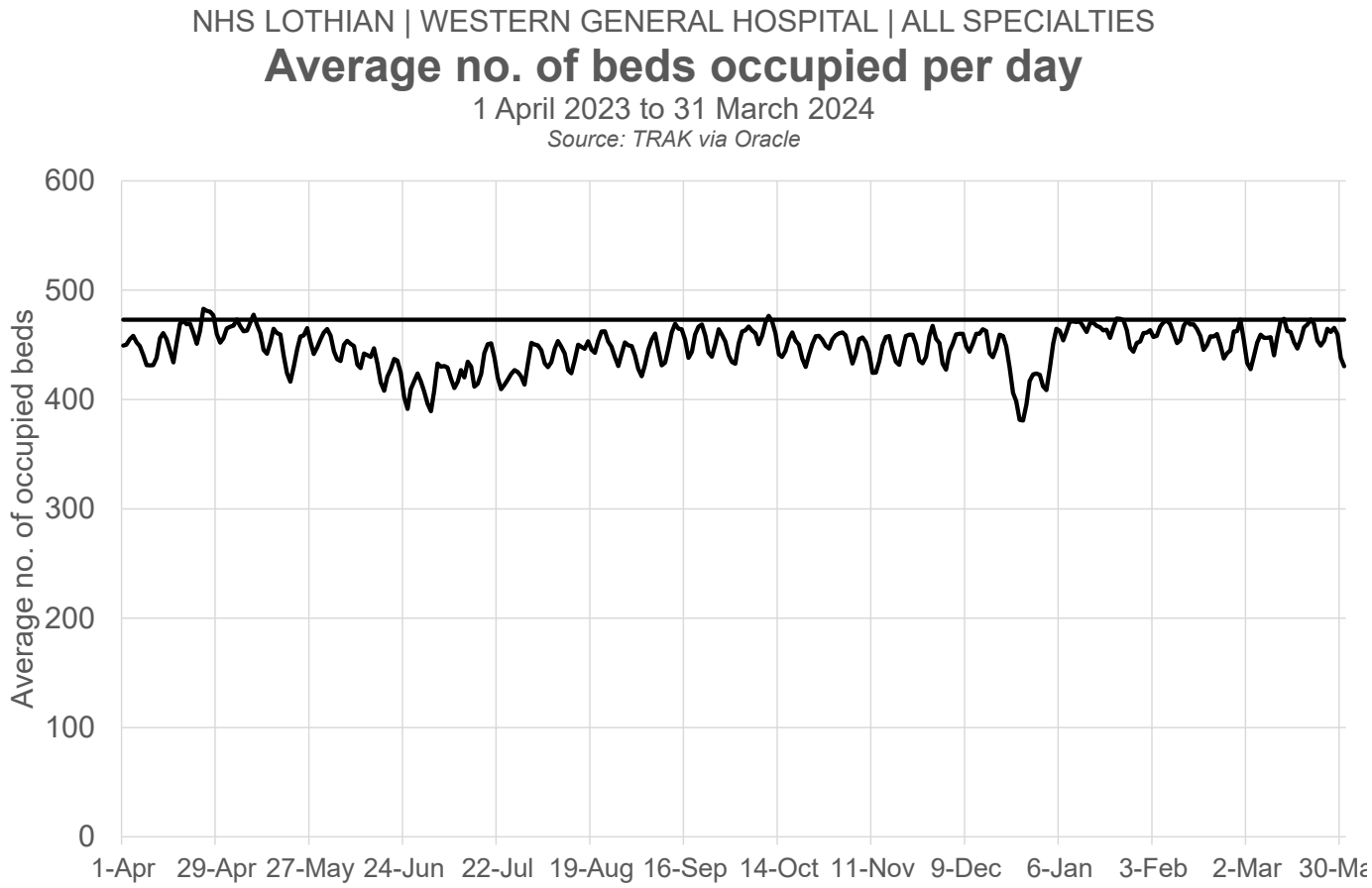
Note slightly different methodology of developing LoS targets due to SJH DGH bed model

WGH: Proposed changes in length of stay

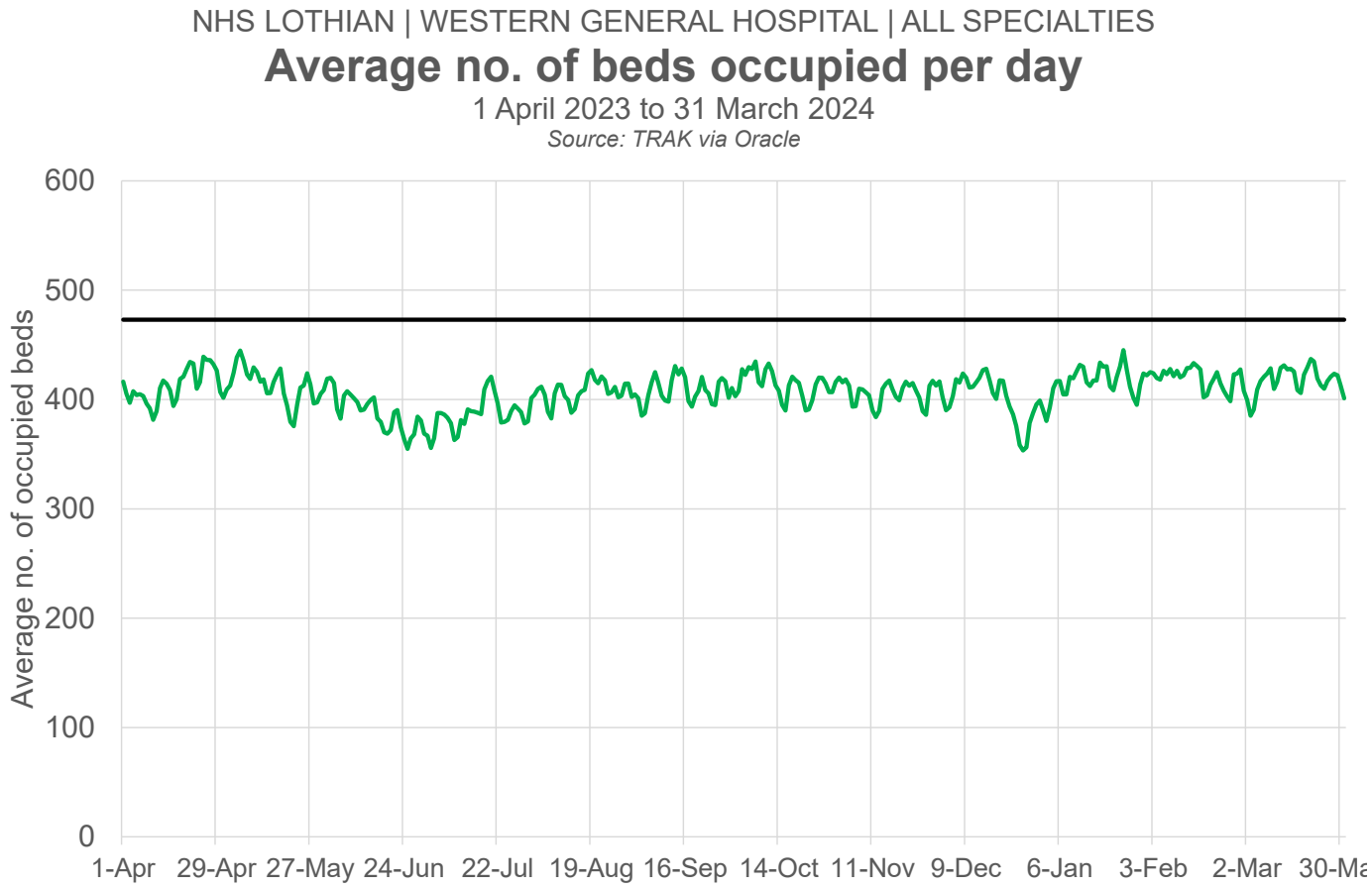


SPECIALTY	AVERAGE LENGTH OF STAY (DAYS)	PROPOSED AVERAGE LENGTH OF STAY (DAYS)
Medicine of the Elderly	24.9	22.5
General Medicine	10.1	8.7
Clinical/Medical Oncology	4.1	3.7
Colo-rectal General Surgery	6.2	5.7
Cardiology / Respiratory Medicir	8.3	7.7
Urology	3.9	4.0
Infectious Diseases	9.0	9.3
GORU	43.5	41.4
Haematology	5.5	3.7
Stroke Medicine	36.4	33.6
Gastroenterology	8.9	8.4
Breast Surgery	1.9	2.4
TOTAL	**8.2**	**7.5**

What if..? (all specialties)



What if..? (all specialties)



The big summary table

SPECIALTY	BED ALLOCATION	NO. OF STAYS	MEAN LENGTH OF STAY (DAYS)	OCCUPIED BED DAYS	OCCUPIED BED DAY SHARE (%)	NEW BED ALLOCATION	NEW OCCUPIED BED DAYS	NEW MEAN LENGTH OF STAY (DAYS)
DELAY-OLOGY	0	1,849	17.87	33,042	20.2%	89	30,050	16.25
MoE	74	1,591	15.41	24,512	15.0%	66	21,736	13.66
CGS	50	2,895	6.00	17,367	10.6%	47	15,441	5.33
GM	55	2,222	7.22	16,053	9.8%	43	15,007	6.75
CO_MO	55	2,730	5.86	15,995	9.8%	43	13,903	5.09
CA_RESP	35	1,556	7.14	11,110	6.8%	30	10,359	6.66
URO	48	2,738	3.81	10,442	6.4%	28	8,617	3.15
HA	19	1,230	6.71	8,250	5.0%	22	7,126	5.79
IF	26	1,091	7.52	8,203	5.0%	22	7,487	6.86
GORU	26	214	31.18	6,673	4.1%	18	6,164	28.80
STROKEM	26	233	25.19	5,869	3.6%	16	4,791	20.56
GI	17	576	8.37	4,823	3.0%	13	4,078	7.08
BS	11	596	1.85	1,104	0.7%	3	424	0.71
TOTAL	**442**	**19,521**	**8.37**	**163,442**	**100.0%**	**442**	**145,183**	**7.44**

Linked Workstream: Acute PDD Roll Out Plans

Draft PPD Roll out plans:

- Royal Infirmary of Edinburgh
- Western General Hospital
- St John's Hospital

Draft Acute PPD Roll out plans above – delivery being monitored through **Acute Unscheduled Care Programme Board.** **Acute PDD S.O.P** developed and being used as part of roll-out

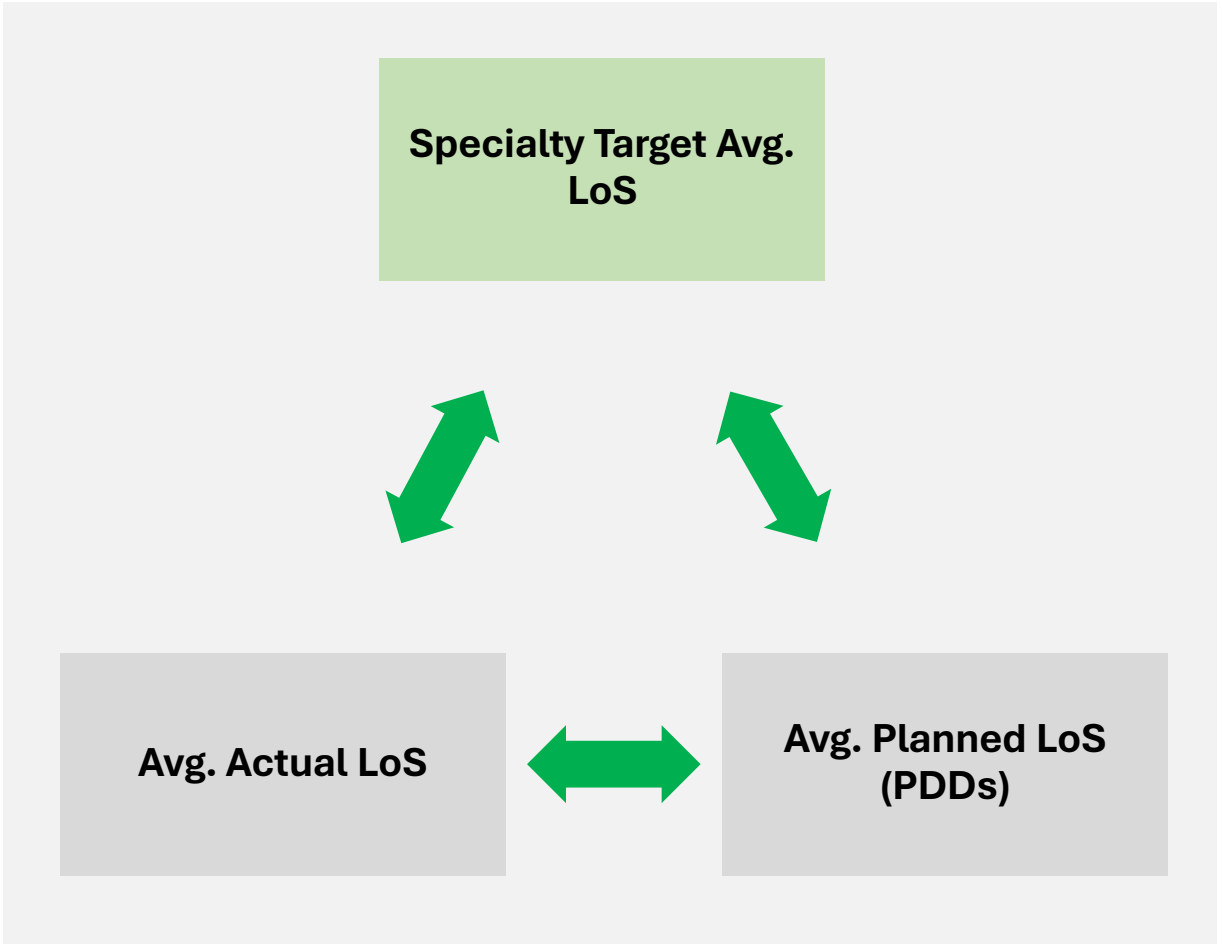
STATUS:

- Currently "on track against plans" as per updates to last Acute USC Board.
- Reductions seen in "non-delayed" LoS in RIE and WGH, and stable at SJH.
- Total occupied bed days for patients in delay has increased on all 3x sites

ACTION:

Next Acute USC Programme Board to sign off specialty LoS targets (see following slides per site) to enable triangulation, monitoring and management of the following per specialty;

- Target length of stay
- Predicted length of stay
- Actual length of stay



Updated Step Diagrams

Reduce Attendances

?10 years

2034/35

Outcome required

Reduced trend of attendance and admission rates/1000 population into ED by HSCP

Buchan analysis showing required changes below

HSCP	ED /1000 population	% ED admitted	Change modelled to ED attendances over 10 years
East Lothian	270-283 increase 4%	25%-30%	10.6 % reduction
Midlothian	314-329 increase 5%	23%-28%	11.4 % reduction
West Lothian	287-305 reduced 7%	22%-23%	1% reduction
City of Edinburgh	257-271 reduced 5%	22%-26%	2.1% reduction
NHS Lothian	274-282 reduced 3%	23%-26%	

Revised interim steps to be developed in 24/25

24/25 Step

- Flow Centre and HSCP SPOC teams to develop **streamlined navigation pathways** and agree how they can collaboratively ensure patient flow is optimised through patients are navigated to the most appropriate urgent care in community or acute.

- Strengthen and ensure sustainability of the Flow Centre workforce model
- Work with FNC/SAS to reduce no. of care home attendances
- Increased development of, and utilisation of hot clinics
- Review “thresholds” for EDs, align with realistic medicine
- To scope & implement opportunities through use of virtual consultation, algorithms, technology to optimise referral flow and support triage / prof to prof advice
- Implement, monitor and evaluate the agreed outcome from minor injury options appraisal
- Review current urgent care pathways to identify and prioritise what is working well, what requires to be improved/developed and agree processes for monitoring and reviewing pathways.

- **KPI: 20% of all urgent care (GP/HCP/SAS) referrals will be made to an alternative**
- **KPI: 30% of all NHS24 MIU/ED referrals will be made to an Alternative**

Reduce Length of Stay

2029/30
Outcome required

95% of patients will be discharged on their Planned Date of Discharge

Lothian will achieve CfSD “level 2” (matching the average for the top 75 percentile performing mainland boards.) in LoS measures;

- *Reduce by 10% points the number of patients in Acute & Community hospital beds with a LOS >14 days*
- *Reduce by 16% points the number of non-delayed patients in Acute & Community hospital beds with a LOS >14 days*

Revised interim steps to be developed in 24/25

24/25 Step

Continue to Implement Discharge Without Delay (aligned to upcoming SG hospital occupancy action plan)

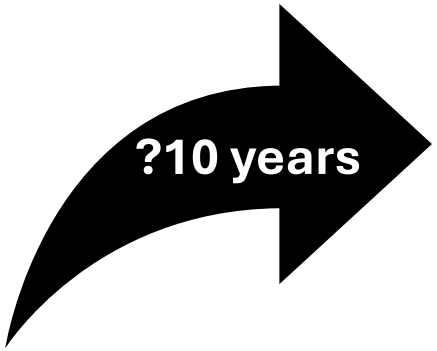
- Implement Phase 3 - Planned Date of Discharge – across identified wards within Acute and Community Hospitals:
- Identify priority area/speciality for implementation of PDD
- Support transition on Trak from Estimated Date of Discharge to Planned Date of Discharge
- Develop spread plans to support implementation of Planned Date of Discharge across Acute and Community Hospitals Support the implementation of Criteria Lead Discharge
- Embed **Early Supported Discharge** and spread to other acute sites

Develop **specialty LoS programmes** on adult acute sites to support optimal flow

Implement recommendations from **OT/PT working group**

Review **diagnostic pathways** with view to improve flow and reduce number undertaken within an urgent ED context

Reduce Admissions



2034/35
Outcome required

Significantly reduced % of admissions through changing the **assessment models of care**, as well as expanding the pathways (currently 8, potential of up to 131 pathways) provided through a **RACU model**

Buchan analysis showing required changes to assessment models of care below;

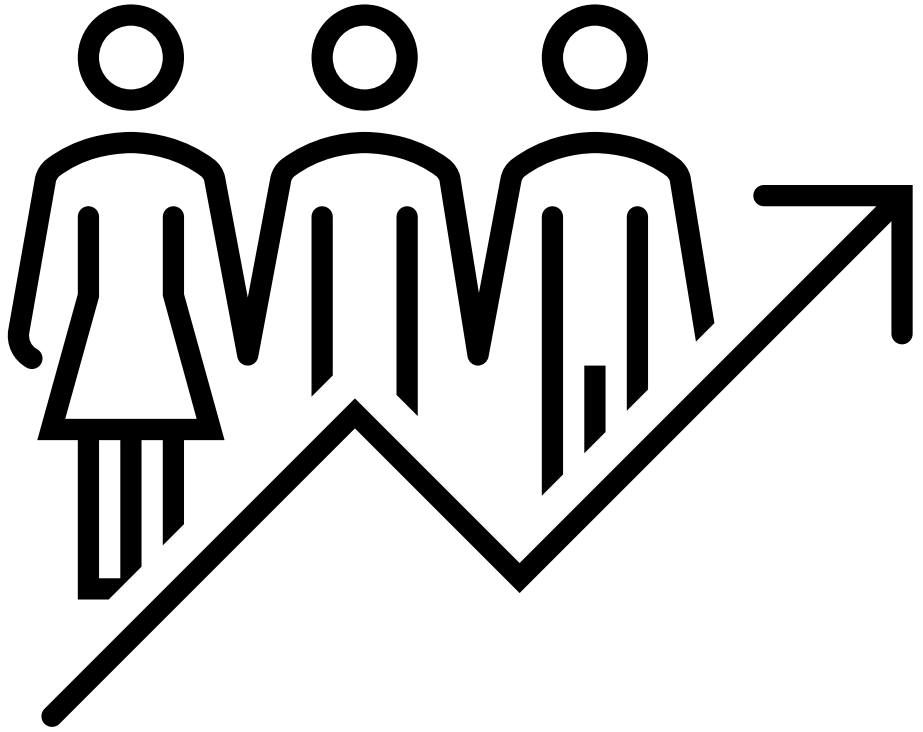
Assessment bedpool	Target discharge/ flow interval	Target discharge rate within this interval
General Medicine	48hrs	50%
Frailty	48hrs	50%
Surgery	24hrs	60%

Revised interim steps to be developed in 24/25

24/25 Step

- **Maximise current capacity at RACU** and review pathways to enable this. Refine case for further expansion of RACU at WGH and development of SJH RACU. Work required to identify what could be deprioritised to fund this.
- Enhance alternatives to hospital admission through developing a **consistent model for delivery Hospital at Home (H@H) and Ambulatory Interface Care** defined benefits, costs plans to maximise this resource through a targeted approach.
- Review existing **Hospital at Home Models and capacity against current national recommendations**. Develop and implement action plan to meet recommendations.
- Develop a strategic approach to **Frailty** that looks to pull together current work, and develop a system approach to managing and supporting these patients in the most appropriate manner. ? Link with **realistic medicine**
- Review current **acute assessment models of care** and develop plans to implement the required step change set out in the Buchan analysis

24/25 Progress



Unscheduled Care Tactical Committee Workplan

Date of Meeting	Programme Update	Lead	Deadline for Submission	Date Last Reviewed at UCTC	Assurance Level Accepted
19th July 2024	DwD Programme Board LoS Programmes	Grace Cowan Michelle Carr	12th July 2024	31st May 2024	
30th August 2024	Navigation Programme Board Virtual Capacity Programme Board	Jenny Long David Hood	23rd August 2024	H@H/Interface Services: 31st May 2024	
11th October 2024	OT/PT Implementation Group Pan Lothian Frailty Programme Board	Jenny Long Pay Wynne	4th October 2024		
22nd November 2024	Pan - Lothian RACU Group ESD Programme Board	David Walker Oli Campbell	15th November 2024	1st March 2024	
Jan/Feb 2025 TBC	DwD Programme Board LoS Programmes	Grace Cowan Michelle Carr			
March/April 2025 TBC	OT/PT Implementation Group Virtual Capacity Programme Board	Jenny Long David Hood			
May/June 2025 TBC	Programme Board Pan Lothian Frailty Programme Board	Jenny Long Pat Wynne			
July / August 2025 TBC	Pan - Lothian RACU Group ESD Programme Board	David Walker Oli Campbell			

Programme: Navigation Programme Board (Reduce Attendances)

What is to be delivered in 24/25

(actions in Step Diagram)

- Flow Centre and HSCP SPOC teams to develop streamlined navigation pathways and agree how they can collaboratively ensure patient flow is optimised through patients are navigated to the most appropriate urgent care in community or acute.
- Strengthen and ensure sustainability of the Flow Centre workforce model
- Work with FNC/SAS to reduce no. of care home attendances
- Increased development of, and utilisation of hot clinics
- Review “thresholds” for EDs, align with realistic medicine
- To scope & implement opportunities through use of virtual consultation, algorithms, technology to optimise referral flow and support triage / prof to prof advice
- Implement, monitor and evaluate the agreed outcome from minor injury options appraisal
- Review current urgent care pathways to identify and prioritise what is working well, what requires to be improved/developed and agree processes for monitoring and reviewing pathways.

Progress Update

- idufgvhifvhifugh.

Is the project on track? (in line with the Step Diagram)

- idufgvhifvhifugh.

Data Analysis

- erferf

Risks

- idufgvhifvhifugh.

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- erferfefe

Programme: OT/PT Workstream (Reduce LoS)

What is to be delivered in 24/25

(actions in Step Diagram)

- Review current arrangements for managing and directing OT & PT resources across the health and social care system
- Ensure adherence to Home First principles where patients are assessed and rehabilitated at home as a default option
- Define a system wide approach to risk management

Progress Update

- In July 2024, following a number of meetings of a SLWG and a Process Mapping exercise, the group successfully identified a number of workstreams that could have a positive impact on patient flow and provide care closer to home
- There is now an agreed implementation plan for the workstreams with an accumulate deadline of March 2025 for completion
- The implementation group will meet bi-monthly to monitor and drive the improvements
- Progress will be provided to the Unscheduled Care Programme Board throughout the project duration

Is the project on track? (in line with the Step Diagram)

- Yes

Data Analysis

- Measurement data to be established as the workstreams are more defined
- Overall aim is to track the impact of the project on:
  - Number of people receiving OT & PT input in a homely setting
  - Number of people receiving OT & PT input in an acute setting
  - Number of referrals to OT/PT broken down by acute/HSCP

Risks

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- Successfully implement the agreed workstreams throughout the remainder of 2024-25

Programme: Discharge without Delay (Reduce LoS)

What is to be delivered in 24/25

(actions in Step Diagram)

- Introduce the Lothian DwD Programme Board (formally pan Lothian DwD Group) with a clear remit to support the delivery aligned to the SG Hospital Occupancy Action Plan / outputs from the Whole System Self-Assessment Tool (SAT)
- Formally transition the Lothian DwD Group to the DwD Programme Board to strengthen governance, ensure accountability, and streamline the delivery of the DwD programme across all acute hospitals and health and social care partnerships.
- Continue implementing Planned Date of Discharge (PDD), weekend discharges, and discharges before noon, while increasing referrals to social work as part of enhancing discharge efficiency.

Progress Update

- A well-structured governance framework has been initiated with plans for the development of Terms of Reference (ToR) post the National DwD Group's ToR approval.
- Regular updates being sought from each acute hospital and health and social care partnership ensure adherence to strategic priorities..

Is the project on track? (in line with the Step Diagram)

- The project is on track with a clear governance structure being implemented and strategic priorities aligned. The establishment of the Programme Board and development of ToRs are imminent, ensuring robust management and oversight..

Data Analysis

- Plan is to utilis outputs from the Whole System Self-Assessment Tool (SAT) to analyse and improve discharge processes.
- Bi-monthly Programme Board meetings to review and discuss data-driven insights for continuous improvement in discharge procedures.

Risks

- Variability in discharge efficiency and potential delays in integration of best practices across all wards and partnerships.
- Possible challenges in sustaining improvements and embedding new discharge protocols system-wide.

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- Official formation and first half-day workshop of the DwD Programme Board by the end of August/beginning of September 2024.
- Bi-monthly DwD Programme Board meetings for consistent and timely reporting and strategic oversight.

Programme: Site Specialty LoS Programme + PDD Implementation (Reduce LoS)

What is to be delivered in 24/25

(actions in Step Diagram)

- In line with the PDD SOP, fully implement PDD across the RIE, WGH, SJH inpatient wards by March 2025

Progress Update

- PDD SOP produced in March 2024 and approved at USC Programme Board
- Acute Hospital PDD Implementation Plans developed for 24/25 with targeted performance reviews at monthly Acute Unscheduled Care Program Board Meetings
- LOS Programme initial discussions across the WGH and SJH have taken place and further work underway. Specialty LoS meetings have commenced across the RIE site

Is the project on track? (in line with the Step Diagram)

✓ PDD Implementation is progressing as per the site implementation plans

✓ LoS Programme is on track as more detailed work is planned across the acute sites

Data Analysis

- Across PDD wards there are notable variations at different points in the year. Within SJH the data shows overall minor fluctuations suggesting a relatively consistent alignment between the PDD and actual LOS. Further work required to determine the difference in PDD setting and actual LoS across RIE and WGH

Risks

- DwD funding and the available allocation of resources to support the roll out of PDD across the WGH has been highlighted (in particular working alongside EHSCP on site)
- System pressures and staffing shortages could negatively impact the scale and spread of PDD

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- Continue to closely monitor the Acute Hospital PDD Implementation across inpatient wards and produce monthly data sets to show the impact of this work (March 2025)

Programme: Early Supported Discharge (ESD) (Reduce LoS)

What is to be delivered in 24/25

(actions in Step Diagram)

- Embed Early Supported Discharge (ESD) with AMU at the RIE with a focus on enhancing Pathway 1 where there is a requirement for short-term domiciliary support at home (in partnership with MHSCP, EHSCP, ELHSCP)

Progress Update

- Continues to progress with full engagement from RIE, EHSCP, MHSCP & ELHSCP Teams
- ESD project within the RIE currently underway (space identified for an ESD Hub and being prepared for regular use) to enable HSCP and Acute colleagues to have real time discussions to expedite discharge from AMU
- A PDSA will take place within the AMU Dept to identify patients with ESD potential via the AMU Flow Coordinator
- A new Daily Rapid Run Down will be tested from Mid-July within the ESD Hub to enable on site teams to use daily Boxi reports to expedite ESD patient discharges

Is the project on track? (in line with the Step Diagram)

✓ ESD has working well with EHSCP but performance has started to decline which is being reviewed. Continued variation across ELHSCP and MHSCP

✓ The project continues to have good all-round engagement with strong inter-personal relationships across the health and social care teams

Data Analysis

- Since December 2023 EHSCP data has shown a significant improvement in the reduction in OBDs, and more detailed analysis is underway to identify the rationale for this. However there has been a change since mid-June with a dip in performance

Risks

- Difficult to identify the specific cohort of patients

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- Focussed PDSA cycles to ensure that any specific improvement ideas are documented to show any meaningful change supported by robust data analysis
- The ESD Steering Group will continue to meet monthly to review progress and focus on identifying any barriers to early discharge (until December 2024)

Programme: Maximising RACU (Reduce Admissions)

What is to be delivered in 24/25

(actions in Step Diagram)

- idufgvhifvhifugh.

Progress Update

- idufgvhifvhifugh.

Is the project on track? (in line with the Step Diagram)

- idufgvhifvhifugh.

Data Analysis

- erferf

Risks

- idufgvhifvhifugh.

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- erferfefe

Programme: Virtual Capacity Programme Board (Reduce Admissions)

What is to be delivered in 24/25

(actions in Step Diagram)

- idufgvhifvhifugh.

Progress Update

- idufgvhifvhifugh.

Is the project on track? (in line with the Step Diagram)

- idufgvhifvhifugh.

Data Analysis

- erferf

Risks

- idufgvhifvhifugh.

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- erferfefe

Programme: Pan-Lothian Frailty Programme (Reduce Admissions)

What is to be delivered in 24/25

(actions in Step Diagram)

- idufgvhifvhifugh.

Progress Update

- idufgvhifvhifugh.

Is the project on track? (in line with the Step Diagram)

- idufgvhifvhifugh.

Data Analysis

- erferf

Risks

- idufgvhifvhifugh.

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- erferfefe

Programme: Redesign of Acute Assessment Function (Reduce Admissions)

What is to be delivered in 24/25

(actions in Step Diagram)

- idufgvhifvhifugh.

Progress Update

- idufgvhifvhifugh.

Is the project on track? (in line with the Step Diagram)

- idufgvhifvhifugh.

Data Analysis

- erferf

Risks

- idufgvhifvhifugh.

What is planned for remainder of 2024/2025?

(please include indicative timescales)

- erferfefe

USC MTFF

USC Finances

Governance Overview

NHSL & IJBs

Pan Lothian Funding
Circa £300m

USC Programme Board

USC Recurring Investment
Circa £13m

SG Funding
Circa £5m

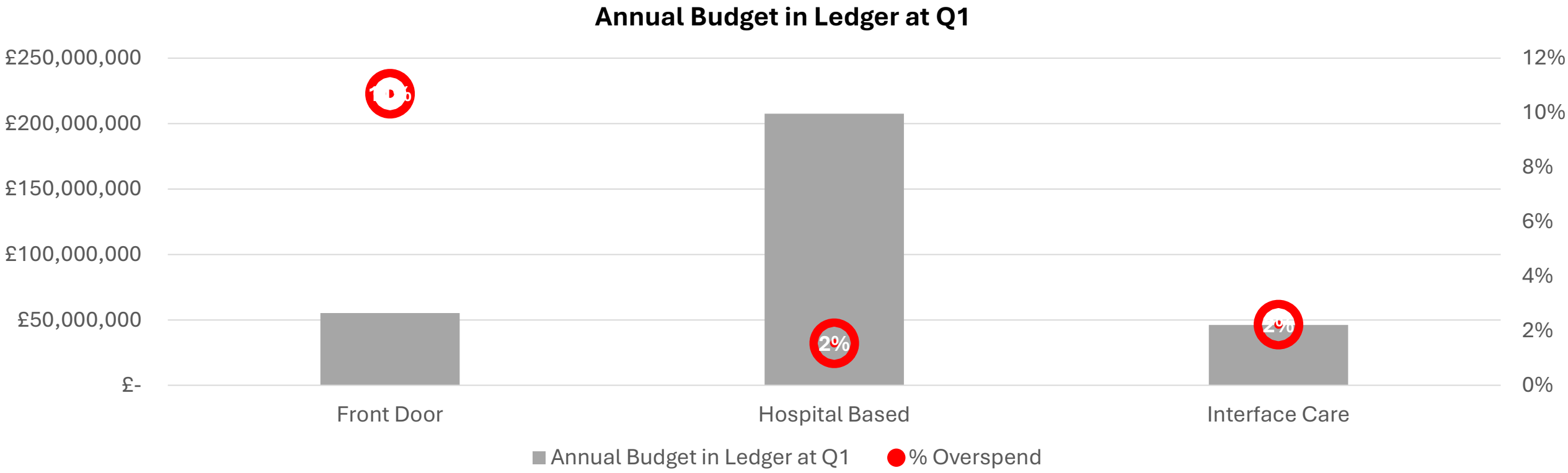
Recovery Plans Required:

- 23/24 Programme review - **£2.1m**
- Pause Flow Centre expansion - **£0.5m**
- Pause RACU expansion **- £1.3m**
- Review of USC Historic Investments **£0.72**

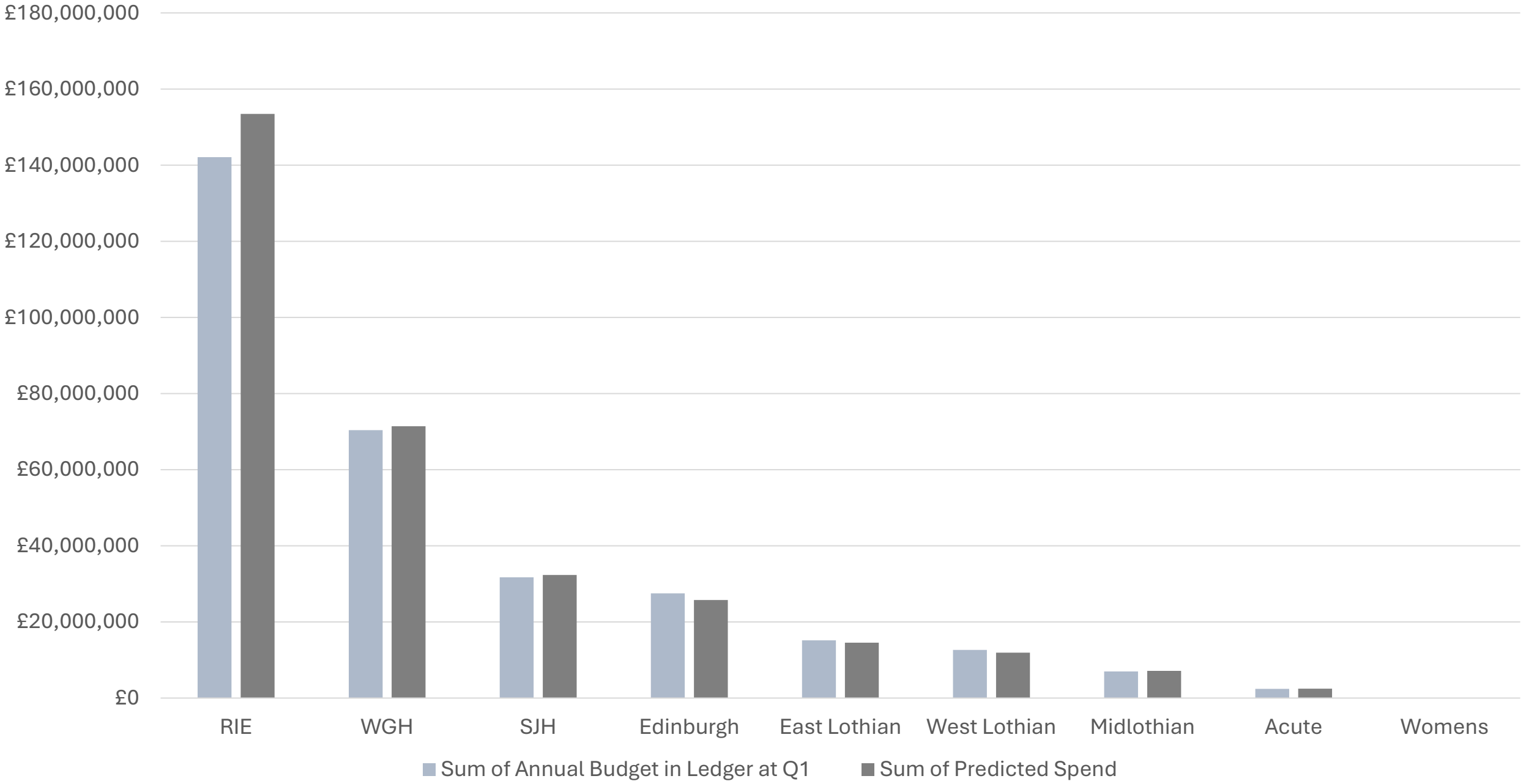
- **Requirement to focus on £300m portfolio in coming years**

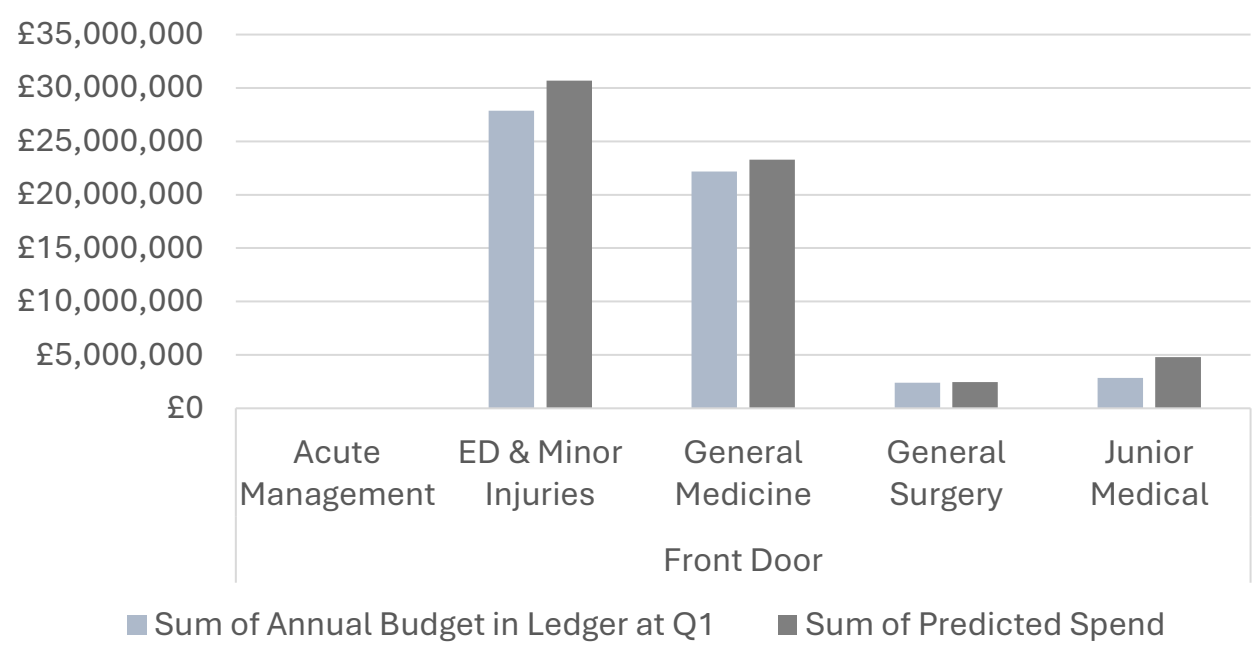
USC PILLAR BUDGET & SPEND

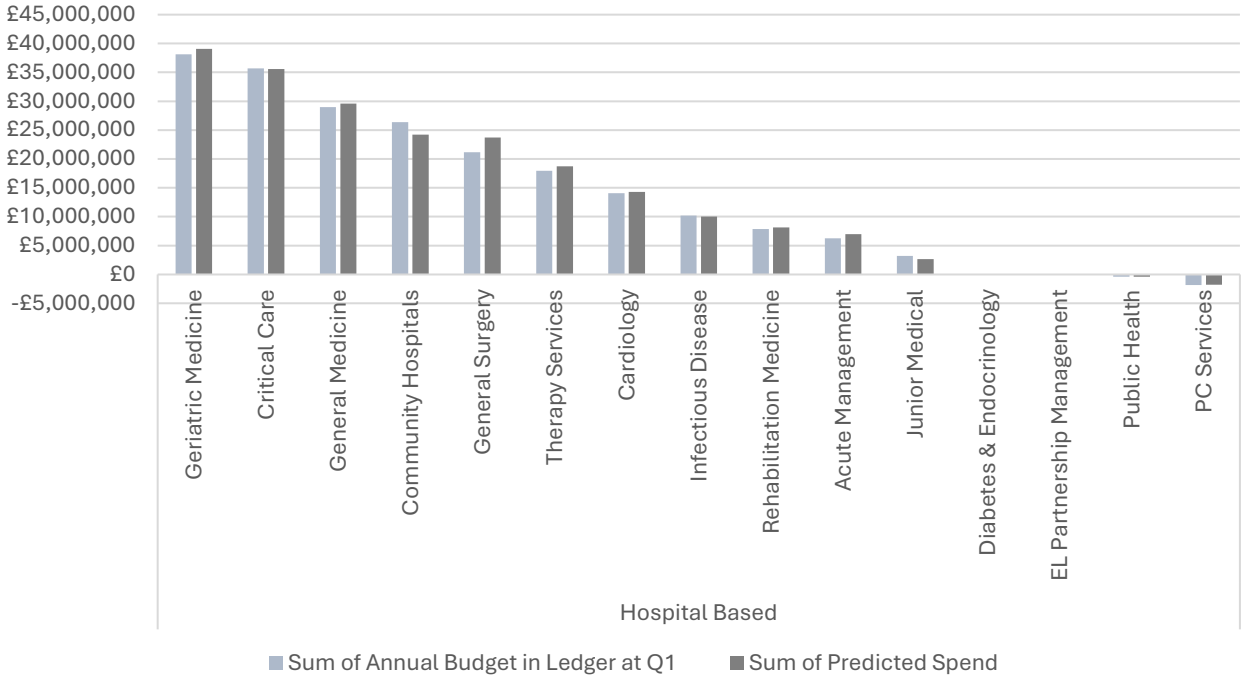
Pillar	24/25 Annual Budget	24/25 YTD Position: Under/(Over)	24/25 Q1 Forecast: Under/(Over)
Front Door	55,299,313	(1,906,126)	(5,917,672)
Hospital Based	207,539,598	(1,066,448)	(3,207,146)
Interface Care	46,196,752	(307,361)	(1,028,435)
Grand Total	**309,035,663**	**(3,279,935)**	**(10,153,253)**

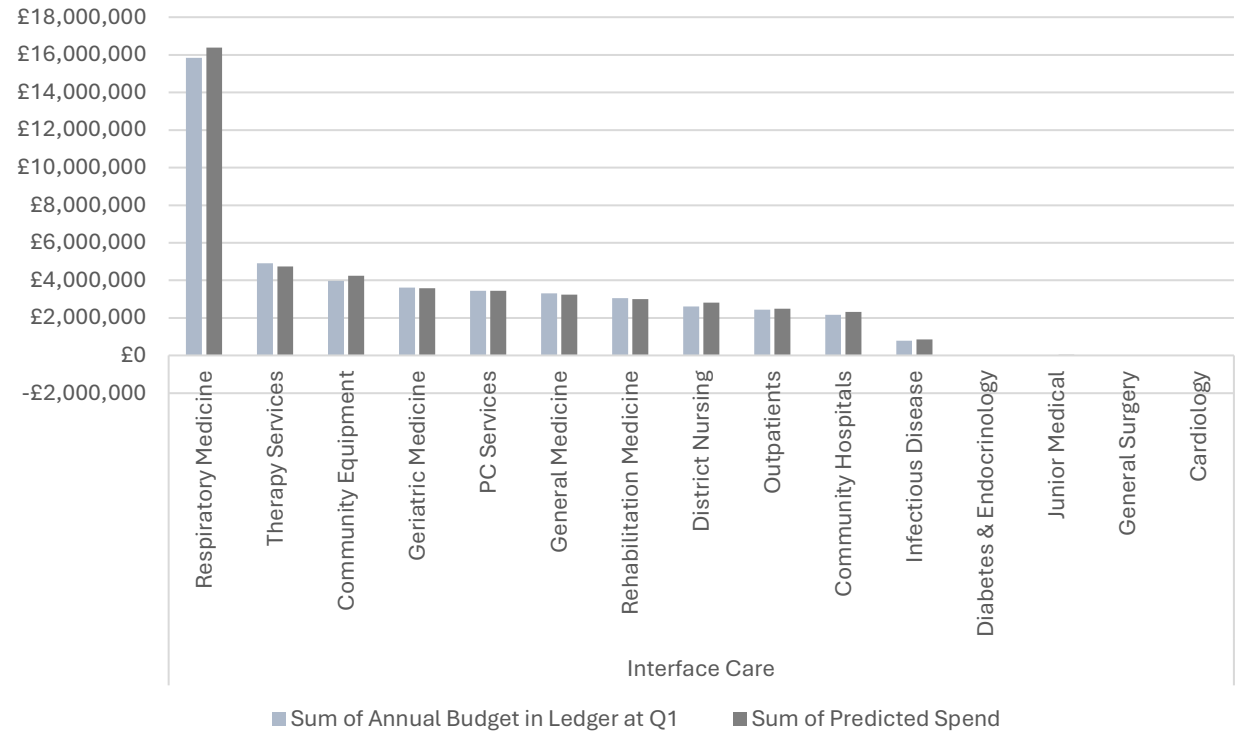


LOCATION


£180,000,000
£160,000,000
£140,000,000
£120,000,000
£100,000,000
£80,000,000
£60,000,000
£40,000,000
£20,000,000
£0
RIE
WGH
SJH
Edinburgh
East Lothian
West Lothian
Midlothian
Acute
Womens
Sum of Annual Budget in Ledger at Q1
Sum of Predicted Spend

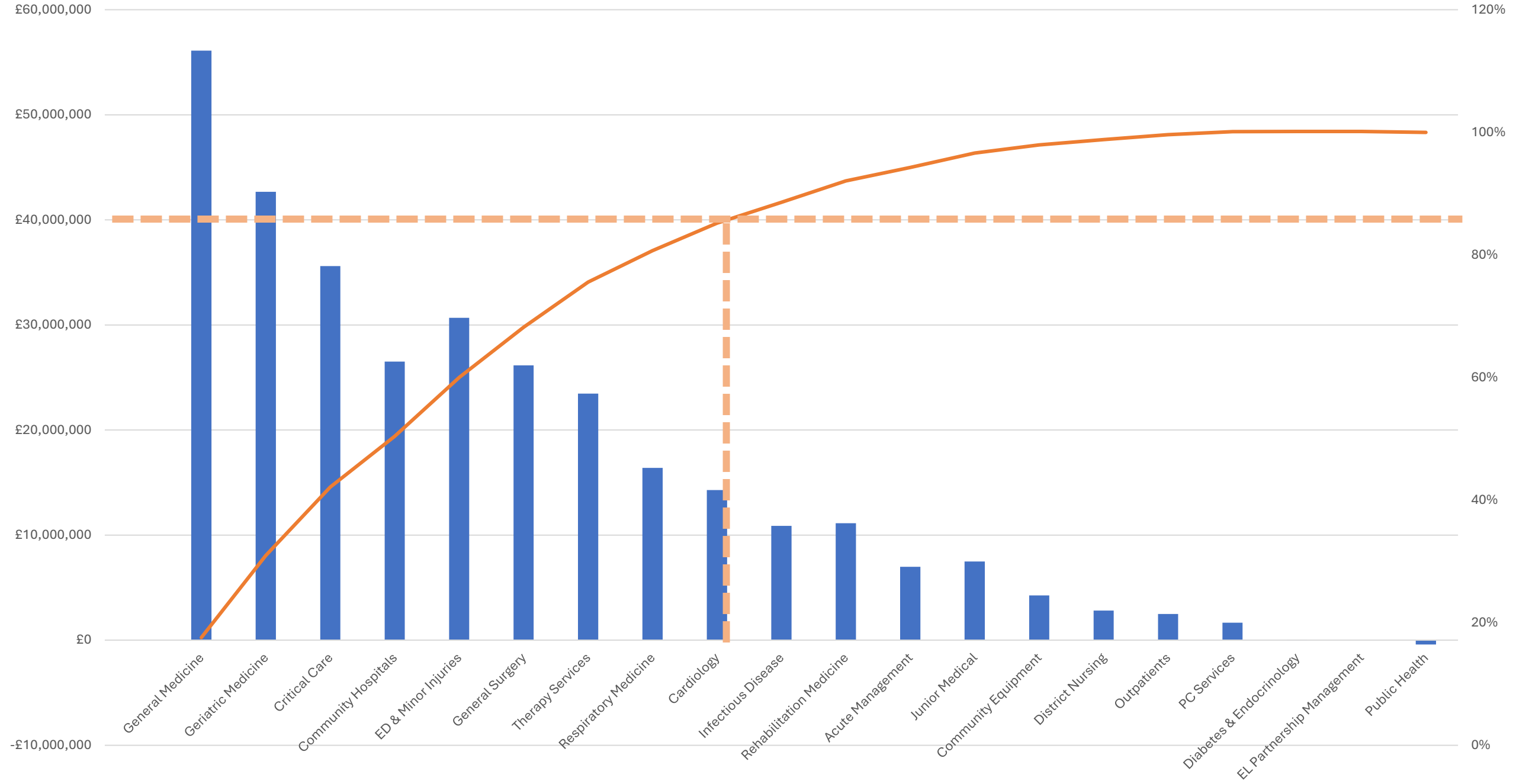




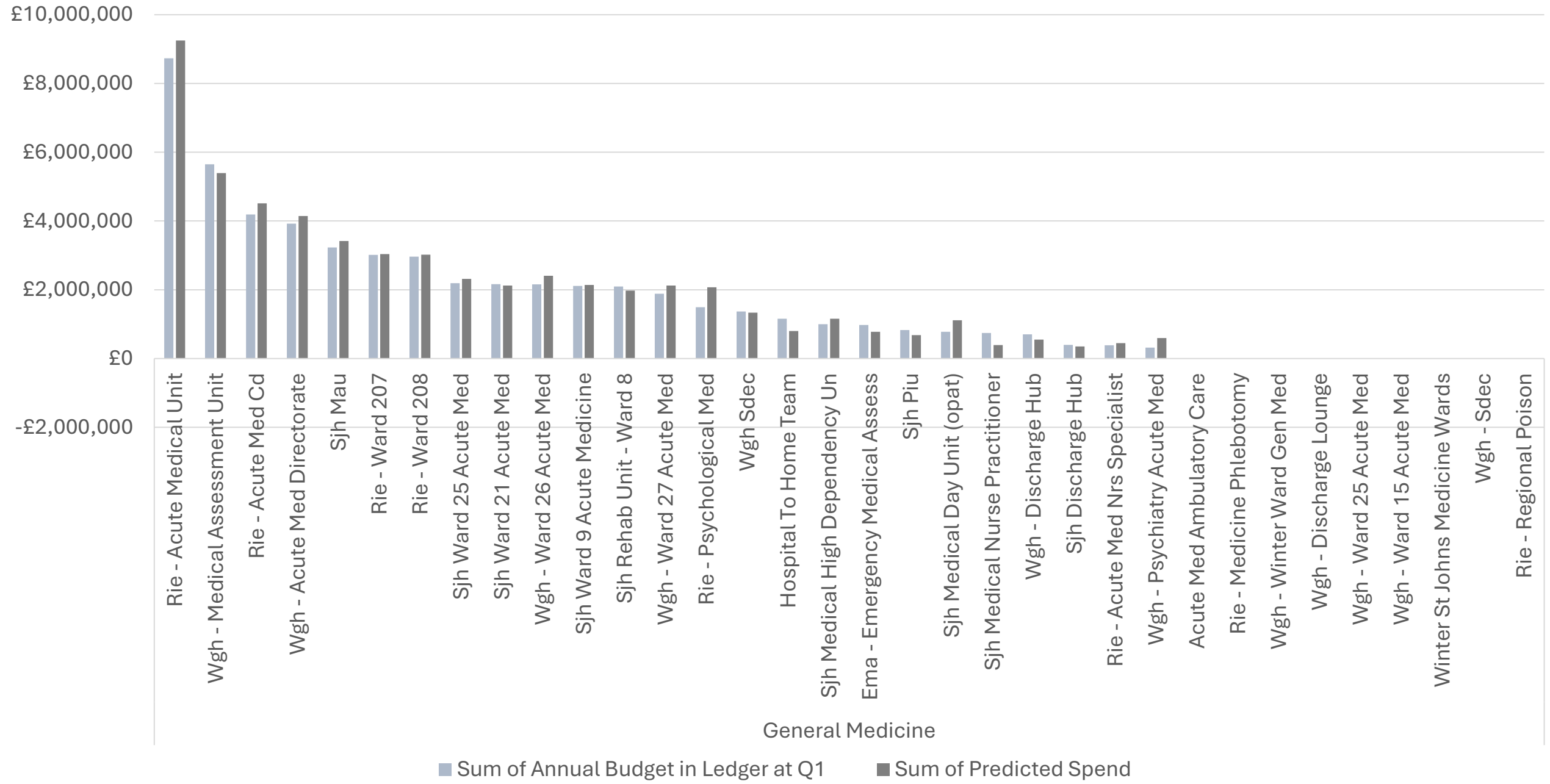


Breakdown of 3x pillars

PARETO ANALYSIS ON PREDICTED SPEND OF SERVICES



GENERAL MEDICINE



....and so on.....

Other considerations

Proposed // Revised USC Measurement Framework WORK IN PROGRESS

- Attendance rates/1000 population into ED by HSCP (total population and >75s)
- Unplanned Admission rates/1000 population by HSCP (total population and >75s)
  - Target = reducing trend on baseline tbc
- 4hrEAS
  - Admitted
  - Non-admitted (target = 85%)
- Bed Occupancy
  - Target = 85%
  - Emergency bed day rate for adults (per 1000 population)

- Attendance rates/1000 population at ED by HSCP (total population and >75s)

REDUCE ATTENDANCES

Navigation Programme Board (encompassing FNC + SPOCs)

% redirection

% Utilisation of alternative capacity

Clinical Pathway Review Board

- Total occupied bed days for all patients, and patients in delay
- Actual LoS vs PDD LoS vs Target LoS
- % Bed Occupancy

REDUCE LoS

OT/PT Implementation Group

DwD Programme Board

Site/ Specialty LoS Programmes + PDD implementation

TOBDs for patients not in / and in delay

Actual & Planned (PDD) LoS for each specialty against targets

% PDD set within 48 hours of entering ward

- Admission rates/1000 population by HSCP (total population and >75s)
- Proportion of last 6 months of life spent on acute site
- % of frailty patients discharged within 48hours
- % of General Medicine patients discharged within 48hours
- % of Surgical patients discharged within 24hours

REDUCE ADMISSIONS

Pan Lothian RACU Group

Number of appointments that would have been ED attendances

4hr Compliance

Virtual Capacity Programme Board

Trend in admission rates by relevant condition

H@H group

Interface working groups

Pan-Lothian Frailty Programme Board

Trend in admission rates for those categorised as frail

TOBD for those categorised as frail

ESD Project Board

TOBD for unplanned patients

% discharged from AMUs within selected timescales

Realistic Medicine

IJBs role in USC

- **Strategic Planning and Commissioning**: IJBs are required by legislation to develop a strategic plan for the integrated health and social care services within their remit. This plan includes commissioning unscheduled care services, ensuring that these services are effectively planned and coordinated to meet the needs of the population. The IJB must ensure that the strategic plan is aligned with national health and wellbeing outcomes and integration principles.

- **Governance and Performance Monitoring**: IJBs are tasked with the governance and oversight of the commissioned services, including unscheduled care. They are responsible for issuing directions to Health Boards and Local Authorities on how these services should be delivered. These directions are legally binding and ensure that the services provided are consistent with the strategic objectives and performance criteria set by the IJB.

IJB USC Indicators

- *As per LSDF Measurement Framework PLUS*

- Falls Rate per 1,000 Population in Over 65s
- Proportion of Last 6 Months of Life Spent at Home or in a Community Setting
- Number of Days People Spend in Hospital When They Are Ready to Be Discharged
- Percentage of Total Health and Care Spend on Hospital Stays Where the Patient Was Admitted in an Emergency
- Percentage of People Admitted from Home to Hospital During the Year, Who Are Discharged to a Care Home
- Percentage of People Who Are Discharged from Hospital Within 72 Hours of Being Ready
- Expenditure on End of Life Care

Making sense of this puzzle……

How can we evaluate & analyse ?

- Options include;
  1. Thematical analysis against a series of principles and evidence base
     - Activity mapped as best as possible to LSDF / IJB indicators

  2. Conceptually top slicing (minus any sacred cows) and proposals agreed as to how to reinvest in line with principles and evidence base. Then, look at what risks would remain / how to mitigate against
     - Proposals mapped as best as possible to LSDF / IJB indicators

  3. Visually divide the budget into blocks, then rebuild system
     - “Blocks” mapped as best as possible to LSDF / IJB indicators

  4. A combination and sequence of the above

  5. ….Other options?

“Straw Man” Principles based on LSDF & IJB Legislation

1. Efficiency and Best Value

How could this spend achieve the same or better outcomes at the same cost or lower, while maximising resource use, minimising waste, and delivering care closer to the patient's home?

2. Person-Centred and Localised Care

How could this spend enhance the delivery of care that is more tailored to individual needs and easily accessible within the community?

3. Prevention and Sustainability

How could this spend support the long-term prevention and therefore sustainability of services, while avoiding short-term solutions that might compromise future care delivery?

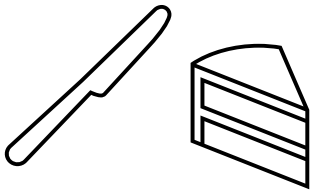
4. Integration and Collaboration

How could this expenditure foster better integration between health (including acute) and social care services, as well as partnerships with third-sector and community organisations, improving coordination and reducing fragmentation?

5. Outcomes-Based Approach

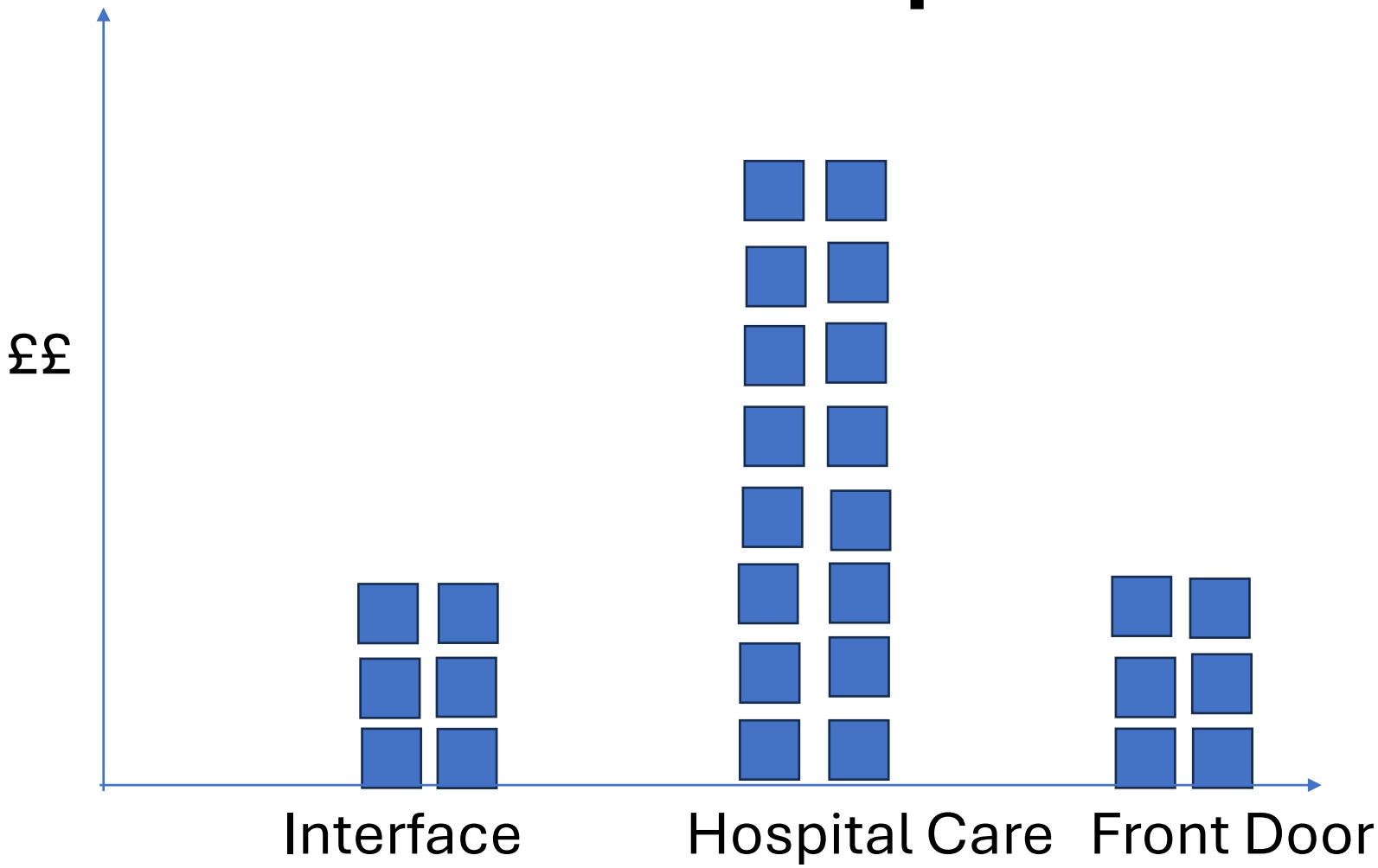
How could this spend be more effectively aligned with achieving the key outcomes (measurement framework) outlined in the LSDF, particularly in terms of measurable improvements in health, well-being, and reducing inequalities?

The Top Slicing Concept…



- As a thought experiment // tabletop exercise …..
- Reallocation of £300m …..too hard
- Have to assume we've got core provision correct
- Do we "virtually" top-slice a % of total spend (excluding certain critical services) to develop conceptually a reinvestment pot?
- I.e. Do we conceptually reduce all costs by 20%?
- Would provide a >£60m pot to then evaluate how to spend differently and this is done in line with LSDF / IJB indicators in line with evidence base
- Once headline changes generated, evaluation of the impact on other services.
- Revised models would need to be worked towards in coming years

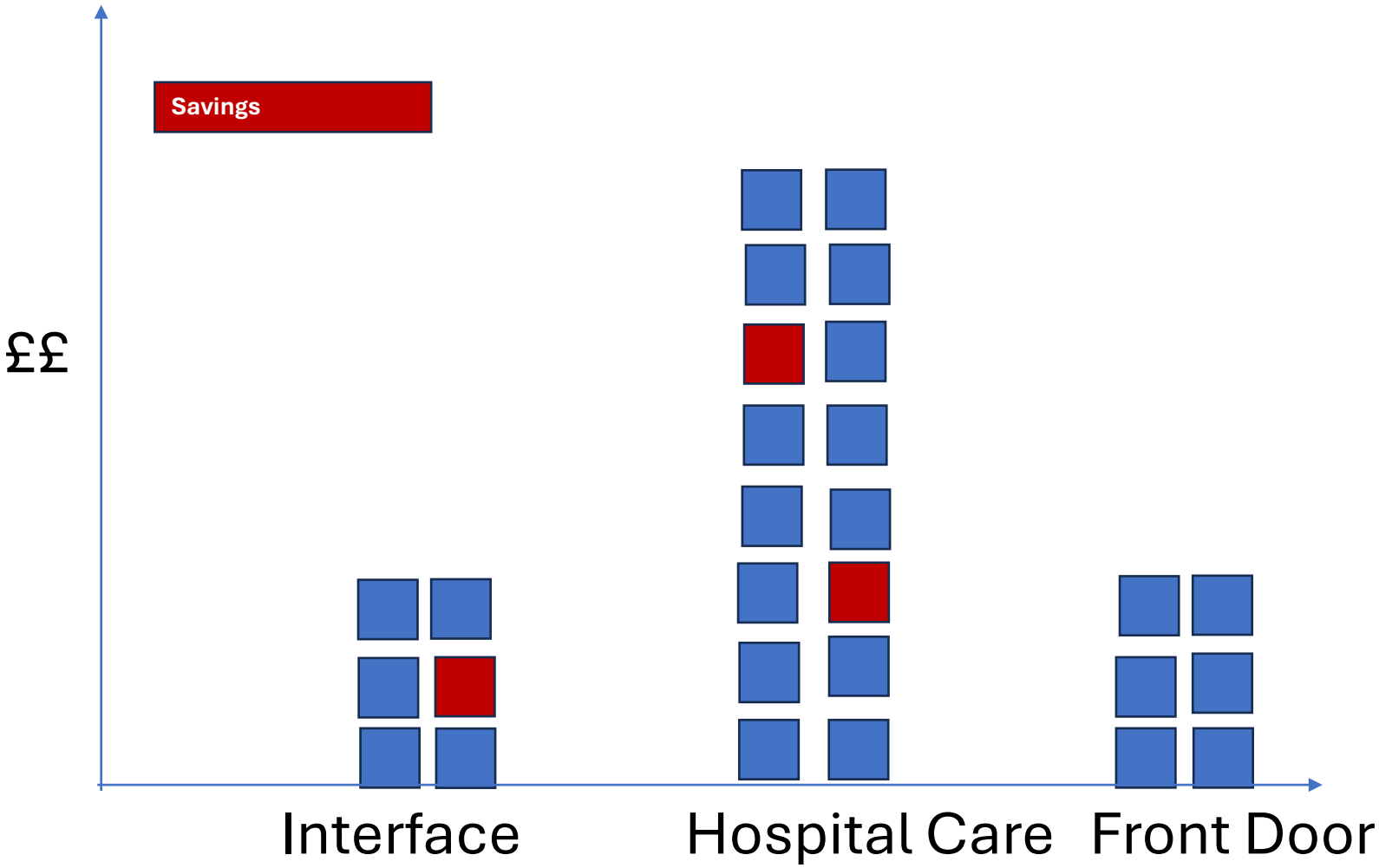
The Block Concept



?Other Pillars? Primary Care?

USC activity outwith USC Pillar (ie care @ home etc)

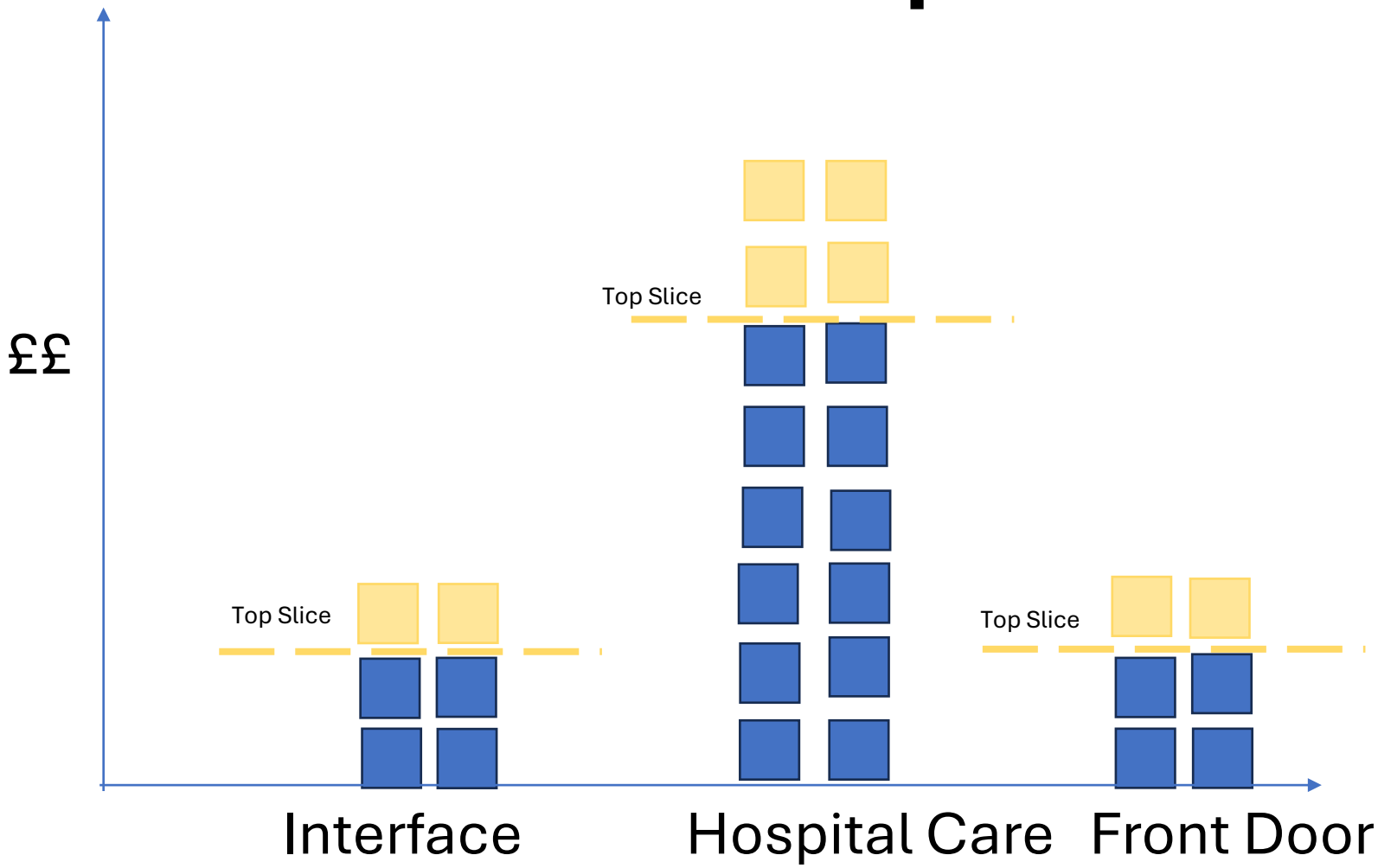
What we tend to do



?Other Pillars? Primary Care?

USC activity outwith USC Pillar (ie care @ home etc)

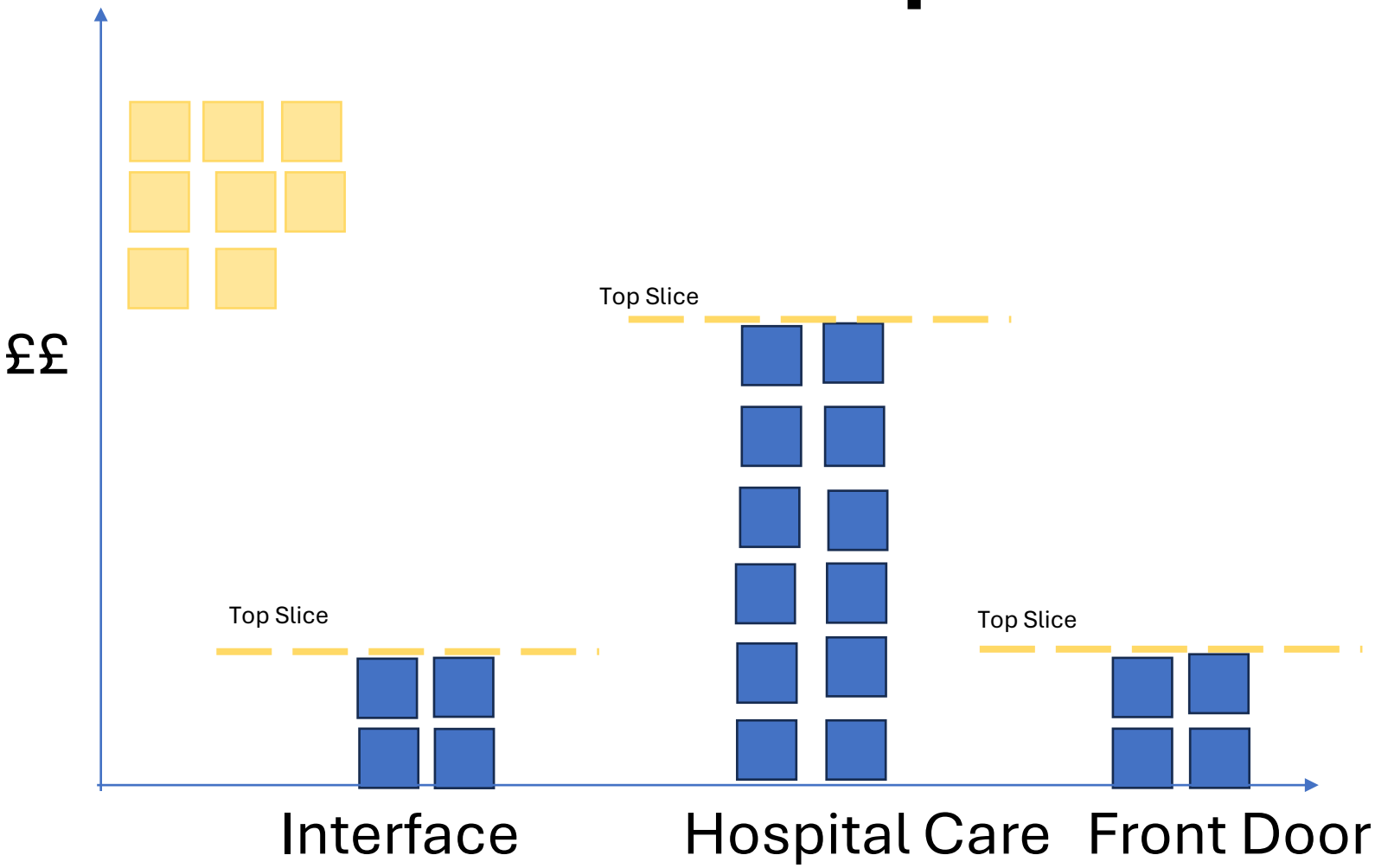
The Block Concept



?Other Pillars? Primary Care?

USC activity outwith USC Pillar (ie care @ home etc)

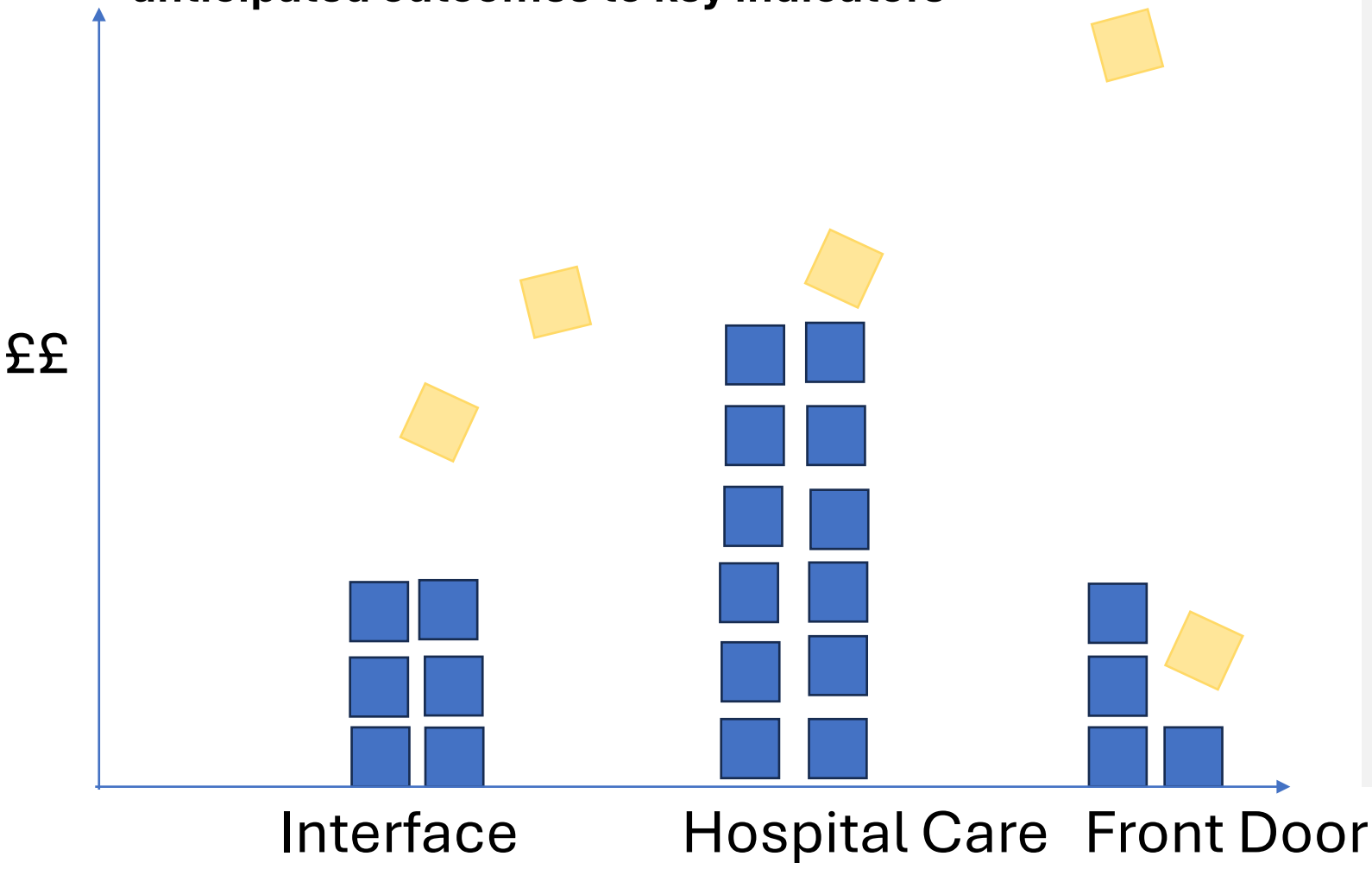
The Block Concept



?Other Pillars? Primary Care?

USC activity outwith USC Pillar (ie care @ home etc)

Reallocation based on evidence base + alignment of anticipated outcomes to key indicators



?Other LSDF Pillars?

Primary Care?

USC activity out with MTFF (i.e. care @ home etc)

Thoughts / Feedback?