ITEM No …18……..…..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 JUNE 2019**

REPORT ON: **UPDATE ON DELAYED DISCHARGE, UNSCHEDULED CARE AND WINTER PRESURES IMPROVEMENT PROGRAMMES**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB36-2019**

1.0 PURPOSE OF REPORT

1.1 This report details the progress made against Home and Hospital Transition Improvement Plan 2018/19 and updates the Integrated Joint Board on the work of the Unscheduled Care Board. In addition the paper reports on the performance to manage patient flow during the winter period and seeks agreement from the Integrated Joint board to sign off the Tayside area report to the Scottish Government which describes the Tayside performance during the winter period (1st November 2018 – 31st March 2019).

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the progress made against the 2018/19 Home and Hospital Transition Improvement Plan as reported in section 4.2 and as detailed in Appendix 1.

2.2 Notes the work of the Unscheduled Care Board during the previous financial year and the change projects associated with this work-stream as detailed in section 4.3

2.3 Notes the progress made in implementing the winter plan during 2018/19 as detailed in section 4.4 and as detailed in Appendix 2

2.4 Notes the requirement to produce a winter plan for 2019/20 and requests that this be submitted for IJB consideration prior to submission to the Scottish Government

2.5 Approves the report on the progress made across Tayside during the winter period 2018/19 as attached at Appendix 2 and confirms agreement for this report to be signed off for submission to the Scottish Government.

3.0 FINANCIAL IMPLICATIONS

3.1 There are no financial implications, the improvement plan will be delivered within current budgets, and through resources allocated to the Partnership through Unscheduled Care Funding to test new models of working.

4.0 MAIN TEXT

4.1 Background to Discharge Management

4.1.1 A delayed discharge is a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date (ISD Delayed Discharges Definitions and Data Recording Manual).

4.1.2 The focus on effective discharge management is reflected through the National Health and Wellbeing Outcomes and their indicators. There are two indicators that relate directly to effective discharge management:

- National Indicator 19: Number of days people spend in hospital when they are ready to be discharged;
- National Indicator 22: Percentage of people who are discharged from hospital within 72 hours of being ready.

4.1.3 Standard delays are defined by ISD Scotland as delays where the standard maximum delay period applies. This includes patients delayed due to awaiting assessment, care packages, housing, care home or nursing placements. The standard maximum delay period is now 72 hours. Code 9 Complex delays are used by ISD Scotland to describe delays where the standard maximum delay, therefore 72 hours, is not applicable. This is in recognition that there are some patients whose discharge will take longer to arrange and would include patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, Patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation

4.1.4 The partnership's performance in relation to discharge management is reported quarterly to the Performance and Audit Committee. Over the first part of the last financial year, Dundee continued to show an improving picture with the Quarter 3 report indicating continued improved report in the rate of bed days lost to delayed discharge for people aged 75+ (for both standard and complex delays) and for emergency bed day rate for people aged 18+.

4.1.5 This performance against standard delays dipped in the first 3 months of this year as the partnership experienced a rise in demand for social care packages of support which outstripped the current capacity leading to patients being retained in hospital for longer. This change in provision can be aligned to a range of changes within the Care at Home services within Dundee. The retendering of Care at Home contracts commenced which brings a level of uncertainty across current providers, in the lead up to Christmas a local independent provider faced business and financial challenges at a national level which restricted availability for a short period, putting additional strain on the other services; a small provider withdrew from their contract and the internal services remained in a period of redesign. In addition to the delay in discharge home, this change in capacity also impacted on the 'discharge to assess' model which supports people to be assessed in a homely setting prior to making a decision in relation admission to residential care. We therefore experienced an increase in people awaiting admission to a care home setting.

4.1.6 The level of service and provision will be monitored over the early part of this financial year as new providers are introduced and changes to contractual arrangement are bedded in. The retendering process also introduced an increased number of framework providers which will enable a flexible approach to service provision. While it is anticipated that this will bring a more settled level of service provision to Dundee, we anticipate that there will be a continued growing demand for services. In line with the budget proposals for 2019/20 an additional £600,000 will be allocated to the external care at home provision and the management of this budget will be closely monitored.

4.1.7 For adults who have a complexity of circumstances the main reasons for delay is where a person is awaiting completion of Guardianship processes, awaiting a place in specialist facility, awaiting completion of complex care arrangements and exercising their statutory right of choice. We continue to work towards developing a range of supports and options which will further improve our position and the previous financial year, new accommodation with care developments were made available.

4.2 Home and Hospital Transition Improvement Plan

4.2.1 Within Dundee a Home and Hospital Transitions Group (the Group), chaired by the Head of Health and Community Care, oversees performance and improvement actions in relation to unscheduled care and patient flow into and out of hospital. The Group aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be. Each financial year the Group sets out the improvement actions for the following year. These actions reflect the previous year's performance, identified gaps and new national targets.

4.2.2 A copy of the improvement plan for 2018/19 is attached as Appendix 1 and details the progress made. Highlights for improvement related to the Improvement plan 2018/19 include:

- Investment in Just Checking systems as an assessment tool to support more independent living.
- Further embedding of the Dundee Enhanced Community Model for support for Older Adults.
- Expansion of the Moving Assessment into the Community project.
- Investment in training to upskill staff to support people with palliative care needs.
- Further expansion of the Integrated Discharge Management Hub to include specialist liaison staff and to test out a Tayside wide model of integrated discharge.
- Continued investment in the Power of Attorney campaign
- Development and testing of an early indicator of deteriorating health and wellbeing tool which will be rolled out this year.

4.2.3 The Scottish Government allocated a ring fenced budget for the improvement of delayed discharges at a local level. This budget was mainstreamed as part of the 2017/18 budget settlement, however as the partnership had allocated the funding to projects and redesign work with a 2 – 3 year span, it was agreed to maintain the fund as a change fund until the completion of the project and redesign phase. During this financial year projects were monitored and evaluated and proposals for mainstream funding included within the budget statement for 2019/20.

4.3 Unscheduled Care

4.3.1 Improving unscheduled care across Scotland is a key ministerial priority for the Scottish Government. Through the National Unscheduled Care, 6 Essential Actions Improvement Programme, the aim is to improve the timeliness and quality of patient care from arrival to discharge from the hospital and back into the community, aiming to ensure that 95% of patients attending Emergency Departments anywhere in Scotland are seen, treated and discharged or admitted with four hours, ultimately working towards 98%. Significant improvements have been made across NHS Scotland however it was recognised that more needed to be done to ensure these successes are sustainable; as such, the launch of the new improvement focused approach Unscheduled Care Programme in May 2015, based on six fundamental actions is aimed at progressing and sustaining improvements.

4.3.2 The Unscheduled Care Programme is aimed at achieving safe and effective care delivered to every patient, every time without unnecessary waits, delays and duplication through the implementation of six essential elements:

1. Clinically Focused and Empowered Hospital Management.
2. Capacity and Patient Flow Realignment.
3. Patient rather than Bed Management – Operational Performance
4. Medical and Surgical Processes arranged for Optimal Care.
5. Seven day services targeted to increase weekend and earlier in the day discharges.
6. Ensuring patients are cared for in their own homes or a homely setting.

4.3.3 The Scottish Government recognise that for NHS Boards to maintain progress they must increase their whole system focus, with engagement and alignment of primary secondary, voluntary and third sector organisations, which are vital to a whole system approach as well as supporting the ambition of safe, effective and person-centred care. In 2017, NHS Tayside established an Unscheduled Care Board (the Board) which has secondary and primary care representation and which includes the three Health and Social Care Partnership areas. This collaborative working group provides a leadership role to the improvements across both acute and community care. A number of the Dundee Home and Hospital Improvement Plan redesign projects are aligned to this work. The Board takes a leadership role in supporting the development of the NHS Tayside Integrated Clinical Strategy.

4.3.4 The Scottish Government allocated additional financial resources to progress the Unscheduled Care program. The Scottish Government confirmed to NHS Tayside on the 3rd August 2018 that Tayside Unscheduled Care funding allocation would be £470,894. This resource is in part pre-prescribed in that the resources are to be used to develop an improvement team which includes clinical leadership, improvement and data analysis and project management. The remainder of the resource can be utilised to support local change projects. As with many change funds, the Unscheduled Care Board received a higher level of proposed change initiatives than the fund can support. A process of assessment and criteria was agreed and resources allocated to further embed seven day discharges and work with both general and specialist medicines to support the development of new discharge and unscheduled care pathways.

4.3.5 Over the last year the following projects were tested and demonstrated improvements in both performance and outcomes for patients. The projects funded included:

- Further development of the Acute Frailty Team
- Implementation of an outpatient pathway for the management of Unilateral Pleural Effusion.
- General Surgery – Unscheduled Surgical Flow Management
- Pharmacy Funding for 7 day discharge modelling
- 7 day physiotherapy and OT services
- Additional Care at Home services
- Additional Integrated Discharge Hub Coordinator
- Additional Enhanced Social Care Support to target same day discharge
- Weekend transport
- Technology to deliver Home and Mobile health Monitoring Solutions

4.4 Winter Pressures Plan

4.4.1 NHS Boards and Health and Social Care Partnerships are required each year to submit a report to the Scottish Government setting out their intended actions to manage the season pressures occurring in winter. The potential pressures include an increase in demand across Emergency Departments, the impact of seasonal influenza, the impact of extended Public Holiday close down of services, deteriorating weather conditions and the potential resulting need for additional inpatient beds and community services. The Winter Plan defines the level of preparedness for winter, sets out the range of planned actions to address the potential impact and puts in place arrangements to monitor and respond to any disruption to capacity and flow. The Scottish Government resources the implementation of the Winter Plan through additional national resources of which the Tayside share was £737,734. The planning and implementation of the Winter Plan is overseen by the Unscheduled Care Board who hold devolved responsibility for the distribution and monitoring of the Winter Plan funds. The Winter Plan applies to the period 1st November 2018 – 31st March 2019.

4.4.2 In their guidance Preparing for Winter (2018/19), the Scottish Government highlighted key areas, of which the following formed the whole system approach for Tayside:

- Resilience
- Unscheduled/Elective Care
- Out-of-Hours
- Norovirus
- Season Influenza/Influenza like illness
- Respiratory Pathway
- Key Partners/Services
- Mental Health

4.4.3 The Tayside Winter Plan 2018/19 built on the learning from the winter of 2017/18, where despite forward planning, it was recognised that further work could be done to improve responsiveness, ongoing communication and decision making. Whole system planning commenced in April 2018 to ensure that preparations were agreed and implemented prior to the commencement of the winter period. This approached ensured that all key partners were sighted and involved (Health and Social Care Partnerships; NHS Tayside; Scottish Ambulance Services; Out of Hours; Primary Care and Public Health). The plan took into account the evolving medical inpatient models and the improvements made across health and social care partnerships to support unscheduled care.

4.4.4 There were a range of key actions identified to implement the Winter Plan, however those most relevant to Dundee Health and Social Care Partnership include:

- Further development of the Assess to Admit Model
- Increase in senior decision makers
- Redesign of the inpatient bed model to support the ongoing progression of patients through the acute and Medicine for the Elderly pathways
- Introduction of a designated Acute Medicine for the Elderly Unit
- Additional funding to improve Out of hours General Practice resilience
- Further investment in professional to professional communication to share decision making
- Introduction of near patient testing to identify and treat flu like symptoms
- Targeted campaigns to increase uptake of Flu vaccination
- Increased support from psychiatric liaison into acute hospital settings to support patients with co-existing mental health and physical ill health issues

4.4.5 A copy of the 2018/19 winter report for Tayside which sets out the performance during this period is attached at Appendix 2. This report has been submitted to the Scottish Government in line with the requested timelines by NHS Tayside, with confirmation that the report has yet to be approved by each of the Integrated Joint Boards within Tayside. The IJB is asked to approve this report for final submission to the Scottish Government.

4.4.6 It is anticipated that the Scottish Government will confirm their intention to release additional financial resources to Board areas to address winter pressures during the winter period 2019/20 and will request NHS Bards and their partners to develop and submit a Winter pressures plan for this period. The completion of the Tayside Winter Pressures Plan will be developed and agreed by the Unscheduled Care Board and signed off by NHS Tayside and Health and Social Care Partnerships. A copy of this plan will be presented to the IJB for consideration prior to submission to the Scottish Government.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

6.0 RISK ASSESSMENT

The following key high level risks were identified in the previous paper and remain. Risks will be identified and managed within each service in more detail and managed by the Dundee Primary Care Improvement Group. Further information on risk associated with each development are noted in appendix 1.

Risk 1 Description	That the Home and Hospital Transitions Improvement Plan and the Unscheduled Care Action Plan are not fully implemented and do not achieved the desired outcomes.
Risk Category	Operational
Inherent Risk Level	Likelihood (3) x Impact (4) = Risk Scoring 12
Mitigating Actions (including timescales and resources)	The plans sit across a range of service areas and are aligned to a number of other redesigned work. In assessing the programmes the ability to implement proposed changes has been used as a key criteria.
Residual Risk Level	Likelihood (3) x Impact (3) = Risk Scoring 9
Planned Risk Level	Likelihood (3) x Impact (3) = Risk Scoring 9
Approval recommendation	This risk should be accepted.

6.0 CONSULTATIONS

The Chief Officer and the Clerk were consulted in the preparation of this report.

7.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

8.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 17 June 2019

Diane McCulloch
Head of Health and Community Care

Appendix 1

HOME & HOSPITAL TRANSITION IMPROVEMENT ACTION PLAN - 2018/19

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator	Lead Officer	Action Update
National Outcome 1: Healthier Living and National Outcome 5: Reduce Health Inequalities	• **National Indicator 1**: % of adults able to look after their health very well or quite well • **National Indicator 12**: Emergency Admission Rate (per 100,000 people aged 18+) • **National Indicator 13**: Rate of emergency bed days for adults	Use Unscheduled Care Information to clarify and understand local performance, gaps in service and redesign pathways in one specialist area.	Diane McCulloch Lynne Morman Dougie Lowdon Jenny Hill	Development of Acute Medicine for the Elderly unit in Ninewells to enable comprehensive geriatric assessment to take place and facilitate early discharge back to patient's home environment
		Further develop use of technology enabled care as a means of enabling people to live independently and look after their own health.	Alexis Chappell Vicki Stewart Lynne Morman Karen Lesslie	Investment in Just Checking systems as an assessment/screening tool to reduce reliance on social care
		Further embed Enhanced Community Model for support for Older Adults and consider the Community Model for Support with Adults as a means of reducing emergency admissions and enabling people to live independently and look after their health in their own home or homely setting.	Locality Managers Mike Andrews	Review of staffing model and links to DECSA
		Further develop awareness and use of anticipatory care plans for all Adults where a plan would be of benefit to the Adult.	Jacqueline Thomson	Promotion and development included. Improvement Advisor appointed via Palliative End of Life Care pilot site for Dundee Care Homes – ACP. Education Programme in place through Palliative Care Education Unit. Currently no central register of ACPs so unable to access the full impact.
National Outcome 2: Independent Living	• **National Indicator 18**: % of adults with intensive care needs receiving care at home • **National Indicator 15**: Proportion of last 6 months of life spent at home or in a community setting	Expand the 'Moving Assessment into the Community' project for older people to develop a frailty model for people of all ages.	Jenny Hill	Criteria for services expanded to ensure services respond to identified need regardless of age.
		Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways. Specific focus on development and expansion of 'Discharge to Assess' i.e. no patient should be discharged to a care home from hospital without a home based assessment.	Lynne Morman	Following test period, tendering process underway to embed model
		Increase our investment in intermediate forms of care such as step up/step down accommodation and support for all adults.	Locality Managers Lynne Morman Angie Smith Mike Andrews	Expansion of step down housing model – 5 properties with a further HWC about to be tested

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator	Lead Officer	Action Update
		Further develop discharge planning arrangements for adults with mental ill-health and learning disabilities and substance misuse issues	Arlene Mitchell Lynne Morman	Integration of substance misuse liaison post to the Discharge Hub to promote improved pathways.
		The work around the Mackinnon pathway is being reviewed regarding numbers of beds Further develop discharge planning arrangements for adults with physical disability and acquired brain injury.	Beth Hamilton Lynne Morman Jenny Hill Angie Smith Gillian Crighton Claire Tester	A pilot is underway around the development of an ambulatory care model involving discharge from the hospital, but remaining a day attendee for intensive therapy Further development of rehab pathway into Mackinnon Centre. Recruitment of additional discharge coordinator to support improved discharge processes across the younger adult pathway i.e. Carseview and CBIR Scoping of service requirements for younger adult pathway i.e. bed base, CRT, step down resource
		Evaluate current project and seek further investment in resources which support assessment for 24 hour care taking place at home or home like settings.	Mike Andrews Lynne Morman Craig Willox	Year end evaluation information being prepared by Red Cross with a view to reporting on impact. USB bid provides a further 106K to enhance provision over winter period and potentially test Tayside wide approach
		Redesign services to ensure rapid access to palliative services.	Beth Hamilton David Phillips Karen Lesslie	Macmillan Foundations in Palliative Care training rolled out cross the social care workforce
		Review access to end of life services so that people are supported in their place of choice.	Beth Hamilton	Pilot work ongoing with Marie Curie to support discharge for t hose at end of life stage to die at home.
		Review patient pathways between Carseview Hospital and the community.	Arlene Mitchell Lynne Morman	Workstreams developed around Crisis Care, Home Treatment and Rehabilitation which will be progressed through the Mental Health Alliance.
		Support the redesign of specialist services discharge pathways through redesign of referral and response models	Jenny Hill	Modelling in place for specialist rehab for younger people. To be further refined prior to implementation.

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator	Lead Officer	Action Update
National Outcome 2: Independent Living	• **National Indicator 18**: % of adults with intensive care needs receiving care at home • **National Indicator 15**: Proportion of last 6 months of life spent at home or in a community setting	Further expand the fully Integrated Discharge Management Team by incorporating specialist workers to improve communication, facilitate better outcomes and further develop opportunity for discharge assessment for all patients at Ninewells.	Karen Gall Lynne Morman Lee Foggarty Gillian Crighton	Multidisciplinary staff group now established with addition of MHO post, liaison psychiatry OPS and SMS, and AHP staff
		Promote Power of Attorney through local campaigns as a means of increasing number of Power of Attorneys so that Adults are not waiting in hospital settings for decisions about their care upon discharge.	Arlene Mitchell	DHSCP have funded a share of the Tayside PoA campaign. Agreed to continue.
		Review and remodel care at home services to provide more flexible responses	Beth Hamilton Karen Lesslie David Phillips	Re-energise of service redesign approach to delivery of care across health and social care
		Further develop models of Community Rehabilitation to support transitions between home and hospital	Alexis Chappell Matthew Kendall Claire Tester Matthew Perrot	Remodelling progressing to support locality based community rehabilitation.
		Further embed seven day discharge.	Lynne Morman Gillian Crighton	7 day inpatient AHP and discharge coordinator service now mainstreamed
National Outcome 3: Positive Experiences and Outcomes	• **National Indicator 5**: % of adults receiving any care or support who rate it as excellent or good	Develop and implement discharge management procedures and guidance to promote consistency in practice in relation to discharge management and use of planned date of discharge.	Lynne Morman	Completed
		Establish and implement a Discharge Management Learning Framework and Learning Networks as a means of promoting and enabling consistency in practice and ensuring effective person centred communication during transition between hospital and home.	Lynne Morman Mike Andrews	Regular staff briefings being held across all teams to ensure consistent communication of strategic approach
		Develop an 'early indicator of deteriorating health and well-being tool', for use by front line social care staff to reduce the instances of hospital admissions, increase the use of preventative interventions, and assist people to look after their health and well-being.	Karen Lesslie David Phillips Gill Reilly	Early Indicator Tool developed and agreed. Will be rolled out during 2019/20

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator	Lead Officer	Action Update
National Outcome 6: Carers are Supported	• **National Indicator 8**: % of carers who feel supported to continue in their caring role	Implement a statement and pathway for involving Carers in discharge planning process in line with section 28 of the Carers (Scotland) Act 2016 in partnership with Carers and Carers Organisations	Lynne Morman	Carers involvement incorporated into Learnpro module for NHS staff
National Outcome 7: People are Safe	• **National Indicator 14**: readmission to hospital within 28 days • **National Indicator 16:** Falls rate per 1,000 population in over 65's	Further implement the planned date of discharge model so that patients , carers are involved in a well-planned discharge and have coordinated follow up care where required upon discharge	Lynne Morman Karen Gall	Further expansion of this approach across younger adult pathways
		Further develop post discharge support to people with long term conditions in order to contribute to a reduction in emergency hospital admission and readmission to hospital	Beth Hamilton District Nursing AHP Gillian Crighton Lynne Morman Jenny Hill Mike Andrews Jacqueline Thomson	Embed 'home first' approach with enhancement of community rehab/social care pathways, DECSA and Red Cross Assessment at Home Service.
		Further develop local fall pathway initiatives to reduce risk of falls.	Matthew Kendall	Falls Action Group developed. Testing initiatives. Deep dive of data to be considered in one LCPP area.
National Outcome 9: Resources are used Efficiently and Effectively	• **National Indicator 20**: % of health and care resources spent on hospital stays where the patient was admitted in an emergency.	Establish integrated systems and processes which support information sharing and improved communication (All Indicators)	Alexis Chappell Lynne Morman Lynsey Webster Joe Donnelly	Escalation procedures in place. Issues regarding the introduction of new e systems not yet fully resolved.
		Review the systems and mechanisms for reporting around discharge management and provide regular reports into the Performance and Audit Committee.	Alexis Chappell Lynne Morman Lynsey Webster	Performance reports incorporated into the regular quarter by reports for PAC.
		Work with the Unscheduled Care Board to implement the Unscheduled Care board Action Plan	Diane McCulloch	Dundee Actions incorporated into the USC programme and action plan.
		Work with Partners to develop the 2018/19 Winter Pressures Plan and ensure arrangements are in place to support any escalation of the plan	Diane McCulloch	Winter plan developed and achieved.

Appendix 2

Health & Social Care: Local Review of Winter 2018/19

NHS Board, HSCPs:	NHS Tayside Dundee, Angus & Perth and Kinross HSCP SAS	Winter Planning Executive Lead:	Lorna Wiggin, Director of Acute Services, NHS Tayside Vicky Irons, Chief Officer, Angus, Health & Social Care Partnership David Lynch, Chief Officer, Dundee, Health & Social Care Partnership Gordon Paterson, Chief Officer, Perth & Kinross, Health & Social Care Partnership Dr Elaine Henry, Clinical Lead Winter Planning

Introduction
As in previous years, to continue to improve winter planning across Health & Social Care we are asking local systems to lodge a draft of their winter review for 2018/19 with the Scottish Government to support winter planning preparations for 2019/20.

Local reviews should have senior joint sign-off reflecting local governance arrangements.

We expect that your Chairs and Chief Executives are fully engaged in the review.

We expect this year's local review to include:

- the named executive leading on winter across the local system who will produce the local plan for 2019/20
- key learning points and planned actions
- top 5 local priorities that you intend to address in the 2019/20 winter planning process

Completed reviews should be sent to **Winter_Planning_Team_Mailbox@gov.scot** by no later than close of play on **Friday 3 May.**

Thank you for your continuing support.

JOHN CONNAGHAN CBE

Chief Performance Officer, NHSScotland
and Director of Delivery and Resilience

Introduction

NHS Tayside, and its partner organisations have taken a collaborative approach for winter planning in 2018/19 through the Tayside Unscheduled Care Board.

The winter plan was developed in collaboration with key partner organisations as well as being part of the local Unscheduled Care Action Plan. It was underpinned by the Six Essential Actions taking full account of the Scottish Government's winter planning correspondence, 'Preparing for Winter' 2018/19 and Supplementary Checklist of Winter Preparedness.

This year we were determined to learn from previous winter challenges and to proactively invest in initiatives to maintain our key services over public holidays and periods of increased illness as well as to try and prevent illness and admissions. NHS Tayside is undergoing transformation and much of this work was integrated into our winter plan.

The winter plan was developed based upon the key areas highlighted in the 'Preparing for Winter' Guidance (2018/19) to ensure early prevention and response to minimise potential disruption to services and ensure that we continue to provide safe and effective care of our population and timely access to services. In particular, continuous improvement work with our Emergency Departments, delayed discharge performance, inpatient/day case, cancer, mental health and outpatient services, to deliver against national standards and maintain progress over the winter.

Approach

The scope of the winter plan was whole system with a focus on the following key areas in line with the Scottish Government 'Preparing for Winter', (2018/19) guidance:

Resilience
Unscheduled/ Elective care
Out-of-Hours
Norovirus
Seasonal Influenza/ Influenza like illness
Respiratory Pathway
Key partners/ Services
Mental Health

Local Review of Winter 2018/19

A local Winter Wash-Up Session was held on Monday 25th March 2019. The aim of the session was to review and reflect on this winter period 2018/19, using the learning to inform and plan ahead for the year ahead's system pressures, winter and all year round planning.

The session was broadly attended with representation from across Health and Partners Organisations.

The session was introduced by the Head of Service Health and Community Care, Dundee Health and Social Care Partnership, Clinical Lead for Winter Planning and Associate Medical Director, providing an overview of the approach to winter planning taken and sharing data to demonstrate the outcomes achieved as a result.

Following this, attendees worked in groups with facilitated discussions based upon the approach taken in the winter plan of:

Prevent – Illness and Admissions within our population and staff
Inform and Respond – Whole System Escalation Framework & Business Continuity Planning
Business as Usual Strategies – review of winter Improvement Projects/Initiatives
Communicate - Communicate Identified pressures and the action needed to maintain Business as Usual

The groups were asked to consider the following questions in each group:
What went well?
What could have gone better?
Key Lessons

Feedback from this local review of winter is detailed throughout the sections of this report. Overall feedback has highlighted the success of the way people have worked, communicated and improved outcomes.

1 Clear alignment between hospital, primary and social care

The winter plan set out how the activities and approach would respond with an escalation of our business as usual activities and continuation of capacity and flow improvements to minimise disruption to service provision and to improve outcomes for patients and staff across hospital, primary and social care services.

The Tayside Unscheduled Care Board developed the detailed implementation plan for resilience and flexibility going into winter and ensured robust assessment of bids and allocation of resources to:

- Provide additional funding for care at home placements in our regions to keep people at home to prevent them becoming hospital patients

- Support an “Assess to Admit” model in community and with PRI and Ninewells which has at its core the principal of realistic medicine that patients wish to be cared for in their own homes. Several strands across the whole Heath and Social Care community mean that enhanced social care, community nurses, therapists and doctors see that hospital admission is not inevitable and therefore an additional funding for Health & Social Care Partnerships to increase the support available in communities and to support earlier in the day discharge. This was a combination of additional consultant physician workforce at weekends to increase the ambulatory care assessment in hospital and to increase social care and allied health professional (AHP) capacity. Respiratory medicine increased their Consultants working at the weekend and public holidays as well as increased respiratory nurse specialists. The Gastroenterology team increased staffing on public holidays to increase endoscopy to support early diagnosis also supports decision making, improved patient experience and creates capacity and flow with ability to discharge earlier for some patients. Investment in AHP hospital resource meant increased ability to discharge patients over seven days.

- The increase in senior clinical decision makers, including senior nurses over the public holiday period, learning from the public holiday review led by Sir Lewis Ritchie, to support weekend discharge rates resulted in a 20% increase in weekend discharges. This covered medical specialties and included Consultants as well as specialist nurses and junior staff to help admit patients. There was an extra “Clerking shift” to help with first assessment and this also provided training in acute care.

- Redesign the inpatient bed model through additional beds and service set up to meet patient needs. The additional 12 beds at Ninewells Hospital were not simply “surge beds” but enabled the ongoing progression of the Acute Medicine and Medicine for the Elderly model. This included identifying a designated Acute Medicine for the Elderly (AME) unit where all frail people from Medical Assessment Unit (AMU West) were transferred into. This allowed the designated Frailty Team to undertake a comprehensive multi-disciplinary review over a 24-72 period, with aim of assessing people’s needs and discharge from acute hospital. By transferring frail people timely from the Acute Medical Unit, AME increased overall capacity for non-frail people in AMU allowing these patients time to be assessed by the Acute Medical team over a 24-48 hour period. Again aimed at timely discharge from hospital. The number of patients cared for through the AME Unit from 3 December to 11 March was 327. The full evaluation to end March is being completed for the Unscheduled Care Board and early data shows the mean length of stay at 2.5 days with 80% of patients discharged on the planned day of discharge. This is a benefit for patients, families and care providers.

- The aim of AME project was to accommodate the predicted 10-15% increased admission numbers over winter months by increasing front door discharge rate from Acute Medical area by more than 10% from standard target of 60% to over 65% hence minimising increased admissions into Ninewells Hospital. This has been maintained and is evidenced by a reduction in bed occupancy and by maintaining the four hour ED performance.

- Increase the Medicine for the Elderly step down winter beds at PRI by four and implement the separation of scheduled and unscheduled acute inpatient wards to maintain elective performance and provide care in the right setting. Tay Ward beds fluctuated over the period from 18 to 20 (four to six additional beds). This has been hugely successful as there has been no cancellation of elective cases at PRI as a result of bed capacity issues. There was only one elective case cancelled at Ninewells due to bed pressures.

- Provide funding to improve service resilience for extra Out of Hours General Practice (GP) sessions and for more GP advice calls to reduce pressure on our Emergency Department (ED). This would mitigate disruption to critical services and support patients to self manage illness at home.

- Invest in professional to other professional communication to share decision making and discharge home from hospital assessment areas to complete investigation and treatment. This support has kept our bed occupancy at an optimal level (90%), reduced patients in inappropriate settings (boarding) and improved patient experience.

- Improve the prevention and management of influenza like illness through investment in near patient testing equipment to prevent un-necessary admissions for flu like illness, to reduce the need for ward closures and impact on patient care. Only one bay was closed this winter due to flu. Patients were tested and started on appropriate anti viral medication within 20 minutes and half of patients were discharged with a positive diagnosis who didn't require admission. A full comparison with the introduction of near patient testing this year will be reviewed at the May meeting of the Unscheduled Care Board.

- Targeted campaign to significantly increase Flu vaccine uptake compared to previous years with peer vaccinators at the heart of our programme. Increased uptake from 18% two years ago and second worst performance in Scotland last year to 54% and an ambition to break through 60%

.

- Investment for the first time at winter to increase the support available from the psychiatric liaison service to increase assessment within acute admission units and to improve time to assessment which is core to "Treat as One" for patients with co-existing Mental and Physical ill health issues in our acute general hospital. Dedicated Specialist Mental Health Nurse input was provided to the care of deliberate self-harm patients requiring psychiatric assessment. Evaluation to date has demonstrated that patients are being seen in a timely fashion which means they are not having unnecessarily prolonged stays in hospital. This is good for patients individually as they get a timely assessment and management plan, and leave a stressful environment. Staff have also given feedback the positive impact that this service has made.

1.1	**What went well?**

One particular area of impact was investing in staff to provide care at home. This allowed discharge of people to the care of community teams, with the system being agile and responsive enough that when it was realised there was not enough home care packages there was the ability to reallocate some winter funding slippage to this to enable more people to go home. This allowed wards with limited bed capacity to discharge people to their home environment where they wanted to be. Another area of particular merit is the "assess to admit" model across the whole of the system. This allowed senior nursing, AHP and medical staff to visit patients at home allowing the provision of high quality care at home without a traditional model of hospital admission

One of the main sources of investment was in the Acute Medicine for the Elderly Assessment Unit (AME). Although this model introduced increased winter bed availability, this was not simply surge beds that ran in a traditional secondary care inpatient bed model that many other board areas have opened. The AME unit assessed and discharged on average 100 people per month with a mean length of stay of 2.5 days with the majority of patients actually going home on their planned date of discharge. The ward was also very popular with existing nursing staff applying to work in the area and has been assessed by the multi professional teams as an ideal way of going forward looking after these patients. This model will be a priority for unscheduled care at Ninewells and PRI as part of the Operational Plan.

The Winter Wash-Up Session held on Monday 25th March 2019 offered the opportunity to receive feedback on how effective the actions to improve alignment of Hospital, Primary and social Care Services is detailed as follows:

General Feedback

- Supported clinical risk assessment and management decisions at the front door
- Approach Whole system collaborative – Step Up Step down
- Acute Medicine for the Elderly (AME)
- Promoting that hospital is not the best place if care accepted
- Dedicated communication channels across the system to improve preparedness and planning
- Winter funding for trainees to allow extra medical workforce into the evening and weekends
- Meeting structure monthly, weekly & cross site huddles effective in promoting cross site and service working
- Built on relationships , promoting Business as Usual , trusting in good systems
- Robust planning of pathway of clinical pathways

Key partners/ Services

- Whole system working and communication
- Cross site communication
- Partnership huddles locally
- Dundee discharge hub 'tests of change; in new areas

NHS Tayside Communications

- Information provided quickly, improved sharing of messages
- More co-ordinated and memorable messages
- Good assistance from Comms Team for Infection Control messages
- Felt more joined and connected across Partnership
- Regular info issues to staff
- Use of social media more successful, regular posts and messages to support the winter campaign
- Evening Telegraph series to promote winter campaign
- Communication to public, patients and staff on access arrangements over festive period

Winter Preparedness /Adverse Weather

- Use of Smarty the Penguin to promote winter wellness
- Winter Zone on Tayside Intranet Well updated including key information required for the winter period

Respiratory Pathway

Enhanced Home support to respiratory services in particular to COPD patients post discharge

- Effective Discharge planning for patient with COPD, 7 days by Respiratory Clinicians
- Access to Oxygen Therapy hospital sites, GP and OOH services
- ACP for patients with Significant COPD and Palliative Care plans for those with end stage disease are in place across respiratory pathway
- Communication plans to support the work of the Respiratory Pathway and service
  - Information Cards - Prevention approach
- Clinics provided in Health settings and Care Homes and offered to Care Providers.
- 'Mop Up' plan in place to ensure all staff could receive Flu vaccine.

Out of Hours (OOH)
Winter Planning monies in OOH were used to put additional GP shifts into the weekend rota (Saturday and Sunday) throughout the months of December and January. This enabled OOH an additional GP in the base at the busiest times to deal with increased patient demand. Demand for OOH increases during the winter period due increasing levels of viral, respiratory and gastric illnesses in the community. Cases are dealt with well before they become more serious and likely to require hospital input. Having additional capacity for the busiest periods not only benefits patients it means that the staff working feel supported thus they are more likely to perform better and its less likely that there will be sickness absence. For OOH it also has the positive impact that it encourages GPs to work in the Service and we are less likely to encounter problems with rota coverage which impacts negati**v**ely patient safety. A fuller rota, within a well functioning OOH Service benefits the whole system including day time Practice and hospital based services.

In addition to the GP's seeing patients, the Service also used some of its allocation to put on additional telephone advice shifts. GPs provide professional to professional advice for a range of services including SAS, community nursing, nursing homes and community pharmacy. Having a dedicated GP to answer these calls means that these Services and professionals are not kept waiting for a response and this ensures that they are able to keep patient flow moving and work efficiently. This is particularly important for the Ambulance service. Having the opportunity to obtain clinical advice from the GP also helps prevent unnecessary hospital admissions and if answered speedily means that there is less likelihood of the patient being transported to hospital as others can't obtain the advice they need within a reasonable timescale. Providing telephone advice not only assists the OOH Service its very beneficial for others and ensures all parts of the system are working together effectively to deliver the best care possible for patients.

What Worked Well?

- Shift uptake – shifts were filled and additional capacity achieved.
- Additional GPs on duty to deal with the increased winter demand has a positive impact as outlined above not only for OOH Service itself but impacts positively on the system as a whole.
- Winter period was busy for OOH, the nature of the flu season this year meant that there was a lot of lower level illnesses that we were able to deal with successfully in the community.
- Being included in the wider NHS Tayside winter planning process from the outset was very welcome. We were able to contribute and felt involved. The weekly meetings were very helpful – it felt joined up and was well organised and managed centrally

Mental Health

Perth Royal Infirmary
There has been a trial of dedicated Specialist Mental Health Nurse input to the care of deliberate self-harm patients requiring psychiatric assessment at Perth Royal Infirmary (PRI) over the last two months. This test of change is now complete, showing very significant benefits this change has delivered. All patients presenting with deliberate self-harm require a psychiatric assessment prior to discharge. The existing arrangement relies on the input of the on-call Psychiatry doctor from Murray Royal Hospital. Due to their other responsibilities assessments are often delayed until later in the day, and on occasion the following day. In addition, patients are only reviewed if they are referred between 9-11am – so a patient presenting after this time who is fit for discharge will not be seen until the following day. Finally, patients who are receiving any form of active medical treatment, even if it will be completed before the next opportunity for review, are not seen. The benefits seen in PRI as a result of this change are as follows;

- Patients are being seen in a timely fashion which means they are not having unnecessarily prolonged stays in hospital. This is good for patients individually as they get a timely assessment and management plan, and leave a stressful environment. As importantly this has an impact on patient flow and bed availability, increasing our capacity to admit patients. As you know there are very significant pressures on length of stay and bed occupancy in unscheduled care in PRI. Whilst we recognise psychiatric services are under significant pressure, we cannot afford unnecessary delays in access to emergency psychiatric assessment.

- A proportion of this group of patients “discharge against medical advice” while waiting for assessment, thus not getting the psychiatric assessment and follow-up they need. Furthermore, higher risk patients who wish to self-discharge need to be detained under the Mental Health Act to ensure they do stay for psychiatric assessment, which creates unnecessary distress for the patients, and has significant work force and cost implications as they often require1 to 1 nursing care.

- The availability of the specialist nurse service at Perth Royal Infirmary meant that patients were receiving the same high quality and timely assessments as they receive at Ninewells Hospital, The specialist nurses have also been able to provide us with advice on the management of psychiatrically unwell patients still receiving active medical treatment, improving the standard of care they receive as inpatients, and providing essential support for ward staff looking after these often complex and challenging patients. NHST is committed to equity of access to services and this is particularly important in potential vulnerable patients with mental health problems. The continuation of this service would work towards equality of access across NHS Tayside. The Unscheduled Care Board has agreed to support this service in the short term while a bid for Unscheduled Care Funding is prepared.

- The nurses have also been able to deliver assistance for the care of non-self-harm psychiatric patients. Previously we have not been able to access regular General Adult Psychiatric review of these patients whilst in Perth Royal Infirmary due to a lack of capacity amongst Perth Psychiatry Services.

Angus
Local Angus Mental Health Community Services show no variance, change in referral patterns or other pressures as a result of the winter season

Scottish Ambulance Service (SAS)
The Unscheduled Care and Winter funding finance plan recognised the pivotal role played by SAS and as such there was a commitment to fund extra weekend vehicles for the winter period. This was in addition to separate SAS national funding.

1.2	What could have gone better?

Feedback around what could have gone better in relation to improving alignment of Hospital, Primary and Social Care Services is detailed as follows

Unscheduled/ Elective care

- Many of the successful initiatives this winter have been driven within medicine. The focus of the next Unscheduled care board meeting in early May will be to move this focus to surgery, orthopaedics and specialist services.
- Embed the culture of frailty across the whole acute service.
- Still full up on Sunday – need to increase weekend discharges and maximise ambulatory care over 7 days.
- Problems recruiting to vacant therapy posts over winter reduced the ability to assess and discharge.

- Reducing homecare impact on inpatient bed capacity
- Reduced Homecare staff increased agency hospital staff
- Staffing is a major challenge. Recruitment of Newly qualified practioners is underway.

Key partners/ Services
The provision of homecare services has risen significantly over the past few years however there were some challenges around provision of services over the winter period and learning needs to be taken from that. It is acknowledged that we cannot continue to grow this resource at the rate we have up until now and need to get smarter as a HSCP about how resource is used to make sure it's available for those who need it. This includes reviewing eligibility criteria, promoting more robust assessment models including assessment at home, making better use of technology and really promoting self care and early intervention.

- Look at shorter, focused home care
- Make Home Assessment and Recovery Team (HAART) more multi-professional/ more therapists

Out of Hours
From OOH perspective there is nothing that the service would change due to it not working well. From workload predictions know the best time to increase capacity and where additional shifts will be more useful are known. The time of some of the shifts were slightly altered just to differentiate what they were for the GPs booking them (in future this will be less of an issue as a new rota system allows a description of the shift), this however did not have any adverse impact.

1.3	Key lessons / Actions planned

Organisational

- Organisational support to realise prevent planning
- Ensure early planning for winter
- Leadership – planned, co-ordinated whole system priority
- Leadership – dedicated winter plan USC clinical lead
- Promoting all year round planning with a Business as Usual approach

Unscheduled/Elective Care

- Take frailty into surgery

Key partners/ Services

- Integrating discharge planning pathways in the 3 HSCPs
- Coordination of transport
- Must prioritise Homecare

Out of Hours

For consideration going forward for 2019/20, **i**ncreasing capacity in Angus with an additional GP on duty afternoon and evening for the base, for the same period would be helpful. Patients often walk in to the MIIU rather than go through NHS 24 so increasing capacity during the peak winter period would be useful particularly as the car shifts are busy and there is not much opportunity for the visiting GP to support any surge at the base.

Mental Health

Perth Royal Infirmary

Trial of dedicated Specialist Mental Health Nurse input to the care of deliberate self-harm patients requiring psychiatric assessment at Perth Royal Infirmary (PRI) recommendation to continue this service as business as usual , PRI reporting great benefits for this vulnerable patient group, as well as improvements in bed capacity.

General

- Cross site calls same time over 7 days
- Robust system to have clinician every day
- Data Systems to support Safety and Flow Huddles: Use IT/Trak to inform huddle thinking and plans
- Explore Frailty Tool & supporting IT system used Victoria Hospital Kirkcaldy/ NEWS on Trak
- Consider how diverts are managed and communicated
- Transport – key priority consideration of timing planning co-ordination to impact on admission/discharge timing

- Volunteer transport cannot be booked for urgent cases

2 Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods

2.1 What went well?

Support an "Assess to Admit" model in community and with PRI and Ninewells which has at its core the principal of realistic medicine that patients wish to be cared for in their own homes.

- Additional funding for Health & Social Care Partnerships to increase the support available in communities and to support earlier in the day discharge. This was a combination of additional consultant physician workforce at weekends to increase the ambulatory care assessment in hospital and to increase social care and allied health professional (AHP) capacity. Respiratory medicine increased their Consultants working at the weekend and public holidays as well as increased respiratory nurse specialists. The Gastroenterology team increased staffing on public holidays to increase endoscopy to support early diagnosis also supports decision making, improved patient experience and creates capacity and flow with ability to discharge earlier for some patients. Investment in AHP hospital resource meant increased ability to discharge patients over seven days.
- Increased senior clinical decision makers, including senior nurses over the public holiday period, learning from the public holiday review led by Sir Lewis Ritchie, to support weekend discharge rates resulted in a 20% increase in weekend discharges.
- Prioritisation to staff out of hours and Home care. The budget spend was assessed monthly to ensure that any underspend was identified and this was redirected during the winter period to increase OOH shifts for GPs and to provide a further 300 hours of homecare in January when this was identified as a pressure.
- The acute physicians recognised the effect that they had in decision making at times of pressure so during the winter period they flexed their working patterns to match increased admissions.
- Respiratory services has worked an asymmetrical job plans for years. They increase inpatient capacity in Nov. This year demand was lower so they delivered increased out-patient capacity to aim to reduce waiting times.
- In previous years we have seen a decrease in discharges at time of peak activity. This was not the case this year.
- Senior team members joined the cross site Huddle calls. This meant that core USC leads and senior managers and HSC partners could inform about pressures in their parts of the system and respond with a whole system approach. When one area was under acute pressure i.e. Orthopaedics during a frosty spell the On Call teams felt involved and supported but did not need to join meetings when they were of little direct benefit.

2.2 What could have gone better?

- Plan to increase senior decision makers across all acute areas.
- Vacancies and staff sickness required the use of agency staff. Work already underway to recruit newly qualified staff in the Autumn and recruitment of therapists was delayed but more whole system understanding of the effects of this.
- Sickness and vacancies in junior medical staff also saw pressures but appointment of Rota co-ordinators and Clinical director for Rotas in response

- Drive to increase pre-booking of ambulances is being championed by senior nurses.
- Review of weekend pharmacy underway to see if increased dispensary hours are more effective than extra pharmacists.
- Review ongoing of 7 day discharges across PRI site to ensure weekend discharge rates maintained and increase at times of pressure

2.3	**Key lessons / Actions planned**

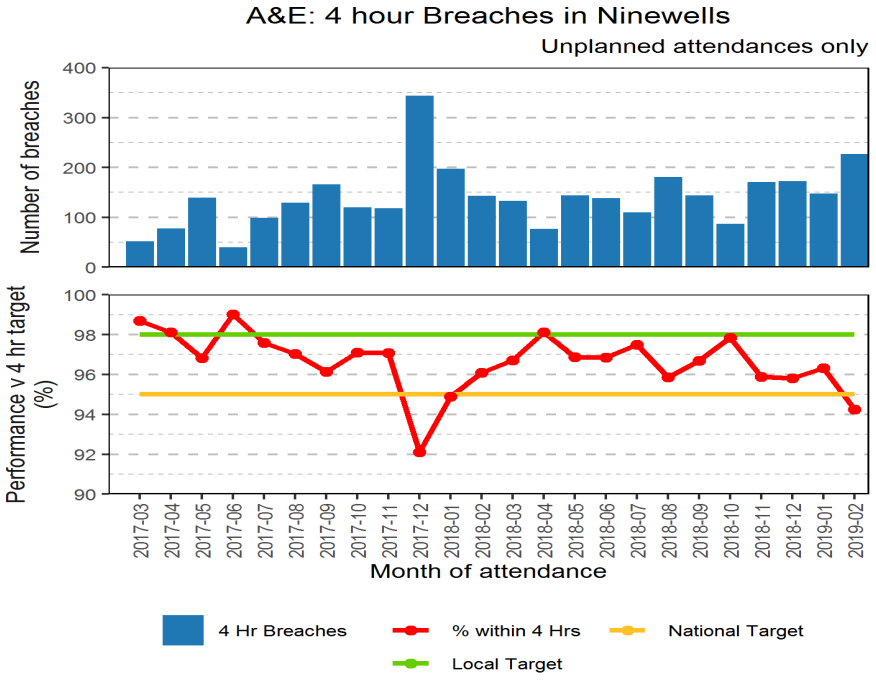
- Whole system approach key
- Flexible increase in senior staff
- Widen effects to surgery and specialist services
- Prevention of illness worthwhile
- Whole system calls at same time: Don't add any more meetings!
- Respect and kindness: Trust your colleagues

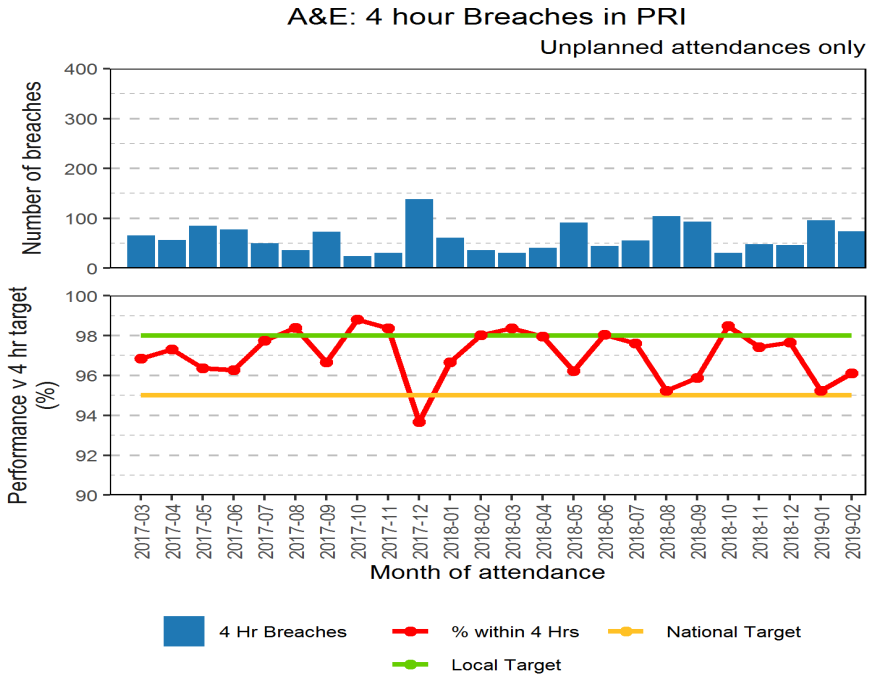
3 Local systems to have detailed demand and capacity projections to inform their planning assumptions

The winter plan set out the standards to be measured. The full impact of the winter plan effectiveness will be reviewed at the Unscheduled Care Board Meeting on 8 May 2019 when the end March validated data is available from the Business Unit and other partner organisations. Data available to end February, where available is provided below

3.1 What went well?

Emergency Access Standard - Four hours from arrival to admission, discharge or transfer for ED treatment (95% with stretch target of 98%). NHS Tayside remained the top performing mainland board achieving the 95% throughout winter at PRI and Ninewells with the exception in February 2019 with performance at Ninewells at 94.2%.

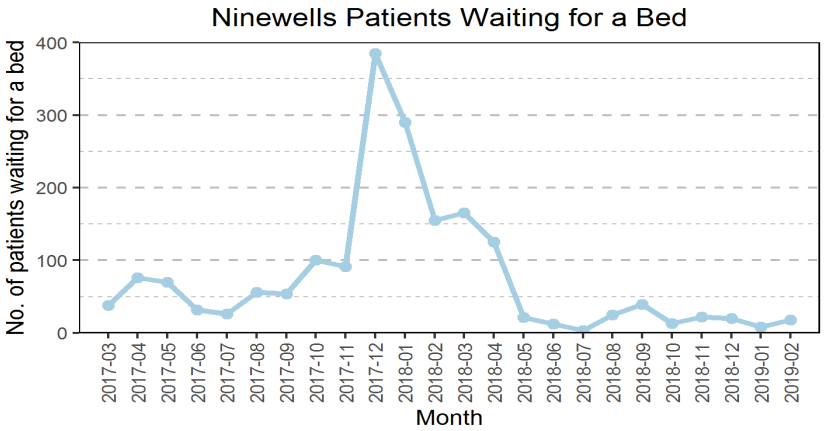


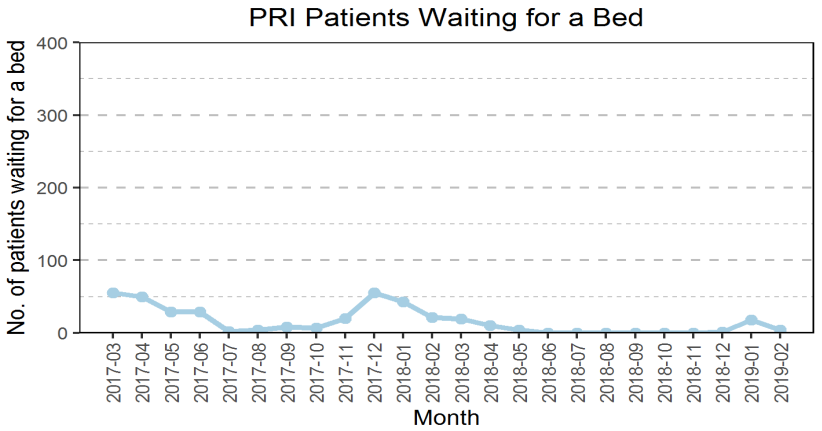


Number of waits for a bed experienced each month

A significant improvement again this winter when compared to the previous year is demonstrated below.

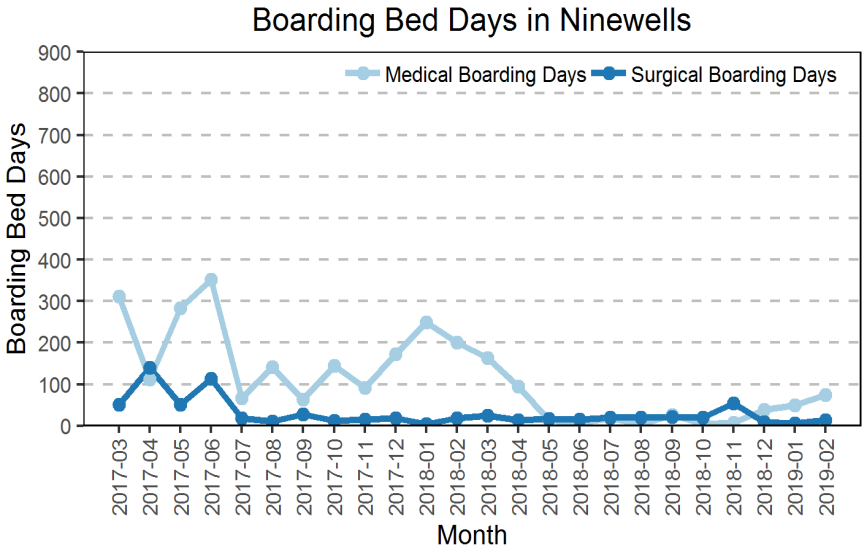
At Ninewells, in the past three months (Dec-Feb 2019) there have been **46** patients who had to wait on a trolley or in a chair compared to **830** patients over the same period in 2018. At PRI, there have been **23** patients who had to wait on a trolley or in a chair compared to **119** patients over the same period in 2018.

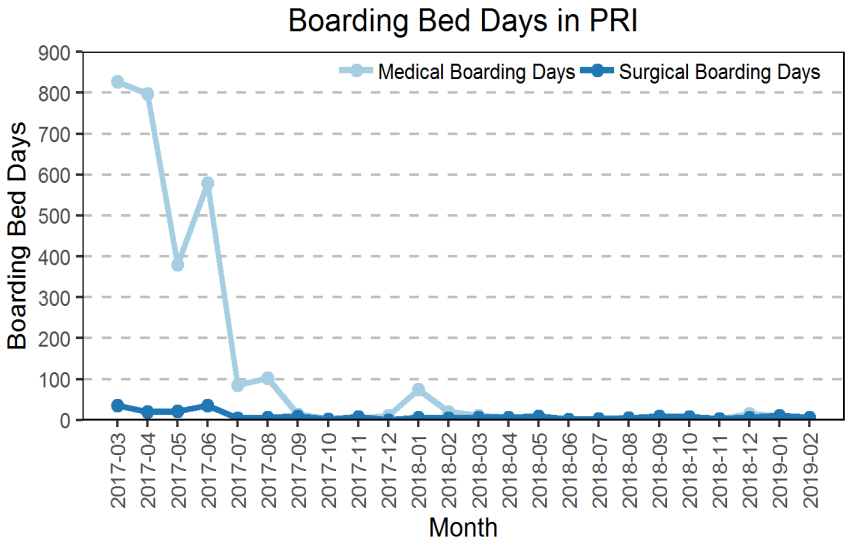




Patients in inappropriate locations – Boarding

Boarding was significantly reduced this winter and we almost entirely stopped boarding outwith Medicine. This was done against the background of a reduction in beds from the footprint over the previous year.

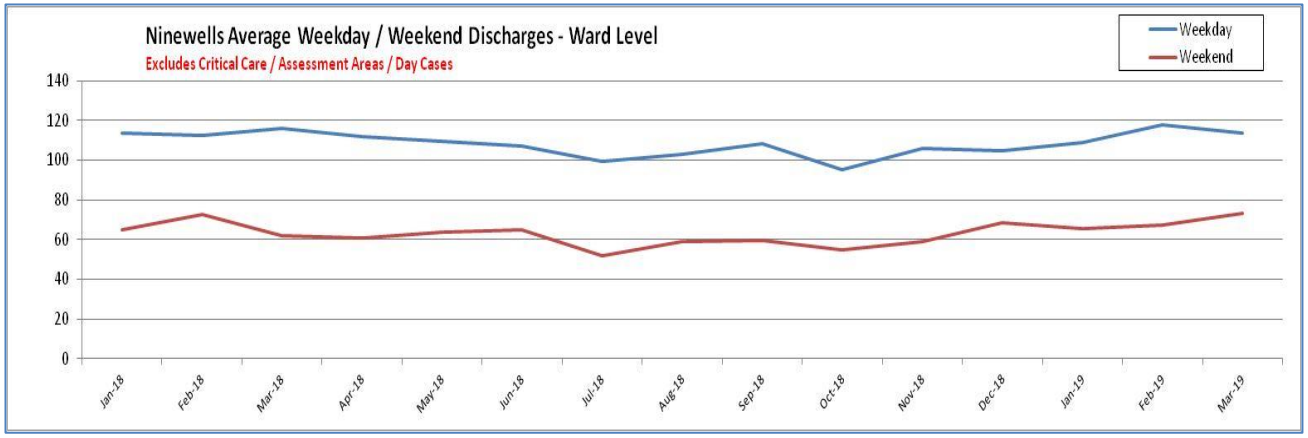




Increase Discharge Rate from Acute Hospital

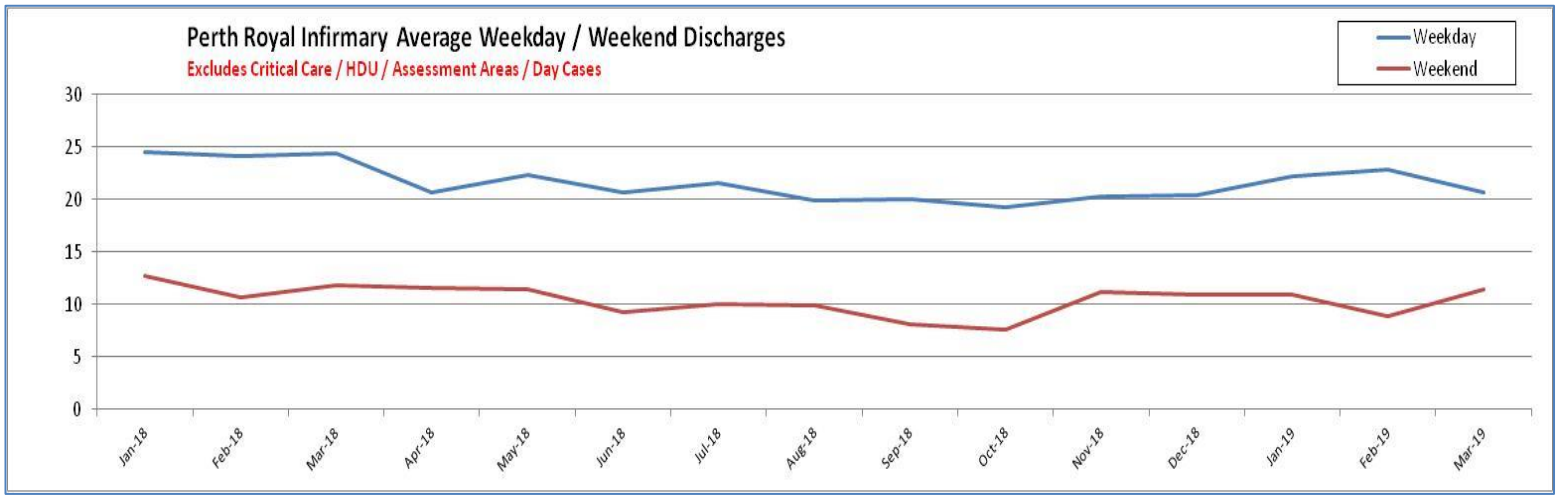
The graphs below show the increase in weekend discharge this winter at Ninewells.

Ninewells



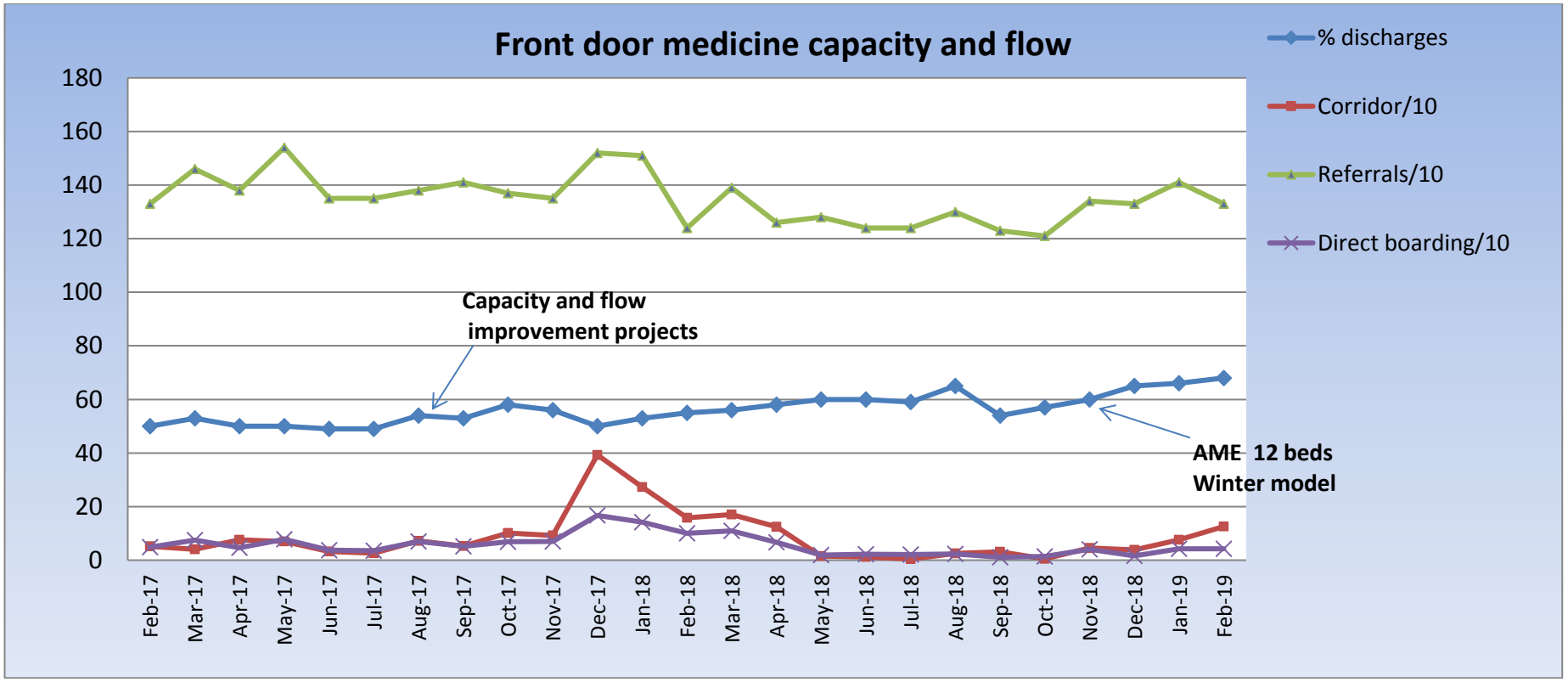
PRI

The weekend discharge rate has not increased at PRI compared to previous winter but has increased when compared to summer 2018. This will be a focus for the unscheduled care board actions for 2019/20.

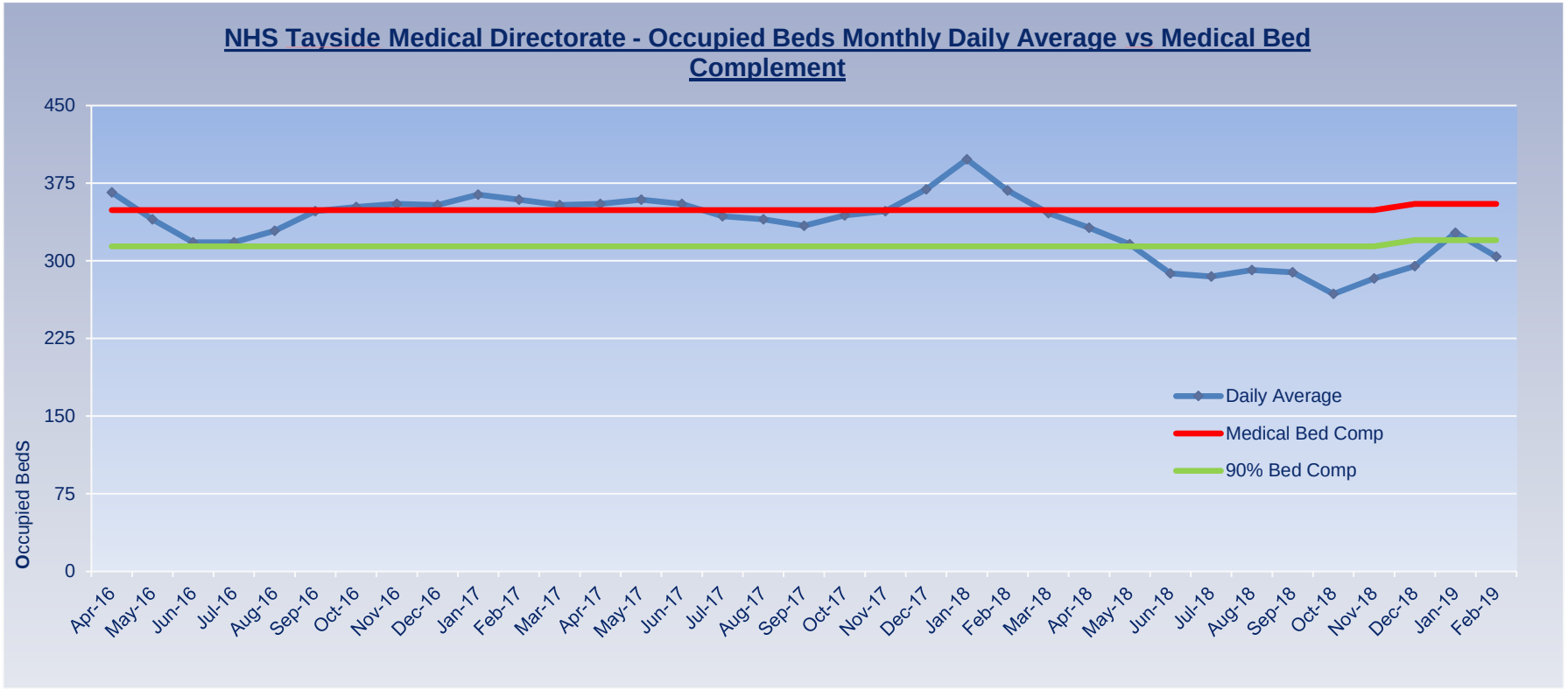


Increase AMU discharge rate > 65% and maintain ward occupancy at below 90%

An example of how flow improvement activities all marginally impact on one measure is shown below. The capacity and flow improvement journey in Ninewells Hospital began in July 2017 and has seen a sustained impact with continued improvement in the direct discharge rate from the Acute Medical Unit. The programme made up of several coordinated projects aimed to increase the discharge rate from 50 to 60% by summer 2018 and therefore by reducing admissions into Ninewells Hospital, reduce downstream ward occupancy to below 90%. The cornerstone of the Winter plan 2018-19 was to increase this discharge rate above 65% to accommodate predicted increase admission numbers (green line below), and this was achieved for the first three months of winter with a discharge rate of 68% in Feb 2019 (blue line below). March data is awaited.



As a consequence of mitigating the predictable increased winter admissions to hospital by matching this with a model that increased Acute Medical Unit discharge rate we can see that Medicine occupancy has increased but remains around the 90% level that the organisation and the Unscheduled Care Board aspire to (blue line). This has been possible through continuous improvement projects. Most Boards in Scotland have winter occupancy in unscheduled care areas of over 100% and last year NHS Tayside peaked at 109% average monthly occupancy in January 2018.


NHS Tayside Medical Directorate - Occupied Beds Monthly Daily Average vs Medical Bed Complement
Occupied BedS
450
375
300
225
150
75
0
Daily Average
Medical Bed Comp
90% Bed Comp
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
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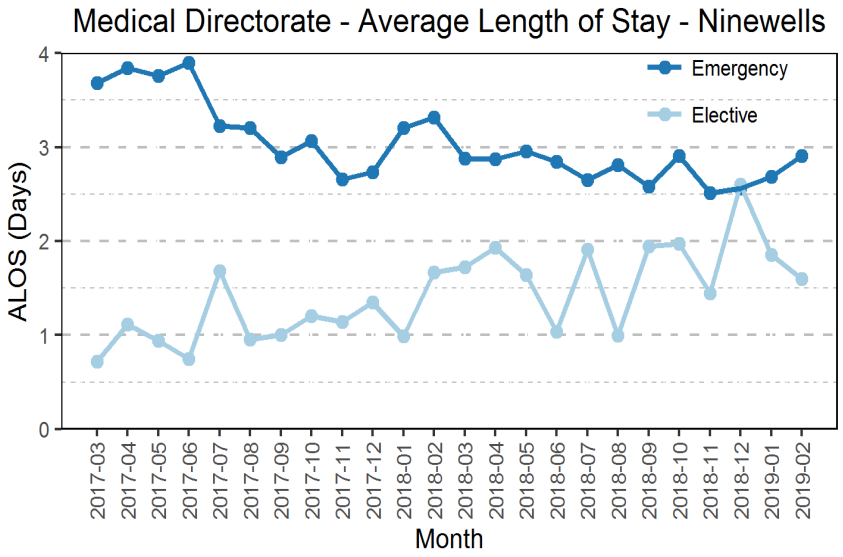
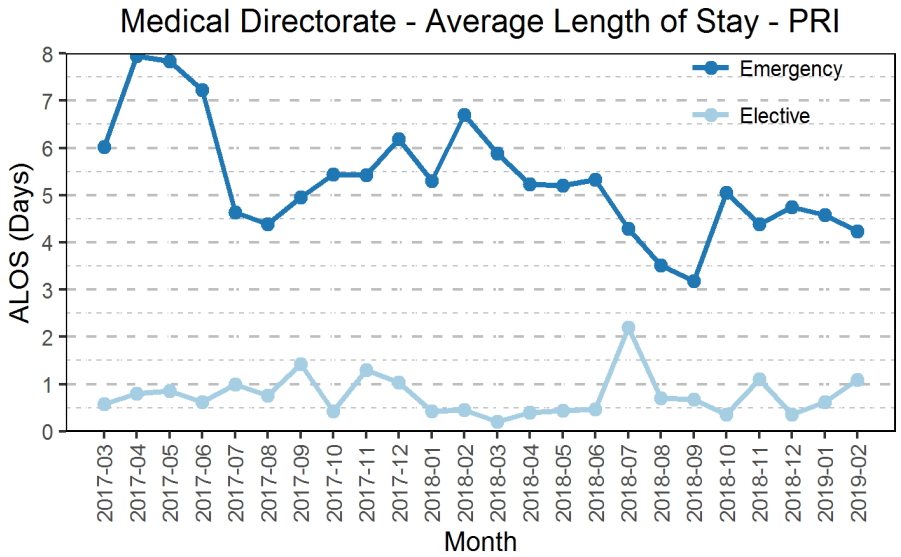
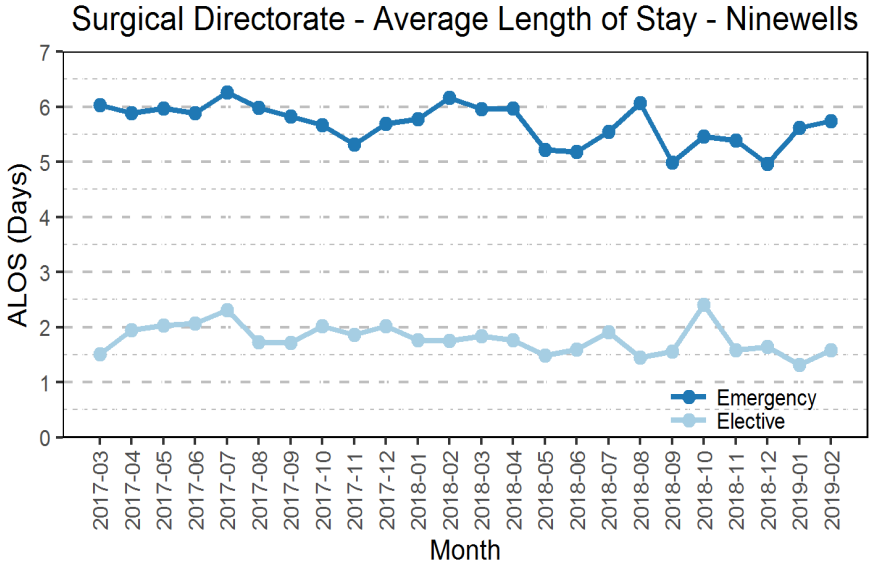
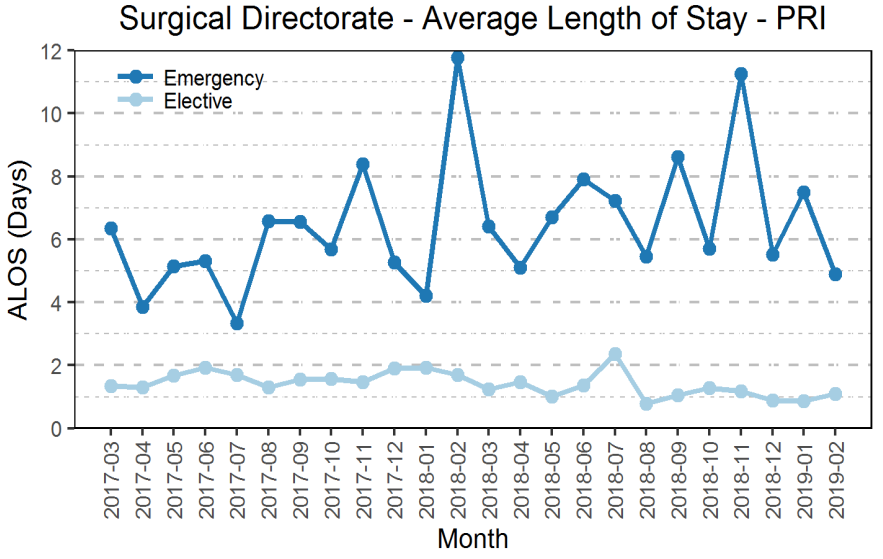
Reduce Length of Stay by this winter compared to last winter

A reduced length of stay in Medicine has been achieved when compared to last winter.









3.2	What could have gone better?

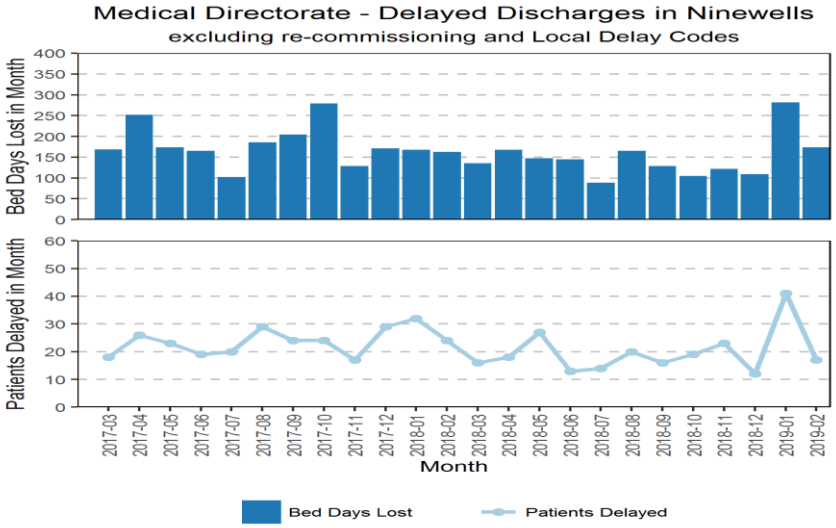
Patients in Inappropriate Locations - Delayed Discharge

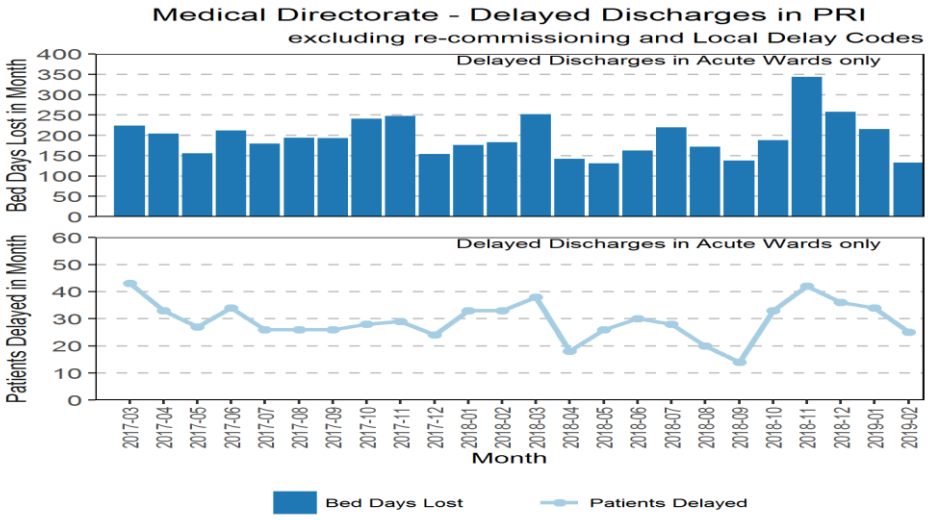
During winter, the number of patients who are Dundee residents who experienced a delay to discharge at Ninewells unfortunately did increase when compared to the trajectory through the summer of 2018 which had been achieved through the Unscheduled Care Board projects including Integrated Discharge Hub. The increased number of delays was not anticipated or flagged up during winter planning and caused a marked disruption. However this was mitigated to some extent through the additional home care funding given to Dundee for short term packages of care. The AME Unit and an improved position in Angus over the winter was supported through regular discharge huddles.

The number of patients delayed in PRI improved throughout winter when compared to the November 2018 position, although this position was challenging to sustain throughout March 2019 with difficulties in maintaining the necessary hours of home care. Given the relatively small size of the unscheduled care inpatient beds, the number of bed days occupied by patients with a delayed discharge significantly impacts on capacity and flow and has resulted in diverts of unscheduled activity to Ninewells Hospital.

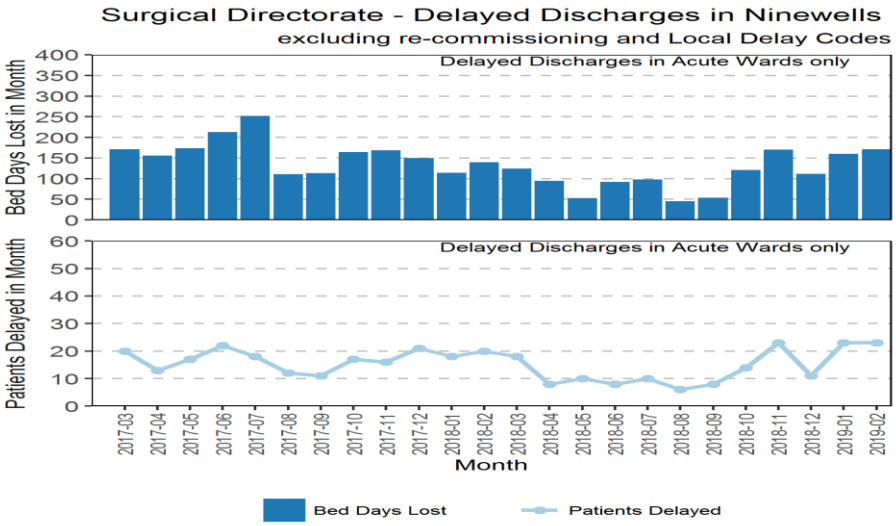
Work will be done for next winter to look at how we can ensure a system wide focus on keeping social care availability over the winter as a key step to keeping people at home as much as possible.

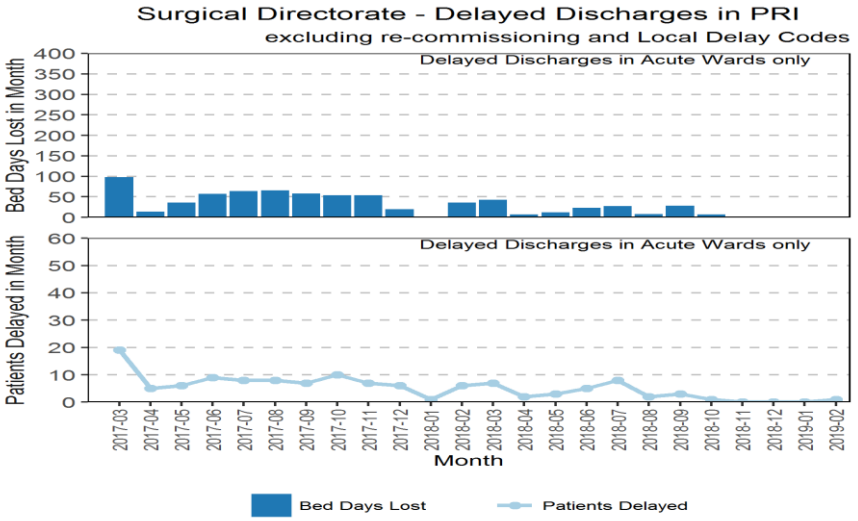
Medical





Surgical


Surgical Directorate - Delayed Discharges in Ninewells
excluding re-commissioning and Local Delay Codes
Delayed Discharges in Acute Wards only
Bed Days Lost in Month
Delayed Discharges in Acute Wards only
Patients Delayed in Month
Month
Bed Days Lost
Patients Delayed


Surgical Directorate - Delayed Discharges in PRI
excluding re-commissioning and Local Delay Codes
Delayed Discharges in Acute Wards only
Bed Days Lost in Month
Delayed Discharges in Acute Wards only
Patients Delayed in Month
Month
Bed Days Lost
Patients Delayed

3.3	Key lessons / Actions planned

- Empowering front line teams to reduce and manage delayed discharges, particular importance of social care and home care to prevent admission and facilitate timely discharges
- Work to ensure a system wide focus on keeping social care availability over the winter as a key step to keeping people at home as much as possible
- Transport continues to be a key priority requiring further work around discharge planning and co-ordination to minimise delays.

4 Maximise elective activity over winter – including protecting same day surgery capacity

4.1	What went well?

- Weekly update to all winter team of elective cancellation
- Only 1 patient had their operation cancelled due to winter bed pressures.
- Involving on call surgical and ortho Consultants in decision making during busy weekends: Colleagues felt involved and engaged in decisions
- Use of STAR weeks: these are times of peak demand such as 3 weeks over the Christmas and new year periods where elective work is reduced to maximise the ability to meet increased unscheduled demand. This has greatly reduced cancellations and the disruption and distress that this causes patients and their families.

4.2	What could have gone better?

- Better linkage to planned care.
- Work is ongoing though the major redesign process of “Shaping Surgical Services”

4.3	Key lessons / Actions planned

- Plan to look at flexing elective and unscheduled care over the year.
- Shaping surgical services is a major redesign process across the whole of Tayside
- Increased clinical leadership in programmes to increase clinical staff engagement and increase co-production with management colleagues
- Focus of Unscheduled care board will expand to surgical services over next year.

5 Escalation plans tested with partners

The Whole System Safety and Flow Triggers and Escalation Framework was produced to assist in the management of health and social care capacity across Tayside and Fife when the whole system, or one constituent part of the system is unable to manage the demand being placed upon it.

The whole system framework was aimed at improving the management of system-wide escalation, encouraging wider co-operation, and making local and regional oversight more efficient and effective. The framework was designed to bring together the variance in operational escalation systems and protocols across the partner organisations across Tayside to manage local and regional monitoring of operational pressures.

Learning from last winter was that our whole system framework missed opportunities for clear and simple communication of decisions. This year the Winter Plan aimed to address this with simplification and clarity of huddles to allow staff at all levels to deliver consistent and relevant decision making.

Scottish Ambulance Service (SAS) Resilience Planning

As described in the Winter Plan 2018/19, SAS maintains a comprehensive contingency planning framework to manage the consequences of when the level of demand exceeds the ability of the Service to meet it. The Generic Capacity Management Contingency Plan and Resource Escalatory Action Plan (REAP)[1] Guidance Document is used for this purpose. The Capacity Management Contingency Plan would be implemented in circumstances when there is: increased demand, reduced capacity or reduced wider NHS services over festive periods.

No Requirement for REAP to be implemented in Angus Community

Winter Plan 2018/19 Summary of Key Actions for Resilience included:

Adverse Weather

- Transport - procedure review for 4x4 vehicles
- Staff accommodation & catering arrangements
- Links to across resilience and contingency planning and adverse weather policies arrangements across Health and social care Partnerships

SAS

- REAP - for capacity management and contingency planning
- Additional directives regarding adverse weather planning
- Additional funding for extra weekend vehicles

System Wide Escalation Framework

- Review, test and implement Whole System Safety and Flow Triggers and Escalation Framework with partner organisations

Pressure Period Hospital Site Huddle Framework

[1] Scottish Ambulance Service. 2016.Version 6., Generic Contingency Plan, Capacity Management Incorporating the Resource Escalatory Action Plan – REAP

- Revised timing & frequency of Safety and Flow Huddle Process
- Clear and concise communications as part of Safety and Flow Huddle Process

Sector Action Cards

- Use of Winter Actions Cards to support resilience planning across services

Safety and Flow Using and Forecasting and Applying Information Intelligence to Planning

- Effective forecasting and data intelligence for unscheduled and elective winter demand, planning accordingly through the use of predictive data systems

5.1	What went well?

Throughout this winter the safety and flow framework daily huddles continued over seven days with extensive multiprofessional input in comparison to previous years. This made a significant impact on the ability to make clinically informed decisions to manage care in the right setting and use Tayside wide capacity effectively. In addition, a weekly winter planning huddle was held and, during pressure points, this was stepped up to daily. The whole system ownership of integrated solutions was evident throughout this approach.

The Winter Wash-Up Session held on Monday 25th March 2019 offered the opportunity to receive feedback on how effective the actions for resilience performed. Feedback is detailed as follows:

Whole System Escalation Framework & Business Continuity Planning
(Health Social Care & Partner Organisations)

- Actions/Response to local triggers
- Departmental/sector winter action cards
- Pressure period hospital site safety and flow huddle framework in place with multiprofessional participation
- Feedback regular. Responsive in live time
- Knowing where system pressure points are helped manage separate parts of the system as part of the whole system
- Communication plan – local knowledge & use of escalation & response processes
- Winter Plan planning meetings become operationally focused from October
- Whole system Safety and Flow Huddle process in place to be escalated with key partners during pressure periods throughout winter
- Preparedness and pre-planning in relation to winter plan and associated Business Continuity Plan

Effective Preparation

- Winter planning sessions were held early in the year to plan, agree and implement winter response arrangements
- Move from winter planning group to operational group with weekly ‘huddles’ to ensure winter plans were mobilised
- Clinical Engagement throughout the winter planning process perceived increase in knowledge about whole system contribution

5.2	What could have gone better?

Whole System Escalation Framework

- Unclear expectations, roles and responsibilities, system wide across all 'inform and respond' escalation processes

Resilience Planning

- Dundee Community – Availability of social care at peak of winter – tendering process in December see key lessons
- Out of Hours (OOH) GP Time spent with Death Verification, Assessment roles to be considered,
- Anticipatory Care Planning (ACP) in Out of Hours and weekends, investment required to prevent admissions
- Multiple Huddles with potential to duplicate information communicated requirement to review: Terms of Reference, Functional requirements, Partnership input, operational needs and accountability
- Prioritisation according to needs of population re allocation of social care
- Better communication required in particular to social work regarding capacity risk - balance between needs in the community versus the needs in hospital
- Planning for a crisis to be inevitable within the acute hospital setting – need to shift the culture
- Infrastructure at weekend not optimum - 7 day communication can be improved, service cover dependent on good will
- Sustainability of staffing to respond to system pressure periods

Data

- Data challenges to support the Safety and Flow Huddle Process, systems not supporting the right data at the right time – e.g. Discharge Data on Edison and Trak , require dashboard to give the right information at the right time

5.3	Key lessons / Actions planned

Key lessons learned and implemented for this year with all winter planning calls and huddles using the same huddle/ cross site call telephone number to maximise the ability for staff to join. One key change which is very difficult to measure is staff experience, however, initial feedback is that our staff felt much more involved in the winter plan and this resulted in much better communication. We had many multi agency "huddles" where our senior clinicians, senior health and social care colleagues and executive and managers were able to discuss the picture across the whole landscape over weekends and times of pressure. This allowed much more agile, patient focused decisions to be made and was done with trust and respect. This proved to be highly successful and has been the key to a cultural shift from perceived blame to integrated working across partners.

Summary of key lessons from local review event
Whole System Escalation Framework

- Infrastructure development and investment to support escalation at weekends
- Clear expectation of role and responsibilities as part of the safety and flow huddle process
- Escalation plans reviewed and further developed to ensure clear escalation actions
- Process improvement to capture actions and communicate effectiveness of these actions
- Consider options for communicating e.g. Telephone which be a barrier as well as the call criteria in the event of an escalations

- Divert Protocols have been tested now need to be reviewed
- Response process across system to be formalised

Data

- What data is required to make planning, escalation and management decisions? - Agree data set required to support
- Business Unit support for data dashboard
- Huddle reports review

6 Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings

A Summary of Key Actions for Infection Prevention and Control from the Tayside Winter Plan 2018/19 included:

- Staff access to and adherence to national guidance on Preparing for and Managing Norovirus in Care Settings
- Infection Prevention and Control Team (IPCT) plans in place now to support the execution of Norovirus Preparedness Plan in advance of season
- IPCT guidance on Staff website and HPS Website
- Awareness and roadshow sessions for winter preparedness
- Prioritisation Flow chart to aid decision making at the 'front door'
- Procurement and adequate resource availability
- Plans to increase staff Flu Vaccination Uptake: Programme - commenced one month earlier this year (September) for staff, peer vaccination programme to increase uptake
- Communication Campaign specific to seasonal illness including Flu
- Near Patient Testing for Flu

Communication Strategy

The NHS Tayside Communications Team had communication plans in place specific to the winter period including seasonal illness including Influenza, influenza like illness and Norovirus as well as adverse weather. The NHS Tayside communication team actively promoted related publicity materials and national campaign assets and shared widely through social media channels. This was targeted at staff, patients and the public alike.

As in previous years, within the Winter Plan of 2018/19 the Communications Team aimed to support the organisation's preparations for winter through the local and national winter campaigns, tailoring the national key messages for the local situation and a local audience and releasing media releases and

social media messages throughout the winter period. Social media was viewed as the best channel for instant updates to information and was used extensively, along with media releases, website updates, radio updates and sharing of messages with local partners for onward distribution.

The Communications Strategy involved key actions:

- Communicating Identified pressures and the action needed to maintain Business as Usual
- Communicating a Whole System Approach
- Tayside wide Winter Communication Campaign (internal/external)
- Festive 'Ready Reckoner' including all key services and contacts communicated across Health Social Care & Partner Organisations

The Winter Wash-Up Session held on Monday 25th March 2019 offered the opportunity to receive feedback on how effective the actions were at preventing illness and admissions from our population and staff. The following sections detail the feedback given:

6.1	What went well?

From the Winter Wash-up Review Session feedback was overall positive in particular around the prevention of illness within our population and staff as well as the winter preparedness and planning.

Winter planning overall felt less reactive, planning in advance, promoting the 'prevent' message.

Summary of Seasonal Influenza/Influenza like illness feedback of what went well:

- Earlier Flu Vaccination Campaign
- Staff Vaccination – 37% last year to 54% this year
- Peer Vaccinations to increase staff uptake of Flu vaccination
- Winter Planning Group Co-ordination of Flu Campaign, reporting to a wider audience
- Point of Care Testing - Increased awareness, knowledge , education amongst staff and patients to prevent admissions
- Angus – Vaccination of 3rd Sector reducing illness
- Myth buster communication re Flu Vac
- Targeted communication about Flu
- Flu internal Campaign more successful contributing to improving vaccination uptake

NoroVirus

- Bed Closures due to Infection - there has also been an improvement with less bed closures as a result of diarrhoea and vomiting (Norovirus) when compared to previous years.

6.2	What could have gone better?

Areas highlighted from the local review that could have gone better included;

Seasonal Influenza/Influenza like Illness

- Point of Care Testing used out with Escalation procedures -'alter prevalence'
- Point of Care Testing not undertaken in Community Hospitals
- Availability of Data re Flu Vaccination uptake in particular to staff numbers etc
- Could have been better awareness of Flu Immunisation Programme in Perth & Kinross
- 'Keep Well in Winter' Campaign could have been better publicised in Primary Care & Communities
- Key messages about Flu Jab needed to promote uptake

Resilience Planning

- Hospital Environment – management of ward environment and side rooms

Communication Campaign

- Availability of data/statistics about where people access information
- More focus on social media access
- Social media algorithms means not everyone sees posts on Facebook for example, consider adverts
- Video to be promoted more as not all aware of video comms
- Posters for wards - Strong messages about ward closures
- Targeted comms to range of age groups e.g. young people
- Email signature to use Smarty Penguin Logo
- How to target people outside social media and press

6.3	Key lessons / Actions planned

Key Lessons learned around preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings include:

Seasonal Influenza/Influenza like Illness

- Focusing on Prevention of illness through Early Communications Campaign to promote Flu Vaccination Uptake
- Continue with Near point testing for Flu with a review of protocol and escalation process
- Continue to support and promote peer vaccinations
- Data availability on winter immunisation uptake, it would be helpful to have live status and regular updates, as well as feedback to services, visual use of uptake
- Consider how to address people's concerns misconceptions about Flu Vac

Service Communications

- Share messages on department social media pages
- Key people list in Partnerships to share messages, consider ways to push through comms to partner organisations
- Ensue a focus on Primary Care as well as acute sites
- Start the Winter Campaign earlier
- Communication Strategy for all year round pressure period planning
- Infection Control to provide info on ward closures for Winter Zone in Staffnet site
- Managers toolkit to share at team meetings
- Make graphics widely available for use by departments
- Information on payslips
- Increase poster use
- Use of information screens in waiting rooms
- Communications - Media Campaign Internal and Public Campaign in the prevention of illness and adverse weather campaigns e.g. Use of 'Smarty' the Penguin to deliver key messages

7 Delivering seasonal flu vaccination to public and staff

7.1 What went well?

Seasonal Influenza/Influenza like Illness

Staff Flu Vaccination uptake has, in the past, been poor with Tayside having one of the lowest levels of uptake across the territorial board in Scotland. A whole system approach was taken this year to engage with staff and also to recruit peer vaccinators which brought us from a level of 18% of staff vaccinated 2 years ago to 54% this year. Thus moving up the attainment across Scotland and we are determined to increase this further in future. This was achieved by engagement across staff in clinical areas with our Public Health and vaccine teams and through a communication campaign.

Near Patient Testing was used for the first time. It is recognised that the rapid diagnosis of flu meant that patients were able to receive appropriate medication within 20 minutes of a swab being taken and many people were able to be discharged home with appropriate medication as we knew that hospital admission would add little to their care.

NHS Tayside Communications

- Information provided quickly, improved sharing of messages
- Good assistance from Comms Team for Infection Control messages

- Felt more joined and connected across Partnership
- Regular info issues to staff
- Use of social media more successful, regular posts and messages to support the winter campaign
- Evening Telegraph series to promote winter campaign

Seasonal Influenza/Influenza like Illness

- Flu internal Campaign more successful contributing to improving vaccination uptake
- Targeted communication about Flu
- Peer Vaccinations communications to improve staff uptake
- Myth buster communication re Flu Vac

7.2	What could have gone better?

Seasonal Influenza/Influenza like Illness

- Key messages about Flu Jab needed to promote uptake

Communication Campaign

- Availability of data/statistics about where people access information
- More focus on social media access
- Social media algorithms means not everyone sees posts on Facebook for example, consider adverts
- Video to be promoted more as not all aware of video comms
- Posters for wards - Strong messages about ward closures
- Targeted comms to range of age groups e.g. young people
- Email signature to use Smarty
- How to target people outside social media and press

7.3	Key lessons / Actions planned

As with the prevention of Illness the delivery of the seasonal flu vaccination to public and staff lessons and actions include:

Seasonal Influenza/Influenza like Illness

- Focus on the prevention of illness through early Communications Campaign to promote Flu Vaccination uptake
- Continue with Near point testing for Flu with a review of protocol and escalation process
- Continue to support and promote peer vaccinations
- Data availability on winter immunisation uptake, live status and regular updates, as well as feedback to services, and to consider the visual use of Flu Vac take
- Consider how to address people's concerns misconceptions about Flu Vac

Communication Campaign

- Provide patient/public education – in advance and during pressure times
- Consider families targeted campaign to avoid visiting the hospital
- More information to public about advantages of care at home – changing expectations

Service Communications

- Continue to share messages on department social media pages
- Key people list in Partnerships to share messages, consider ways to push through comms to partner organisations
- Ensue a focus on Primary Care as well as acute sites
- Start the Winter Campaign earlier
- Communication Strategy for all year round pressure period planning
- Infection Control to provide info on ward closures for Winter Zone in Staffnet site
- Develop a managers toolkit to share at team meetings
- Make info-graphics widely available for use by departments
- Information availability on payslips, posters, waiting rooms

8 Top Five Local Priorities for Winter Planning 2019/20

Our vision for unscheduled care is that people should only be in hospital when they cannot be treated in the community and should not stay in hospital any longer than they need to. We have, as integrated partners taken a whole system approach to identify and implement opportunities for alternatives to admission, timely discharge and improved seven-day working this winter which has been effective.

It was recognised that the shared decision making by NHS Tayside, the Health and Social Care Partnerships of Angus, Dundee and Perth & Kinross, Scottish Ambulance Service and other key stakeholders enhanced how we approached this winter plan. There will be a continued assessment of spending to monitor return on investment with the aim to deliver "business as usual" across the entire year.

The Unscheduled Care Board improvements and winter arrangements have implemented many changes within the medical and community specialities. The unscheduled care action plan for 2019/20 will move forward and extend this into our surgical services and mental health services.

In response to learning from winter, all year unscheduled care planning and ensuring the right level and skills of staff during public holidays and peak leave periods helped increase flow and patient experience. We have already seen staffing plans prepared for the spring holidays and liaison across Primary and Secondary Care for bank holidays to ensure a match between Primary and Secondary Care staff.

To ensure continuous learning and improvement from winter planning, from the “wash up” session held on 25 March 2019. A summary of Key lessons learned that will inform the actions going forward for 2019/20 are:

- Promoting all year round planning with a business as usual approach
- Focusing on prevention of illness through Early Communications Campaign to promote Flu Vaccination Uptake, continue to support and promote Peer Vaccinations
- Communications - media campaign internal and public campaign in the prevention of illness and adverse weather campaigns e.g. Use of ‘Smarty’ the Penguin to deliver key messages
- Maintaining a whole system, multi-professional, multi-agency approach to planning as well as informing and responding to system pressures
- A focus on home care planning at least six months prior to winter is essential. There is limited capacity to increase hours during winter. Next winter we must improve our delayed discharge position significantly to continue to support care in the right setting and an improved patient experience.
- Continuing with the development and investment of the infrastructure to support escalation and early resolution at weekends
- Ensuring clear expectations, roles and responsibilities, system wide across all ‘inform and respond’ escalation processes.
- Empowering front line teams to reduce and manage delayed discharges, particular importance of social care and home care to prevent admission and facilitate timely discharges
- Transport continues to be a key priority requiring further work around discharge planning and co-ordination to minimise delays.
- Focus on frailty across all applicable services

Top Five Local Priorities

- Promoting all year round planning with a business as usual
- Maintaining a whole system, multi-professional, multi-agency approach to planning as well as informing and responding to system pressures
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- Transport continues to be a key priority requiring further work around discharge planning and co-ordination to minimise delays.
- Focus on frailty across all applicable services