PERTH AND KINROSS HEALTH AND SOCIAL CARE PARTNERSHIP

Integration Joint Board

4 November 2016

PERTH & KINROSS WINTER PLAN

Report by Chief Officer

PURPOSE OF REPORT
The purpose of this report is to present to Perth & Kinross Integrated Joint Board the Winter Planning arrangements and improvement plan for Perth & Kinross Partnership. The plan is underpinned by the Six Essential Actions for Unscheduled Care.

1. RECOMMENDATION(S)

The Integrated Joint Board is requested to:

- Note the improvement actions taken forward in 2015/16.
- Support and endorse the improvement actions underpinning the 2016/17 Winter Plan.

2. SITUATION/BACKGROUND / MAIN ISSUES

The Scottish Government issue annual guidance to NHS Boards and Local Integrated Partnerships to support Health & Social Care services to prepare for winter. The Scottish Government request that NHS Boards lodge draft winter plans on winter planning arrangements on behalf of are lodged with the Scottish Government by end of August, and final plans by the end of October.

The continuing focus on integration, improving delayed discharge and the 6 essential actions underpin the planning for winter 2016/17 and help to ensure that Health & Social Care Services are prepared for winter. Winter Plans ensure that safe and effective care for people using services and effective levels of capacity and funding are in place to meet expected activity levels.

The local Perth & Kinross Health & Social Care Plan should be considered alongside the the overall NHS Tayside Winter Plan.

3. PROPOSALS

The focus of the winter plan and improvement actions for Perth & Kinross Health & Social Partnership is to ensure that people get the right care, at the right time, in the right place, avoiding unnecessary admissions to hospital and ensuring that, once admitted, people are discharged as soon as they are ready, contributing to better health outcomes and making best use of resources.

4. CONCLUSION

The aim of the Winter Plan 2016/17 is to assure Citizens, Integration Joint Boards and NHS Tayside Board that we have plans and systems in place to support the early intervention and action at points of pressure and to minimise the potential disruption to services, for people who use services and their carers.

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NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

PERTH & KINROSS HEALTH & SOCIAL CARE PARTNERSHIP

WINTER PLAN

UPDATE ON 2015/16

&

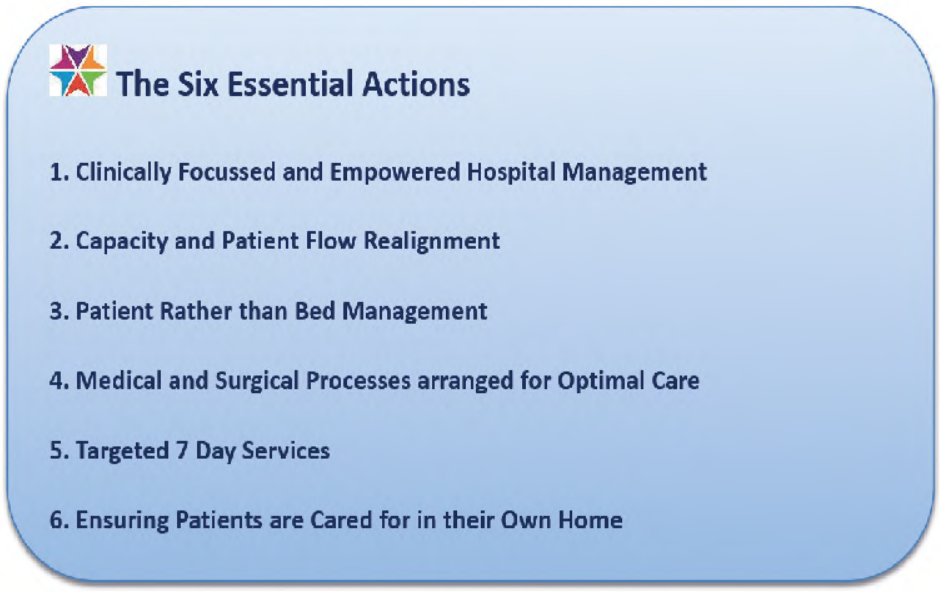
IMPROVEMENTS FOR 2016/17

Version: Final Version 1

1. Introduction

In 2015/16, Perth & Kinross Health & Social Care Partnership prepared a Winter Plan to ensure internal processes and services were in place to allow a focused approach on the planning for the additional pressures and business continuity challenges that could be potentially faced during the winter period. This was to ensure that the Partnership could continue to provide safe and effective care for people using services and that effective levels of capacity are in place in order to meet anticipated increase in activity levels across the whole system.

The plan took account of the Winter Planning Guidance 'The National Unscheduled Care Programme: Preparing for Winter 2015/16' and had a focus on integration, improving delayed discharge and the six essential actions underpinning the guidance.



The following report provides an update on the actions taken forward in 2015/16 and the actions being put in place to meet the potential additional pressures and challenges for Winter 2016/17.

2. Finance

Perth & Kinross Partnership approved the following further investment to ensure the delivery and continuation of services for the potential peaks in demand put upon the system over the Winter Period and beyond. The Partnership utilised the extra funding provided by the Scottish Government for delayed discharge of £789k and the carry forward from 2014/15.

Funding	2015/16	2016/17	2017/18
	£'000	£'000	£'000
2014/15 Carry Forward	295	-	-
Scottish Government Funding	789	789	789
Carry Forward	-	-	69
Total Funding	**1084**	**789**	**858**
Commitments	2015/16	2016/17	2017/18
	£'000	£'000	£'000

Care at Home	450	450	450
Additional Placements (10)	44	173	73
Enhance care model (5 placements)	29	71	-
Increase Reablement hours	95	-	-
Ortho Geriatrics	3	20	20
Power of Attorney	3	6	6
Total Commitments	**624**	**720**	**549**
Acute Surge Beds	351	-	-
NHST	109	-	-
Amount Remaining	**-**	**69**	**309**

3. What Did We Do in 2015/16

In the run up to the festive period in 2015/16 and running into 2016/17, NHS Tayside and Perth & Kinross Health & Social Care Partnership initiated the following improvements to ensure that people living in Perth & Kinross could be safely and effectively supported in hospital and in the community during the Winter period.

3.1 Clinically focussed and Empowered Management

- In October 2015 site based hospital and management structures, safety and flow huddles and real time information sharing through eWhiteboards to prioritise resources and support effective decision making were put in place in PRI. This new process aimed to give a hospital wide view on patient and staff safety, as well as capacity and flow across the whole hospital site. The discussions at the huddles focussed on key information that is vital to the safe effective running of the hospital. The multi-disciplinary, multi-team approach ensures that all issues are raised that affect safety, capacity and flow, patient admissions and discharges.
- In April 2016 the Chief Officer established an extended management meeting to focus the attention across the partnership on delayed discharges. The Resource and Performance group meets weekly at Perth Royal Infirmary to scrutinise the work being done to reduce the number of people delayed in hospitals. The meeting brings senior, middle and team leaders and senior charge nurses together to share ideas for solutions and release blockages in the system. It is recognised that this meeting has already developed better communication, understanding and a shared ownership, all of which is required to tackle our delayed discharge problem.
- Three in-depth explorations of the reasons people require care home placements have been conducted to understand the high demand we have in this area. The 'deep dives' were conducted by a multi-agency panel that explored the individual cases in depth. This was split into three areas; 1) those waiting in hospital for care home place 2) those who require care home placements in a crisis and 3) those who requiring permanent care home placements. The aim in each case was to explore if the assessment of need was comprehensive and if alternative supports could have been arranged to enable people to remain within the community, rather than seek a care home placement. The key finding was that in the majority of cases, it was unpaid carer breakdown that was the catalyst for clients requiring a care home placement. The main need that clients presented with was advanced dementia, which placed increasingly unsustainable demands on families trying to provide support. The main gap in terms of support was in night time support, particularly when clients were up during the night. The learning from this is being taken forward in two projects to put in additional supports into the community, 1) the development

of integrated intermediate care and 2) additional support for carers in the form of flexible respite.
- In 2015-16, PKAVs Carers Hub employed locality focused Carers Support Workers and Hospital Link Worker for Carers, based in PRI, who are working with multi disciplinary teams to ensure co-ordinated support for Carers and to help prevent future crisis.

3.2 **Capacity & Patient Flow Realignment**

- An additional 8 beds were opened in PRI to support the winter surge pressure and to reduce the number of patients being cared for outwith the speciality for their condition.
- A Rapid Improvement Event was completed at the end of April 2016 which identified a wide range of system and process improvements, not only to improve capacity and flow but also to improve pathways of care for service users, carers and staff. Over 49 improvement actions were identified some of which were operational changes and some where wider whole system transformation should be explored. These improvements have now been included within the Capacity & Flow Improvement Transformation Programme.
- The process for funding placements was reviewed and a new model implemented. All funding issues are taken to the weekly Resource and Performance panel. This ensures that Senior Managers have weekly oversight of the budget and any pending pressures

3.3 **Patient rather than Bed Management**

- Medicine for the elderly consultants in place to support management of frail elderly patients working between acute, primary care and community hospital settings.
- Day of Care audit completed in September 2015 for community hospitals and again in April 2016 for community hospitals and PRI. The audit identified that only one patient was identified as being in hospital due to 'in hospital reasons' in community hospitals and Tay Ward, whereas for Acute areas 27 were delayed due to 'in hospital reasons'. This audit is contributing to the Capacity and Flow Improvement Programme.

3.4 **Medical and Surgical Processes arranged to pull patients from emergency department**

- An early intervention and assessment team in PRI (Front Door model) have direct access to the ACE clinic, Psychiatry of Old Age transitional Care Service, Rapid Response and Immediate Discharge Service. This will ensure early referral and assessment to prevent patients moving further into the secondary care system, facilitate early discharge and deliver an integrated, patient centred approach to patients through their care journey. The Front Door model is now being reviewed in line with the Capacity & Flow Improvement Programme and aligns with Enhanced Community Support.

3.5 **7 day Services**

- A joint Perth & Kinross directory of services was put in place providing information on service opening times and cover with contact details in case of an emergency, during the festive season.

- Management and staff rotas put in place to cover the holiday period and the four days post holiday.
- Invested in extended hours for physiotherapists to provide 7 day cover over the festive period to support assessment and discharge to improve hospital flow, and improve patient care and experience

3.6 **Ensuring patients are cared for in their own homes**

- Through the delayed discharge funding, an investment of £450k was agreed to provide approximately 660 additional care at home hours.
- Continued the roll out of Enhanced Community Support in Strathmore and Perth City Localities.
- In Feb 2015 Perth and Kinross Council invested £56,400 in a new digital server to support the next generation of smart telecare equipment. To match this investment, the Scottish Government awarded us a further £42,000 to expand the use of health monitoring and telecare in general.
- A dedicated TEC project team has been developing and promoting strategies and because of this we have seen a 26% increase in clients installed with telecare equipment in the last 12 months, rising from 838 clients in Sept 2015 to 1064 clients in Sept 2016.

4.0 **How did we do?**

The National Unscheduled Care Programme: Preparing for Winter 2015/16 highlighted the critical areas that should be covered in local winter plans and proposed specific local indicators to allow Boards and Partnerships to measure and monitor their progress. These indicators are linked to the above 6 key essential actions for Unscheduled Care.

It has been very difficult to identify increased pressures based solely on the Winter / Festive period. The pressures that the Partnership has been experiencing in relation to capacity and flow across the whole system appears to be a continual pressure throughout the year, although there is a minor peak in admissions during the month of December.

The following is a brief synopsis of some of the proposed key indicators included within the National Unscheduled Care Programme. Additional analysis will be required to understand these fully:

- PRI is consistently operating above the nationally agreed optimum occupancy rate of 85% for an efficient hospital throughout the year. When wards are above this level it does not allow for suitable margins for peaks and troughs in demands so that any minor peak in emergency admissions results in bed shortages, periodic bed crises, patients waiting in corridors or being boarded outwith the required specialty and increased numbers of health care-acquired infections.
- Monthly Emergency Admission figures indicate no statistical variation in seasonal trends although any minor peak in demand results in the above. Over the last 4 years there has been a recurring minor increase in admissions during the month of December.
- Building on from bullet point 1 and 2, there is evidence of an increase in the number of cancelled electives for the months prior to and post festive period.
- There is a slowing down during the month of December for people in a delayed situation actually being discharged. This information is taken from discharge numbers from the delayed discharge EDISON system. This again contributes to hospital pressures when the wards are at capacity.

- Readmission figures do not appear to have a correlation to the Winter Period as month on month numbers of readmissions appear erratic. This is an area through that would benefit from further investigation as almost a quarter of readmissions take place within 2 days.
- There appears to be no seasonal trend in relation to the numbers of people experiencing a delay in discharge. For 2015/16 there were around 54 people in a delayed discharge situation on a daily basis. For the period May to July 2016/17 there were on average 20 patients experiencing a delay but this has now returned to a high of 54 patients on a daily basis. The majority of people are awaiting a care package to be put in place.
- There is no seasonal trend for people experiencing a crisis in the community. For the period of 2015/16, there was an average of 13 people receiving a crisis placement per month.

5 **What Will We Put in Place for 2016/17**

The next section outlines the proposed improvement plans against each of the 6 essential actions for 2016/17. The plan covers improvement areas from Perth & Kinross Health and Social Care Partnership and NHS Tayside Board.

5.1 **Clinically focussed and Empowered Management**

- Continue to identify improvements through the safety and flow huddles sharing real time information and improving communication to ensure safety for staff and patients in relation to admissions and discharges.
  Local Management structures put in place to deliver services that meets the needs of the locality and ensures the use of effective measurement and reporting mechanisms to sustain responsive, high quality locality services.
  Business continuity plans reviewed for each service area and facility to ensure the continuous operational service of critical services during adverse weather conditions over the winter period.

5.2 **Capacity & Patient Flow Realignment**

- Finalise and implement the emerging Capacity & Flow and Intermediate Care model to support pathways in hospital and out of hospital and create capacity through integrating intermediate care teams and developing a discharge hub.
- Develop a Frailty Pathway and approach with the district nursing service to identify and manage appropriately locality patients with early referral / advice from geriatricians, where required. In addition a frailty screening tool will be developed for use across acute and primary care sectors. The frailty pathway will provide person centred care, improve people's experience of care, reduce harm, and improve quality of life.
- The Deteriorating Patient Working Group will review and oversee the delivery of the recommendations from the SIGN 139, Care of Deteriorating Patients. The 3 main areas of improvement will be the development of:
  - National Early Warning Scoring Chart
  - Treatment Escalation Plans
  - Deteriorating Patient Record
- Patients waiting for private Welfare Guardianships have contributed to delayed discharges. In order to improve this, we have aligned a part-time Mental Health Officer (MHO) to the Hospital Discharge Team, in order to oversee and give advice to staff and families on securing a Welfare Guardianship and we have recruited a full-

time MHO to be based in the Hospital Discharge Team, to start in the middle of October. We have also introduced a new procedure whereby the Council will take over the Welfare Guardianship, if the family are not making reasonable steps to complete the process quickly.

5.3 **Patient rather than Bed Management**

- Implement the recommendations from the deep dive into readmissions and failed discharges.
    - Hospital wards to complete discharge summary and set realistic Predicted Date of Discharge (PDD) to reduce the number of cancelled discharges
    - Improve information sharing and communication between ward, community services, families and carers to ensure better outcomes and support on discharge.
    - Complete deep dive into readmissions to understand the reasons for readmissions to improve the quality of care on discharge.

- The Community Care service is being restructured in order to shift resources into more early intervention and prevention support. The majority of service users will be increasingly be supported with brief interventions, with the aim on rehabilitation and self-help. The model also gives more leadership capacity within our localities and sub-localities. This is in line with the aim to work more closely with our communities, particularly when supporting people with complex health and social care needs. This is also in line with our aim of ensuring our community care team model is ready for moving into an integrated locality team approach. Crucially, the new structure will enhance the resources within the Hospital Discharge Team, enabling additional staff to move into this team. There is project work beginning to develop the Hospital Discharge Team into an integrated Discharge Hub and the community care Reablement service into an integrated intermediate care service.

5.4 **Medical and Surgical Processes arranged to pull patients from emergency department**

- Review the Front Door model included within the Capacity & Flow Improvement Programme ensuring robust pathways with Early and Preventative Care functions through statutory and non statutory provision. The model will improve patient experience by promoting independence in patients admitted to hospital by providing alternative pathways rather than acute care and supporting patients as close to home as possible, using a person centred approach, as well as ensuring appropriate pathways are identified for patients who require acute hospital care to reduce admission length of stay.

5.5 **7 day Services**

- Review workforce plans and capacity to provide 7 day cover where appropriate.
- Physiotherapy staff are being asked to volunteer for extended working hours to assist in the patient flow at PRI. Priority for cover will be around the two weeks of Festive Holiday Period where weekends and holiday impact on the overall cover. Next priority is to provide extra physiotherapy weekend cover for December, January and February.
- Discussions with MFE consultants and General Practitioners to provide medical cover in community hospitals and communities over the Festive period.

- Additional social work capacity will be put in place over the festive period, where and when required.

5.6 **Ensuring patients are cared for in their own homes**

- Develop a directory of services and alternatives to admission in partnership with NHS Tayside, specifically for Perth & Kinross.
- PKAVs will continue to connect with local community resilience groups in rural areas of Perth & Kinross to support local emergency plans over the winter period.
- PKAVs will strengthen engagement with voluntary sector services who provide support in areas such as transport, befriending visits, shopping and meals for older people living at home to build up the community base to their support.
- Review the role and function of support staff across health and social care to produce a generic support worker role.
- Promote and Increase the use of innovative technology.
- Continue to roll out Enhanced Community Support aligning with Locality based Integrated Care Teams.
- Review the community medical model of care.
- Review of Community Hospital Models
- The Living Wage negotiations for commissioning care at home have commenced. The contract strategy for recommissioning new framework agreement for care at home was approved at PC SMT in September. A staged approach for procurement was agreed and procurement for the South Perthshire will commence at end of October 2016, with North Locality being Phase II and Perth City Phase III.
- A comprehensive action plan is being developed from the new Technology Enabled Care that will support the Joint Strategic Plan and Locality Action Plans over the next 3 years.
- Recruitment of a Carers Respite Development Officer through PKAVs to increase early identification of unpaid Carers requiring respite breaks and to work with local partners to develop respite opportunities in Perth & Kinross.

6.0 **Key Risks**

- Delayed Discharge – As a result of a lack of capacity and flexibility in service provision, there is a risk of an increase in the number of patients experiencing a delayed discharge and longer length of stay in hospital. This would result in poor experience of care, and put patients at increased risk of acquiring an HAI as well as potential decline in their independence.

- Norovirus and Seasonal Flu – As a result of a norovirus outbreak or severe seasonal flu, there is a risk that services will be under increased pressure due to increased demand for services, as well as a compromised ability to meet demand due to staff sickness. This would result in poor experience of care, as well as an inability to provide safe and effective care.

- Care at Home External Providers – There is a risk that Care at Home providers are unable to provide the additional resource required to meet increased demand over the winter period thereby increasing delayed discharges and length of delay. Negotiations have commenced with External Providers to discuss capacity.

7.0 **Critical Areas, Outcomes and Indicators**

The Scottish Government identified the following critical areas which remain key to effective winter planning and should be the bedrock on which winter plans are built. The local

indicators, which underpin each critical area, should be included in relevant local management processes to achieve the outcomes described. Indicators should also align with the USC 6 Essential Action Improvement Programme. The areas highlighted in red are the indicators where Perth & Kinross Partnership could make a direct impact and therefore should consider the regular reporting arrangements to be put in place to monitor performance.

1. Business continuity plans tested with partners. *(Appendix 1 - Checklist 1 refers)*
Outcome: • The board has fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather.
Local indicator(s): • progress against any actions from the testing of business continuity plans.

2. Escalation plans tested with partners. *(Appendix 1 - Checklist 2:1 refers)*
Outcome: • Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.
Local indicator(s): • attendance profile by day of week and time of day managed against available capacity • locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over 2, 4 hours • all indicators should be locally agreed and monitored.

3. Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January. *(Appendix 1 - Checklist 2:2 and 2:4 refers)*
Outcomes: • Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period. • The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimised. • Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.
Local indicator(s): • daily and cumulative balance of admissions / discharges over the festive period • levels of boarding medical patients in surgical wards • delayed discharge • community hospital bed occupancy • number of Social Work assessments including variances from planned levels.

4. Strategies for additional surge capacity across Health & Social Care Services *(Appendix 1 - Checklist 2:2 refers)*
Outcome: • The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans for additional surge capacity across health and social care services is agreed in October. The planned

dates for the introduction of additional acute, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment.

Local indicator(s):

- planned additional capacity and planned dates of introduction
- planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds;
- planned number of additional intermediate beds in the community and the planned date of introduction of these beds;
- levels of boarding.
- planned number of extra care packages
- planned number of extra home night sitting services
- planned number of extra next day GP and hospital appointments

5. Whole system activity plans for winter: post-festive surge / respiratory pathway. *(Appendix 1 - Checklists 2:2 and 6 refers)*

Outcome:

- The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.

Local indicator(s):

- daily number of cancelled elective procedures;
- daily number of elective and emergency admissions and discharges;
- number of respiratory admissions and variation from plan.

6. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance
(Appendix 1 - Checklist 2:2 refers)

Outcome:

- NHS Boards have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.

Local indicator(s) :

- Agreed and resourced analytical plans for winter analysis.

7. Workforce capacity plans & rotas for winter / festive period agreed by October.
(Appendix 1 - Checklist 2:3 refers)

Outcomes:

- Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective admission and discharge of emergency and elective patients. This should encompass all relevant health and social care services.
- Maintain discharges at normal levels over the two 4 day festive holiday periods

Local indicator(s):

- workforce capacity plans & rotas for winter / festive period agreed by October;
- effective local escalation of any deviation from plan and actions to address these;
- extra capacity scheduled for the 'return to work' days after the four day festive break

factored into annual leave management arrangements.
- number of discharges on each of the 4 day festive holiday periods compared to number of normal daily discharges

8. Discharges at weekends & bank holidays
(Appendix 1 - Checklists 2:3 and 2:4 refers)

Outcome:
Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital. Medical and Nurse Directors provide monthly report on weekend (pre-noon) discharge rate progress and performance.

Local indicator(s):
- % of discharges that are criteria led on weekend and bank holidays;
- daily number of elective and emergency admissions and discharges.

9. The risk of patients being delayed on their pathway is minimised.
(Appendix 1 - Checklist 2:4 refers)

Outcome:
- Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer. Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance.

Local indicator(s):
- distributions of attendances / admissions;
- distribution of time to assessment;
- distribution of time between decision to transfer/discharge and actual time;
- % of discharges before noon;
- % of discharges through discharge lounge;
- % of discharges that are criteria led;
- levels of boarding medical patients in surgical wards.

10. Communication plans
(Appendix 1 - Checklist 2:7 refers)

Outcome:
- The public and patients are kept informed of winter pressures, their impact on services and the actions being taken.

Local indicator(s) :
- daily record of communications activity;
- early and wide promotion of winter plan

11. Preparing effectively for norovirus.
(Appendix 1 - Checklist 4 refers)

Outcome:
The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).

Local indicator(s):
- number of wards closed to norovirus;
- application of HPS norovirus guidance.

12. Delivering seasonal flu vaccination to public and staff. *(Appendix 1 - Checklist 5 refers)*
Outcome: • CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance.
Local indicator(s): • % uptake for those aged 65+ and 'at risk' groups; • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.