

DUMFRIES and GALLOWAY NHS BOARD

(Insert date of meeting)



Winter Review

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Date: 15th May 2019

RECOMMENDATION

The Board is asked **to approve** the following points:

- The review of Winter 2018/19 (**Appendix 1**)

The Board is asked **to discuss and note** the following points:

- The significant work and improved performance compared to last winter particularly within the Emergency Care Centre at DGRI
- The considerable joint working across the partnership that was undertaken and the further expansion of whole system collaboration that is planned for 2019/20
- The challenges of delayed discharges across Dumfries and Galloway and the impact this has across the whole system including the ability to delivery patient centred care
- The learning and reflections from this winter which will inform the winter plan for 2019/20

CONTEXT

Strategy / Policy:

NHS Territorial Boards and Health and Social Care Partnerships Annual Review of Winter 2018-19.

Organisational Context / Why is this paper important / Key messages:

Winter reviews are key to ensuring that processes and systems that were tested over winter are evaluated and any lessons learned are used to inform future planning. This review process ensures development of a robust and collaborative winter plan for 2019/20.

GLOSSARY OF TERMS

AHP	- Allied Health Professional
BC	- Business Continuity
CATS	- Crisis Assessment Team
CAU	- Combined Assessment Unit
COPD	- Chronic Obstructive Pulmonary Disease
DCAQ	- Demand, Capacity, Access, Queue
DDD	- Daily Dynamic Discharge
DGRI	- Dumfries and Galloway Royal Infirmary
ECC	- Emergency Care Centre
ED	- Emergency Department
eKISS	- Electronic Key Information Summary System
GCH	- Galloway Community Hospital
HSCP	- Health and Social Care Partnership
HPS	- Health Protection Scotland
HPT	- Health Protection Team
HR	- Human Resources
IJB	- Integrated Joint Board
IPCT	- Infection Prevention and Control Teams
MDT	- Multi Disciplinary Team
NHS	- National Health Service
NIP	- Nithsdale In Partnership
OOHs	- Out of Hours
PFC	- Patient Flow Co-ordinators
SAS	- Scottish Ambulance Service
STARS	- Short Term Augmented Response Service
TTG	- Treatment Time Guarantee

MONITORING FORM

Policy / Strategy	National Winter Planning
Staffing Implications	Review of Winter has no staffing implications
Financial Implications	Review of Winter has no staffing implications
Consultation / Consideration	All areas involved in the Winter Review have contributed to this and the final report will be shared.
Risk Assessment	Risk assessments are completed as required within the areas as noted within the report, i.e. in relation to staff absence / business continuity.
Risk Appetite	<p>Low <input checked="" type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/></p> <p>The Winter Review process is well established and tested, however, due to the so the Risk Appetite would be Low.</p>
Sustainability	The winter review process is well established and embedded into the annual planning cycle and supports the delivery of NHS and HSCP services.
Compliance with Corporate Objectives	<p>Complies with:</p> <ul style="list-style-type: none"> To reduce health inequalities across Dumfries and Galloway. Continue to support and develop partnership working to improve outcomes for the people of Dumfries and Galloway.
Local Outcome Improvement Plan (LOIP)	<p>Outcome 3: Health and wellbeing inequalities are reduced</p> <p>Outcome 6: People are safe and feel safe</p> <p>Outcome 7: People are well connected</p> <p>Outcome 8: Individuals and communities are empowered</p>
Best Value	<p>Effective Partnerships</p> <p>Use of Resources</p> <p>Sustainability</p>
Impact Assessment	Not required

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

NHS Board, HSCPs:	Dumfries and Galloway	Winter Planning Executive Lead:	Julie White
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1	Clear alignment between hospital, primary and social care
1.1	<p>What went well?</p> <p>The introduction of a new Unscheduled Care Governance Structure has ensured the required governance across the whole programme. The change in the Unscheduled Care programme board from being chaired by the acute site director to the COO/CO, has enabled increased partnership working and ensured whole system approaches. All work streams have representation from primary, acute, community and social care and these report directly to the programme board.</p> <p>The winter planning group is a key work stream that reports directly to the USC programme board.</p> <p>There has been an improvement in data collection, analysis and the sharing of data across the partnership. Closer working with the health intelligence team has enabled this improvement. System wide data is shared in a user friendly format which has aided both management and front line staff to interpret..</p> <p>The introduction of monthly Day of Care surveys in all acute and community hospitals has been undertaken to understand the extent of, and reasons for, delays in the health and social care system. This whole system approach allows targeting of areas of improvement across the partnership.</p> <p>The established flow coordinator team covers DGRI and all 4 localities, cottage hospitals and community. They have a consistent and standardised approach to patient flow. The team effectively communicates across the partnership ensuring the effective utilisation of community resources.</p> <p>The daily, weekly flow meetings held in DGRI and each of the localities respectively have ensured the optimisation of community resources to minimise delays. Representation at these meetings includes community services such as reablement, rapid response and the transition team.</p> <p>Within Nithsdale locality a single point of contact (SPoC) has been developed over the past few months, this has streamlined the referral process and is working well.</p> <p>The transition team has provided additional capacity for patients requiring care at</p>

	<p>home packages with and without a start date which has reduced delays.</p> <p>Progress with the frailty pathway has seen the early identification of frail patients within the combined assessment unit in DGRI. This has enhanced the AHP front door model and closer working with community services and social work to promote timely discharge.</p> <p>Communication through use of short videos for both staff and public on social media received positive feedback. Topics included;</p> <ul style="list-style-type: none"> ○ Approaches to Winter health ○ Emergency Department Ready ○ Getting Ready for Winter Message ○ New Discharge Lounge ○ Integrated Respiratory Team ○ Improving Patient Flow ○ Nithsdale in Partnership ○ Flu is Coming ○ Winter Response Ward D7 <p>A flowply session was run across the partnership which had good impact on understanding of flow and acute pressure on flow.</p>
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1.2	<p>What could have gone better?</p> <p>There was an improvement in communication across the partnership yet there is further scope for improvement. For example a review of the escalation process across the whole partnership may result in a more consistent and efficient response.</p> <p>DDD is established across all acute and community hospitals, however it has been identified further work is required to ensure an effective and consistent approach.</p> <p>Despite the progress with the collection, analysis and sharing of data there is scope for improvement particularly within cottage hospitals.</p> <p>Managing patient and their family's expectation particularly when the system is under pressure.</p> <p>The frailty pathway is in the early stages with the frailty nurse not commencing their post until April 2019. Processes are not yet embedded across the full partnership.</p> <p>Staff shortages across all areas and a reliance on bank and locum staff has impacted on communication, relationships and joint working across the partnership.</p>
1.3	<p>Key lessons / Actions planned</p> <p>Agree communication strategy for continuous and consistent public and staff</p>

	<p>engagement linked to patient flow.</p> <p>Progression of The Primary Care Transformation Programme to further strengthen the alignment between primary and secondary care. A local interface group between primary and secondary care commenced in April 2019, this group will further enhance communication between primary and secondary care and ensure service developments occur in tandem</p> <p>Education and training for frontline staff including medical staff on the basics of discharge planning and the principles of DDD</p> <p>Data for improvement to be shared consistently across the partnership</p> <p>Flowcopy sessions planned to be delivered in the community, to ensure a consistent understanding on the importance of flow.</p> <p>Review current escalation process across the partnership.</p> <p>The Out of Hours Sub Group of the Unscheduled care programme board are working towards agreeing a model for the OOH period, which will be a Hub and Spoke model. There will be a GP in the hub during the OOH period with ANP's and Community Adult General Nursing (CAGN) extending their hours to operate across the 24/7 period. It is envisaged that the extension of CAGN to 24/7 working across the region will commence in October 2019 – pre winter. The data utilised to inform this model, suggests that 80% of OOH work could be undertaken by nursing and of that 84% is unmet anticipated care from day time services. Further impact projected is that this will prevent unnecessary admissions to hospital.</p>
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2	Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods
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2.1	<p>What went well?</p> <p>Across all the operating directorates appropriate festive staff rotas were in place for medical, nursing, Allied Health Professionals (AHPs) and support staff.</p> <p>Rotas were planned to ensure that the Mondays following the festive weekends were a normal working day and additional staff were scheduled this ensured staff levels were maintained.</p> <p>Additional incentives such as weekly pay for bank staff, helped to ensure vacant shifts were covered and staffing maintained.</p> <p>Processes at the front door within DGRI were enhanced and the introduction of a rapid assessment area made significant improvements to patient flow through the combined assessment unit (CAU).</p> <p>An additional consultant was based in CAU at the weekends to ensure timely senior decision making and review, including downstream wards.</p>
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Maintaining discharges across 7 days is recognised as a key priority. In order to maintain discharges over the weekend, a specific weekend discharge team was put in place. This was refined from the model deployed last winter. The team included; AHPs, social work, consultant, middle grade doctor, pharmacy, senior manager, flow coordinator, & transport coordinator. The data indicates this increased discharge at the weekend and it is suggested this also had a positive impact on a Monday.

Earlier in the day discharges are key priority and there was some improvement. The data indicates a shift of approximately 1 hour from last winter. Monitored time of day of discharge to understand the extent to which earlier in the day discharge was being achieved.

This is a multi factorial issue but the introduction of a discharge lounge within DGRI is suggested to have made some impact on time of discharge. The criteria for the discharge lounge had restricted parameters given the area that was used, pharmacy processes and staffing availability. Further work is planned on the evaluation of the lounge including the criteria.

A transfer team were employed over 7 days (x2 HCSW) to support the transfer of patients from CAU to downstream wards, this team also transferred patients within the hospital when boarding was required. This dedicated team reduced the length of time patients waited to be transferred delay thereby achieving capacity earlier in the day.

The increase in the number of flow coordinators within DGRI has enabled a greater focus on delays in the discharge planning process, complex discharges, and movement of patients to cottage hospital. The team within DGRI communicated throughout the day with their patient flow colleagues based in all 4 localities. The daily, weekly flow meetings held in DGRI and each of the localities respectively have ensured the optimisation of community resources to minimise delays. Representation at these meetings includes community services such reablement , rapid response and the transition team

Delayed discharges remain a key challenge. The number of delayed discharge across the partnership did increase over this winter in comparison to last. For the 5 months ending 28th February 2019, the number of bed days occupied by delayed discharges was 45% higher this winter compared to last. This caused direct impact on performance and flow performance at the acute sites.

The hospital ambulance liaison officer (HALO) role remains pivotal to patient flow. With presence at site huddle and cover at weekends this role has assisted in ensure reduced delays and timely discharge and transfers.

The implementation of an integrated respiratory team across Dumfries and Galloway has begun to provide specific pathways for respiratory patients. The team includes nurse specialist based within each of 4 localities, who by working closely with primary care prevent admissions. The nurses also work with the acute, DGRI and GCH teams to support earlier discharges by providing

	specialist support within a patient's home.
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2.2	<p>What could have gone better?</p> <p>Across all directorates there was key on-going challenges noted mainly around delayed discharges.</p> <p>Despite the improved processes and service in place to manage and prevent delayed discharges, the number of delays did increase across the partnership this winter. Reasons for this were predominantly cottage hospital bed availability and provision of care at home.</p> <p>The reablement service offered support to people who were waiting on long term care packages, this included Rapid Response and Transition (DG1/2). This is however not an ideal use of these services as it results in them becoming blocked with people awaiting care packages.</p> <p>The planned consultant for the Winter beds withdrew in September resulting in ad hoc cover and for a sustained period the winter beds being used as boarding beds.</p> <p>Staff shortages across all areas caused pressure on delivering 7 day service. There was reliance on bank and locum staff, which not only resulted in increased financial costs but caused increased pressure on the system to deliver consistency and efficient hospital flow.</p> <p>The volume of patients discharged via the discharge lounge was lower than predicated. Despite gains in some ward areas the process were neither embedded nor consistently used across the site.</p> <p>The integrated respiratory team is in the initial stages of the programme, while they are working closely with primary care and SAS the impact this winter is not yet partnership wide.</p>
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2.3	<p>Key lessons / Actions planned</p> <p>Work with care providers to agree strategies to address care at home capacity is underway and will be continued. One aspect is a review of the level of internal home care compared to the out sourced provision.</p> <p>Exploring within community services a move to increase capacity of reablement and to prioritise pathways whilst remaining patient centred to ensure the right people get the right opportunities to reduce dependency/reactivate when moving from hospital to home with care needs.</p> <p>Explore how we can prevent using community resources inappropriately and find alternatives.</p> <p>There are workshops planned through a collaborative approach of community services and Scottish care, to deliver sessions on “discharge flow and me” to</p>
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	<p>contribute to solutions for people needing longer term support and care to help with our own flow needs.</p> <p>Recruitment remains a key priority with recruitment events planned throughout the year. Additionally the recruitment of a Recruitment Sustainability Manager post will aim to ensure both short and long term improvements.</p> <p>Continuation and development of the transfer team role. To ensure the role develops into a dedicated and substantive team all year round.</p> <p>Further progression of the integrated respiratory team working closely with primary care and developing process with SAS to both prevent admission and support earlier discharge.</p> <p>Through the unscheduled care improvement programme there are a number of project such as DDD, and criteria led discharge that are focused on patient flow. This programme of improvement requires to be rolled out at pace across all directorates. This programme must be delivered using robust quality improvement methodology and embedded into business as usual.</p> <p>Within mental health the development of a day of care tool alongside a new delayed transfers of care working group with key stakeholders, will aim to address patient flow issues.</p> <p>In DGRI the success of a senior managers within the weekend team, will continue on a Sunday during the year. This will aim to ensure flow is maintained over the weekend.</p> <p>In the mental health a review of clinical medical and nursing leadership, has resulted in the introduction of Senior Nurse Availability 7 days a week. . This will be evaluated over the coming months.</p>
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3	Local systems to have detailed demand and capacity projections to inform their planning assumptions
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3.1	<p>What went well?</p> <p>The introduction earlier in the year of an electronic safety and flow huddle has enhanced the grip and control of the site. By using daily predications against current and predicted bed capacity this has increased the accuracy of the hospital bed status. This resulted in more appropriate escalation.</p> <p>The bed status and subsequent actions are feedback to the wide MDT that attends the huddle, including the ward teams. This communication of hospital status is improving and further refining of ward specific demand and capacity is being developed.</p> <p>This extract is shared with community services such as the reablement team</p>
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	<p>which use this information to assist with their capacity allocation</p> <p>Attendance by the access/booking team at the site huddle allows for refinement of planned admissions to reflect predicted unscheduled demand.</p> <p>Three times daily site status reports for all sites including community hospitals continued to be circulated automatically using data extracted from Topaz via Qlikview to executives, senior management and lead clinicians across acute, community and primary care.</p> <p>Establishment of a Unscheduled Care governance group which meets fortnightly to review recent performance and respond to emerging issues in a timely manner.</p>
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3.2	<p>What could have gone better?</p> <p>It was recognised prior to winter through, local bed management systems, that within DGRI there was a requirement to reconfigure beds in line with demand, to provide more medical capacity and a reduced surgical bed count. While this project is underway the proposed changes have not yet been agreed and implemented. This resulted in increased medical boarding over this winter.</p> <p>The PM site huddle continues to focus predominately on today's demand, despite local systems providing the necessary data to plan for tomorrow's demand and capacity. This results in the huddle remaining reactive to the day's status rather than pro active to tomorrow's predictions.</p>
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3.3	<p>Key lessons / Actions planned</p> <p>Implementation of bed reconfiguration within DGRI, to better align capacity with demand.</p> <p>Further refinement of the site huddle to ensure focus on next day's predicted demand and capacity.</p> <p>To develop ward specific demand and capacity so ward teams have ownership and understanding of their ward status and its impact on the wider site status</p>
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4	Maximise elective activity over winter – including protecting same day surgery capacity
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4.1	What went well?
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	<p>Made use of Systemwatch to help plan reductions in elective operations during expected peaks in emergency admissions this helped to reduce cancellations specifically due to lack of bed availability from 49 in Oct17-Mar18 to 40 in Oct18-Mar19</p> <p>Waiting time's data is monitored on an ongoing basis through the Patient Access Governance Group, which is chaired by the general manager for A & D to maintain control of waiting lists. This group is responsible for adjusting elective capacity to best utilise site capacity in light of unscheduled demand.</p> <p>Scheduled booking team attendance at the site huddle ensures a proactive approach to maximising use of the available capacity.</p> <p>Development of a boarding policy, implemented this winter, which promoted the use of downstream surgical wards for medical boarders and SSU for surgical patients with a short length of stay. This process helped to maintain surgical bed capacity and staff feedback indicated more appropriate boarding.</p> <p>Planned reduction in morning clinics for medical consultants allowed greater focus on earlier in day decision and subsequent discharges.</p>
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<p>4.2</p>	<p>What could have gone better?</p> <p>Planned reduction in elective activity during periods of increased demand took place late in the season which was a factor in the increased list sizes experienced over the winter.</p> <p>Increased appropriate use of the day surgery unit to reduce the demand on inpatient beds.</p>
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<p>4.3</p>	<p>Key lessons / Actions planned</p> <p>Earlier planning of increased elective activity over quieter months so as to reduce elective waiting list during these periods in anticipation of planned reduction in elective activity during times of peak unscheduled demand.</p> <p>Optimised use of the day surgery unit to reduce the demand on inpatient beds.</p> <p>Review of surgical pathways to reduce variation and maximise theatre utilisation.</p> <p>Coordination and communication between the unscheduled care programme board and scheduled care programme board.</p>
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<p>5</p>	<p>Escalation plans tested with partners</p>
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5.1	<p>What went well?</p> <p>Regular meetings with key stakeholders allowed for consistency of understanding of how all Winter Planning aspects worked and were progressing. All partners were aware of contingency plans.</p> <p>It was a mild winter with no extreme weather to test weather contingency plans, however a move into silver command level of escalation was used during an extremely challenging day due to site status. This process worked well and flow was significantly improved.</p>
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5.2	<p>What could have gone better?</p> <p>Giving the weather conditions and flu levels the partnership did not need to deploy contingency plans other than the one mentioned above</p>
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5.3	<p>Key lessons / Actions planned</p> <p>To embed content and understanding of general manager's action pack relating to resilience response issues.</p> <p>The silver command did work well and did improve the flow but the process could be further refined.</p>
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6	Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings
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6.1	<p>What went well?</p> <p>Mild winter with no hospital outbreaks of Norovirus. No onward transmission of flu in DGRI, only one cottage hospital outbreak of flu</p> <p>Used systemwatch to monitor upturns in influenza in the community so that the acute service was able to plan for possible increases in admissions.</p>
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6.2	<p>What could have gone better?</p> <p>FFP3 supply. NPD were unable to source sufficient supplies of the correct masks</p>
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6.3	<p>Key lessons / Actions planned</p> <p>No changes to current plan</p>
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7	Delivering seasonal flu vaccination to public and staff
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7.1	<p>What went well?</p> <p>The staff flu campaign was well attended by NHS D&G staff, with an uptake level of 65%. This is again the highest uptake among NHS Scotland Boards. Staff attended clinics throughout the region, at various locations over various shifts, with the option of attending an individual appointment sent to them via their manager or dropping in to a clinic of their choice. These options made accessing a suitable clinic during work time achievable. Clinic space allocated at Out Patients DGRI improved clinic accessibility and raised the profile of the staff Flu clinics within DGRI.</p> <p>Used systemwatch to monitor upturns in influenza in the community so that the acute service was able to plan for possible increases in admissions.</p>
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7.2	<p>What could have gone better?</p> <p>The uptake level from last year has slightly increased (previously 64%) however we continue to increase staff awareness around Influenza vaccination to encourage higher uptake within frontline staff.</p>
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7.3	<p>Key lessons / Actions planned</p> <p>Continue to gain momentum from previous campaigns, working with managers to improve uptake. This was the first campaign held in the new hospital and various clinic locations had been altered this year, a period of stability is likely to encourage a rise in uptake in forthcoming seasons. Feedback to staff re uptake and efficacy of vaccine is planned for forthcoming staff communications</p>
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8	<p>Top Five Local Priorities for Winter Planning 2019/20</p> <ul style="list-style-type: none"> • Alternatives to acute admission through enhanced community models of care • Enhance and develop sustained Care at Home capacity • Reduce reliance on locum and temporary staff by developing sustained staffing levels across the partnership • Balance scheduled and unscheduled care demand to minimise impact on waiting times • Reconfigure the bed base within DGRI to better align capacity with demand
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