Health & Social Care: Local Review of Winter 2017/18

<table>
<thead>
<tr>
<th>NHS Board, HSCP/s</th>
<th>NHS Fife and Fife HSCP</th>
<th>Winter Planning Executive Lead</th>
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<td>Jann Gardner, Director of Planning &amp; Strategic Partnerships / Interim COO. <a href="mailto:Jann.gardner@nhs.net">Jann.gardner@nhs.net</a> 01592 648189</td>
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Introduction
Last year we asked for local winter reviews to be shared with the Scottish Government. This was a beneficial exercise which helped to identify key pressures and performance, which fed into the ‘National Health & Social Care: Winter in Scotland 2016/17 Report’. The lessons learned and key priorities for improvement were also used to help develop the ‘Preparing for Winter 2017/18 Guidance’ - http://www.sehd.scot.nhs.uk(dl/DL(2017)19.pdf

To continue to improve winter planning across Health & Social Care we are asking local systems to lodge a draft of their winter review for 2017/18 with the Scottish Government to support winter planning preparations for 2018/19. Local reviews should have senior joint sign-off reflecting local governance arrangements.

We expect this year’s review to include:
- the named executive leading on winter across the local system
- key learning points and future recommendations / planned actions
- top 5 local priorities that you intend to address in the 2018/19 winter planning process
- comments on the effectiveness of the wider winter planning process and suggestions as to how we can continuously improve this process. We are particularly keen to hear the views of Health & Social Care Partnerships.

Completed reviews should be sent to Winter_Planning_Team_Mailbox@gov.scot by no later than close of play on Friday 20 April.

Thank you for your continuing support.

Alan Hunter
Director for Health Performance & Delivery

Geoff Huggins
Director for Health & Social Care Integration
Business continuity plans tested with partners.

Outcome:
The local system 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.

1.1 What went well?

- Local Business continuity management arrangements in place.
- The extreme snow and severe weather warnings at the end of February/beginning of March tested our resilience.
- Support from the public, businesses and the armed forces improved resilience when 4x4 vehicles supported the transportation of staff to deliver essential care in the community and to support staff and patient travel to hospitals. Accommodation was also provided for staff to stay overnight when necessary.
- The response of the workforce across acute services and health and social care to the winter pressure and extreme weather.
- Services were innovative during adverse weather and using various technology (“What’s App”) during adverse weather to facilitate deployment.

1.2 What could have gone better?

- An overarching Fife business continuity plan involving all partnerships and agencies.
- A co-ordination centre ensuring the prioritisation of journeys with earlier access to 4x4 vehicles
- Co-ordinating local teams to support care delivery across sectors – e.g. district nursing carrying out care home tasks to ensure vulnerable individuals received support.

1.3 Key lessons / Actions planned

- Reviewing response to adverse weather and improving systems for the future including business continuity plans.
- A succinct transport plan (including transport hub) put in place for staff, patients and supplies with clarification on how the military services/volunteers/external services can be utilised during extreme adverse weather/emergencies.
- An annual table top exercise to test the enactment of business continuity plans.
- A robust whole organisation resilience plan to be written and not just service business continuity plans.

## Escalation plans tested with partners.

**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.

## 2.1 What went well?
- Speciality pull through model built into daily huddle
- Review of current Escalation Plan took place to ensure clarity of triggers for opening additional capacity.
- Work underway to review and strengthen site management arrangements at VHK

## 2.2 What could have gone better?
- Managing capacity during times of high demand for emergency services – across Acute and Community.
- Escalation triggers for opening additional capacity needed to be clearer
- Priority service agreements could have been more concise during adverse weather including emergency plans for staff attendance and greater availability of staff accommodation, senior decision making and triggers.

## 2.3 Key lessons / Actions planned
- Review and agree escalation triggers across the acute and community hospitals
- A clear escalation plan with decision making levels outlined by August 2018. This will include trigger points for ramping up services to facilitate discharge.

3 Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January.

**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.

3.1 What went well?
- New models of core pathways within HSCP implemented for winter.
- Collaboration across Acute, HSCP and corporate was significantly improved.
- Flow to community facilities was maintained over the festive period and a “joint” approach to capacity management was in place. This consisted of Community and Acute Managers working together to problem solve on difficult days.
- Enhanced SW staffing levels in the HSCP Discharge Hub and in the community hospitals supported discharge.
- 7 day working was introduced on some services and where introduced, worked well.
- Assessment bays for rapid assessment of patients before admission in both acute admission areas of Victoria Hospital.
3.2 What could have gone better?

- Utilisation of bed capacity (i.e. profile of beds across specialties) that will be addressed through bed reconfiguration work over the summer period.
- Planning of the surgical programme over the winter months.

3.3 Key lessons / Actions planned

- Community Transformation programme currently taking place in HSCP, if approved will deliver a more robust urgent care model for Fife and a focus on prevention of admission through supporting high health gain individuals and developing community hubs.
- Expand the 7 day service to cover AHPs and Pharmacy incorporated in HSCP and Acute.
- Focus on Nurse led/criteria led discharge and set definite discharge dates, this will allow planning ahead for discharges.
- Review of Surgical Plan for winter to forward plan capacity around known peak periods.

4 Strategies for additional surge capacity across Health & Social Care Services

Outcomes:
- 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, OOH, 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
- OOH capacity
- planned number of extra next day GP and hospital appointments

4.1 What went well?

- Capacity modelling and monitoring planned versus actual placements.
• Working with local care providers to plan for surge capacity.
• Bringing additional assessment beds on stream earlier.
• Use of 9% increase in the community hospital bed capacity to manage surge.
• Use of Advanced Nurse Practitioners (ANPs) in community hospitals

4.2 What could have gone better?
• Demand levels in February became challenging and continued into March – compounded by the severe weather.
• High levels of flu proved challenging
• The out of hours response in the community could be better.
• Escalation triggers for opening additional acute capacity

4.3 Key lessons / Actions planned
• Greater flexibility is required within nursing to support the occasions when additional bed capacity is required.
• Further planning required to ease community flow in February.
• Expand use of ANPs in community hospitals/care homes to include out of hours.
• Using appropriate beds across the whole system and not just close to patients’ locality/home.
5 Whole system activity plans for winter: post-festive surge / respiratory pathway.

Outcomes:
- 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.
- Monthly Unscheduled Care Meetings of hospital triumvirate, including IJB Partnerships and SAS (clinical and non-clinical) colleagues.

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.

5.1 What went well?
- The multi-disciplinary daily safety huddle continues to support decision-making in the very early part of the day by:
  - Overview of hospital activity at 08:00 a.m. and activity/performance over the previous 24 hour period, including Hospital at Night.
  - Patient safety issues including review of patients on PatientTrak with high FEWs.
  - Review of deteriorating patients.
  - Review of DATIX submitted in previous 24 hours.
  - Deaths overnight.
  - Cardiac arrests overnight.
  - Any concerns from the wards, including patients with challenging behaviours, boarding against clinical advice, transfers after 8 p.m.
  - Update from all Support Services.
  - Review of emergency and elective activity for the 24 hours ahead, potential system pressures and planning capacity appropriately, including critical care, repatriations, transfers to community hospitals, etc
  - Review of cancelled elective procedures in the previous 24 hours.
  - Delayed discharge position and community flow.

- This is supported by late morning huddles held at operational level.
- Weekly operational planning meetings continue to look at operational plans for a week ahead and agree a weekend plan for the site. The balance of accommodating elective and emergency admissions is part of this process and informs the decision to open additional capacity if necessary.
The Emergency Care Assessment Suite within the Victoria Hospital continues to extend the number and types of patient that can be assessed and treated there. This includes an enhanced range of interventions including DVT, IV Antibiotics/Infusions, Lumbar Puncture and Blood Transfusion.

The demand for Respiratory Services remain high and a Consultant Nurse post has been developed to focus on treatments that can be supported through our ECAS service or supported at home.

Non invasive ventilation is available via Medical High Dependency Unit and the respiratory unit with a total of 13 ventilators. Clinical respiratory in reach is provided to the Emergency Department and the Acute Medical Unit.

Key managers are on site throughout the festive period with a specialty pull through model built in the daily huddle (high demand for respiratory wards).

Developed a targeted integrated preventative model called High Health Gains, which improves community focussed health and wellbeing outcomes and reduces hospital emergency admissions. This model was trialled within 3 GP practice localities and worked well.

5.2 What could have gone better?

- Planning around “peaks” of activity either because of acuity in terms of types of patients being admitted or in the number of patients arriving at particular times needs further work.
- There were times when our assessment capacity in our acute admissions area accommodated patients overnight and caused difficulty in creating flow in the hospital in the early part of the day.
- Balance of surgical programme across winter months

5.3 Key lessons / Actions planned

- Review of surgical programme
- Review of expected discharge date (EDD) process in VHK
- The High Health Gains model is to be rolled out to all practices within Fife.
## 6 Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

**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.
- Use of System Watch

### 6.1 What went well?
- A weekly winter planning meeting took place to address issues and implement improvements in a timely manner with an escalation and reporting process in place. Supported by an agreed weekly winter monitoring report that allowed decisions to be made to services to mitigate high demand (see Appendix 1 and 2).
- NHS Fife utilise the daily predictor contained within SystemWatch to assist with the prediction of daily emergency admissions to emergency and surgery. This has proved successful and features in the discussion at the daily Safety Huddle.
- The daily safety huddle also provides a summary of key activity from the previous day. ED performance, discharges against predictor, discharges before 1pm, Assessment Performance, update from Hospital at Night (Appendix 3).
- Hospital occupancy from 0700 hours is also discussed at provides a key barometer for the day ahead (Appendix 4).
- The use, presence and transparency of data in the HSCP shared with acute colleagues was helpful. A weekly tracker and cumulative tracker demonstrated activity against demand – planned and actual (Appendix 5).

### 6.2 What could have gone better?
- Initially establishing the reporting methods for the key winter performance indicators for the HSCP.
- Establishing the reporting template for the HSCP.
- Ensuring data and narrative were prepared each week for the HSCP.
- Greater analysis of key areas to plan for the winter
6.3 Key lessons / Actions planned

- Winter plan for 2018/19 to be ready and agreed by August 2018.
- Additional analysis to allow improvement plans ahead of winter (i.e. Complaints, re-admission trend, forecasting for greater population, further intelligence around discharges to aid planning)

7 Workforce capacity plans & rotas for winter / festive period agreed by October.

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 health and social care. This should encompass all relevant health and social care services.
- Maintain discharges at normal levels over the two 4 day festive holiday periods.
- Right level of senior clinical decision makers available 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.

7.1 What went well?

- Structure of daily huddle including Discharge hub, ward staff levels and ‘Safe to Start’. H&SC managers and operational managers work closely together.
- Medical staff rotas delivered a service standard of senior review every 48 hours.
- There was senior manager presence on the site every day of the year and an on-call system in place 24/7
- Additional Consultant cover was implemented in the Emergency Care Directorate on Saturday and Sundays to support capacity and flow decision-making.
- Rotas and staffing levels were agreed well in advance of the festive period and access and cover arrangements were shared with stakeholders.
- Social Work staffing arrangements over the public holidays were robust.
- Discharges over the festive period and the weekend immediately after improved from previous years but did not keep up with demand.
- Additional medical staff available at front door services of VHK.
7.2 What could have gone better?
- Within the GP out of hours (OOH) service rotas were agreed in advance of the festive period however securing shift cover was difficult and arranging cover was challenging.
- Improved flow in VHK on a daily basis – more work needed on expected discharge date (EDD) to support this
- 7 day working with other areas.

7.3 Key lessons / Actions planned
- Community Transformation programme currently taking place in HSCP, if approved will deliver a more robust urgent care model for Fife
- Review of EDD processes, daily huddle planned to help support improvement in flow at VHK
- Plan staff recruitment in advance of winter.
- 7 day working rolled out fully across AHPs and pharmacy.

8 Discharges at weekends & bank holidays

Outcome:
- Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow.
- Robust planning and decision making midweek to support discharges for patients over a public holiday weekend for example Immediate Discharge Letters (IDLs), Pharmacy Scripts, Transport and Equipment to minimise delays.

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

8.1 What went well?
- New models of H&SC implemented for winter.
- Collaboration across Acute, H&SC and corporate was significantly improved.
- The Integrated Assessment Team supports the delivery of our frailty model in Fife which has allowed us to increase the number of patients for whom admission is appropriately avoided either from the Emergency Department or the Acute Medical Unit following a frailty assessment. This service operated over 7 days including public holidays.
The level of weekend discharges from the hospital has remained fairly constant and therefore predictable from a weekend and public holiday planning perspective.

An ad hoc ambulance has been available at weekends to support hospital transfers and patient discharges.

In some areas of the Acute Services Division, AHPs delivered a weekend service and a public holiday service which was in place over the festive period and beyond.

Within the Acute hospital, the Discharge Hub facilitates the discharge of those who require ongoing support from health and social care following an in-patient stay. This service offers a multi-agency, integrated, person centred approach to the assessment of an individual’s needs as they approach discharge. The hub has a key role in community and whole system flow. This service was in place over the festive period and on the public holidays. Over the festive period the Discharge Hub operated with additional staff.

The Hospital Social Work Team contributed significantly over the winter period and this helped to control delayed discharge.

Additional medical staff at peaks times (i.e. Jan/Feb/March) to front door services

### 8.2 What could have gone better?

- Availability of pharmacy for timely discharge was limited.
- 7 day AHP service was only available in limited areas within acute.

### 8.3 Key lessons / Actions planned

- The HSCP will continue to streamline pathways.
- Review pharmacy support for discharge.
- Explore expanding the 7 day service within AHPs wider including the community.
- Implementing a full 7 day service within Pharmacy including public holidays.
- Further development criteria led discharge through the appointment of more ANP staff at VHK
The risk of patients being delayed on their pathway is minimised.

Outcomes:
- Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream speciality 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.

9.1 What went well?
- New models of H&SC implemented for winter
- Collaboration across Acute, H&SC and corporate was significantly improved.
- Development of the Integrated Assessment Team supported delivery of our frailty model in Fife which has allowed us to increase the number of patients for whom admission is appropriately avoided either from the Emergency Department or the Acute Medical Unit following a frailty assessment. As part of the Frailty model a huddle takes place twice each day which includes representation from HSCP. Alternatives to admission included discharge with Day Hospital follow up, discharge with Hospital at Home, transfer to community hospitals, home with a discharge support model which was provided by an Independent Provider – the latter group of patients would have required an inpatient stay for non-clinical reasons. The introduction of the frailty model has resulted in a reduced length of stay for patients over 65 in the Acute Medical Unit, a reduction in the length of stay in the Medicine of the Elderly wards and an increase in the number of patients transferred to Community Hospitals directly from the Acute Medical Unit.
- A Discharge Ambulance is now commissioned all year round supplemented with an additional discharge vehicle over the winter months.
- Small improvement in discharges before noon on the acute site
### 9.2 What could have gone better?
- Discharge planning.
- Boarding levels.
- Discharge Transport options.
- Levels of patients boarding became an issue at peak times.

### 9.3 Key lessons / Actions planned
- Review and wider development of our Discharge Transport Options. Working with the Ambulance Service, in-house services and voluntary services to develop an efficient service for VHK.
- Reconfiguration of beds in VHK is significant in supporting better performance in 2018/19.
- Following review of usage the current Discharge Lounge was closed and an evaluation of its effectiveness undertaken. Any replacement model will form part of the development of a “Site Management” structure in the coming year.
10  Communication plans

Outcomes:
- The public and patients are kept informed of winter pressures, their impact on services and the actions being taken.
- Effective local and national winter campaigns to support patients over the winter period are in place.
- Staff are engaged and have increased awareness of the importance of working to discharge patients over the two 4 day festive holiday periods.

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

10.1  What went well?

- Flu fighters’ media campaign doubled the uptake of flu vaccinations across Fife.
- Social media used throughout winter to raise awareness to public and staff
- Throughout the year, NHS Fife and the Fife HSCP communications teams worked closely with colleagues in health and social care services to keep staff and the public up to date with the work that was being undertaken to alleviate the strain on services over the traditionally challenging winter months.
- We communicated with staff through intranet posts and additions to Dispatch, HSCP Newsletters, Partnership Forums as well as the radio whilst we also took advantage pop-up briefs across our sites.
- The daily huddle has continued to be useful in responding to enquiries around delayed discharge and community flow.
- Communication between the H&SCP, ASD and corporate teams.

10.2  What could have gone better?

- It may have been useful for internal communications to create an area of the intranet specifically dedicated to the redesign of services and what NHS Fife and the HSCP are doing to prepare for winter.
- Access to smart phones for community nurses in severe weather.

10.3  Key lessons / Actions planned

-
• Provision of smart phones for District Charge Nurses and Team Leads.
• Redesign and develop a dedicated Winter Planning intranet section to keep staff/services up to date and share news.

11 Preparing effectively for norovirus.

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.

11.1 What went well?

Preparedness:
• Buy in across the system for outbreak preparedness.
• Outbreak preparedness plans in circulation and actions progressed.
• Senior management ownership of Fife winter preparedness plans and progress updates against key deliverables required on a monthly basis.

Prevention:
• Collaboration between Health Protection and Infection Prevention and Control.
• Senior management support.
• Staff education across Fife and across all disciplines; in total over 30 training sessions were provided in the HSCP, covering 103 trained and untrained nursing staff and 59 ancillary staff including supervisors, shift leaders, porters, domestics and secretaries; 32 training sessions were provided across the acute division, covering 219 trained and untrained nursing staff and clinical managers and 59 ancillary staff including supervisors, shift leaders, porters, domestics and secretaries.

Management:
• Management of and engagement with norovirus prevention and control measures at ward and department level.
• Containment when outbreaks occurred; only one bay closure progressed to a full ward closure.
11.2 What could have gone better?

Both in NHS Scotland and NHSFife the weakest link continues to be the winter bed pressures and the impact on availability of single rooms for patients with norovirus symptoms.

Preparedness:
- New laboratory testing platform introduced just as the season started. There were understandably teething problems with the new system which has an impact on access to appropriate swabs and guidance

Prevention:
- Difficulty reaching all staff to provide education on norovirus prevention & management processes.
- Greater collaboration and joint working with Health Protection Team.

Management:
- Management of and / or planning for terminal cleaning.

Cost to the Organisation
Even a well managed norovirus outbreak has a significant logistical and financial impact on the NHS with a reduction in bed availability, hampered patient flow, many cancelled procedures, increased cost of enhanced & additional cleaning, increased staff costs, increased incidence of complaints and a serious impact on reputational risk.

When an outbreak is not well managed, all of the above costs increase significantly but of particular concern are the enhanced risk to patient (and staff) safety with the concomitant increase in morbidity & mortality.

11.3 Key lessons / Actions planned

- Winter debrief meetings with both the Acute & HSCP to assess the effectiveness of the management of norovirus patients and outbreak wards for season 2017/18.
- Assurance of availability of staff and attendance at norovirus outbreak management update training in both Acute & HSCP.
- Table top exercise of the management of norovirus outbreaks for both the Acute & H&SC Divisions to take place in autumn 2018
- Norovirus preparedness planning in NHS Fife is reviewed by the Infection Control Committee so that it becomes embedded as part of NHS Fife winter planning activity. The responsibility for preparedness and coordination being with the Division’s Senior Management Teams & the Winter Planning Teams, supported by the infection prevention and control service and the health protection team. This worked extremely well this season therefore it would be advantageous to build on this approach for the coming season.
Strict adherence to the norovirus guidance and processes as published by HPS and in the NHS Fife infection control manual, including but not limited to patient placement; timely preparation for terminal cleaning and consistency in methods employed and roles and responsibilities during terminal cleaning.

12 Delivering seasonal flu vaccination to public and staff.

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.

12.1 What went well?

- Flu fighters’ media campaign doubled the uptake of flu vaccinations across Fife, including staff in front line social care roles.
- A flexible and mobile approach to vaccination clinics was highly successful with mobile clinics, clinics in community settings, council facilities, and local authority care homes.
- More than 50% of NHS Fife staff were immunised and around 400 social care staff were also immunised.
- A follow-up survey of those involved with the staff campaign at the end of the season identified many achievements that can be built on in the 2018/19 campaign.
- Uptake of seasonal flu vaccine in those aged 65 and over was 74.3% in Fife, which is slightly above the Scottish average (73.7%) and close to the 75% target.
- Immunisation of primary school aged children (delivered by the Immunisation Team) was 70.7%, similar to uptake in previous years.

12.2 What could have gone better?

- Uptake of seasonal flu vaccine in those falling into under 65 at-risk groups (excluding healthy pregnant women and carers) was poor at 39.6%. This compares to a Scottish average of 44.8% and is well below the target of 75%.
- Pre-school seasonal flu vaccine uptake was 50.0% in Fife, below the Scottish average of 56.9%, and well below the 75% target.
### 12.3 Key lessons / Actions planned

- Overall, the NHS Fife Staff Seasonal Influenza programme for 2017/18 was very successful. Meetings have taken place to review the outcome of the 2017/18 programme and plan for the 2018/19 programme. Further meetings have been scheduled and a detailed action plan is in development.

- The focus will be on achieving the same rate of uptake of the seasonal flu vaccination, improving our uptake among front line staff and consideration of a target for uptake within social care.

- A meeting with GP Cluster Quality Leads is planned to discuss actions that can be taken to improve the uptake of pre-school and under 65 at risk groups in the community for the 2018/19 season.

### 13 Additional Detail

*Include detail around when this review is likely to be considered by the Boards senior management team.*

**Review of Winter 2017/18**
- Winter Review Event 8th May 2018
- HSCP Integrated Joint Board 21st June 2018
- Board Development Session 27th June 2018

**Winter Plan 2018/19**
- HSCP Integrated Joint Board Development Session 19th September 2018
- NHS Fife Board 26th September 2018

### 14 Top Five Local Priorities for Winter Planning 2018/19

There are significant transformation programmes across Acute and HSCP that once implemented will lay the foundations to provide improved services to our patients. These programmes include the community redesign incorporating urgent care review, community hospital redesign, community hubs and the acute transformation programme.

Following the review of winter 2017/18 the following areas have been identified as planning priorities:

1. Review and test Business Continuity Plans across all partnerships and agencies in Fife.
2. Acute Division bed re-modelling.
3. Urgent care flows between primary and secondary care.
4. 7 day Pharmacy within the Acute Division.
5. Review of Escalation Plan and triggers
15 Views on Wider Winter Planning Process & Suggestions for Improvement

- A primary-care focus to support targeted admission prevention.
- Redesign of Emergency Department flow between majors/resus and minors.
- “Specialty-pull” model in the acute division to improve patient flow.
- Robust introduction of EDD and Daily Dynamic Discharge
- Expand the 7 day service programme with the AHP’s to include HSCP as well as the whole of Acute.
- Review of Surgical Plan for winter to forward plan capacity around peak periods.
- Expand use of ANPs in community hospitals/care homes to include out of hours. Also develop criteria led discharge within Acute by appointing additional ANP staff there too.
- Review and wider development of our Discharge Transport Options. Working with the Ambulance Service, in-house services and voluntary services to develop an efficient service for VHK.
- Redesign and develop a dedicated Winter Planning intranet section to keep staff/services up to date and share news.
- Table top exercise of the management of norovirus outbreaks for both the Acute & H&SC Divisions to take place in autumn 2018
# Weekly Winter Scorecard

## Appendix 1

### Weekly Winter Monitoring Report

<table>
<thead>
<tr>
<th>Measure</th>
<th>Area</th>
<th>Definitions</th>
<th>Exception Criteria</th>
<th>Targets/Expectation</th>
<th>Performance and RAG</th>
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<tbody>
<tr>
<td>1</td>
<td>VKH</td>
<td>Emergency Department</td>
<td>Patient treated or discharged within 4 hours of arrival at AKU and A&amp;I (standard)</td>
<td>N/A</td>
<td>&gt;95% Breaches &lt;4 hours</td>
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<td>2</td>
<td>VKH</td>
<td>A&amp;I Assessment</td>
<td>Patients presenting to A&amp;I assessment</td>
<td>N/A</td>
<td>Conversions Rate 140-190 Admissions 60-65% Converted to U12 60-65% Conversion Rate 3-5% Average Lot 3-6 hours</td>
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<tr>
<td>3</td>
<td>VKH</td>
<td>ECGS</td>
<td>Conversion to admission</td>
<td>N/A</td>
<td>Conversion Rate 30% of new patients presenting to ECGS will be admitted</td>
</tr>
<tr>
<td>4</td>
<td>VKH</td>
<td>A&amp;I1</td>
<td>Patients admitted to A&amp;I1</td>
<td>N/A</td>
<td>Admissions 30-50% Discharges 50-60% Conversion Rate 20% Conversion Rate 4-6 hours Average Lot</td>
</tr>
<tr>
<td>5</td>
<td>VKH</td>
<td>A&amp;I2</td>
<td>Patients admitted to A&amp;I2</td>
<td>N/A</td>
<td>Admissions 15-30% Discharges 40-60% Conversion Rate 20-30% Average Lot</td>
</tr>
<tr>
<td>6</td>
<td>VKH</td>
<td>Medicine of the Elderly</td>
<td>Length of stay in A&amp;I or A&amp;IU for patients admitted, discharged or transferred</td>
<td>N/A</td>
<td>&lt;24 hours Time in A&amp;I and A&amp;I for Frail Patients being admitted 24 hours</td>
</tr>
<tr>
<td>7</td>
<td>VKH</td>
<td>GP Referrals to A&amp;I1</td>
<td>Patients presenting to A&amp;I1 who have been referred by GP</td>
<td>N/A</td>
<td>140-190 GP Referrals</td>
</tr>
<tr>
<td>8</td>
<td>VKH</td>
<td>Cancellations Procedures</td>
<td>Patients presenting for surgical procedures any cancellation not related to capacity issues</td>
<td>N/A</td>
<td>Number of Cancellations 0</td>
</tr>
<tr>
<td>9</td>
<td>VKH</td>
<td>Weekend Discharges</td>
<td>Patients discharged from VKH site</td>
<td>N/A</td>
<td>45-50 Number of Discharges 20-30 Number of patients Emergency Care Planned Care</td>
</tr>
<tr>
<td>10</td>
<td>VKH</td>
<td>Patients Boarding</td>
<td>Average number of Patients boarding daily Ward S2</td>
<td>N/A</td>
<td>10-30 Number of Patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average number of EDC patients boarding daily in PC Beds</td>
<td>N/A</td>
<td>25 EDC patients boarding in PC Number of EDC Patients in PC Beds</td>
</tr>
<tr>
<td>11</td>
<td>VKH</td>
<td>Transport Hub</td>
<td>Transport availability for same day discharge/transfer through dedicated discharge van and hospital car</td>
<td>N/A</td>
<td>55% Percentage</td>
</tr>
<tr>
<td>12</td>
<td>All</td>
<td>Inpatient Capacity</td>
<td>Percentage of funded beds occupied</td>
<td>N/A</td>
<td>&lt;90% Bed Occupancy Percentage HHCP 90% Bed Occupancy Percentage 90% Bed Occupancy Percentage HHCP</td>
</tr>
<tr>
<td>13</td>
<td>All</td>
<td>Additional Capacity</td>
<td>Average number of beds open that are unfunded</td>
<td>N/A</td>
<td>Average number of beds HHCP</td>
</tr>
<tr>
<td>14</td>
<td>All</td>
<td>Beds closed due to HAI</td>
<td>Average number of beds closed due to Winter-related HAI</td>
<td>N/A</td>
<td>Average number of beds closed due to HAI HHCP</td>
</tr>
<tr>
<td>15</td>
<td>All</td>
<td>Community Downstream Waiting List</td>
<td>Patient’s admitted in VKH awaiting discharge to a community hospital. Patient’s unfit or not ready for discharge</td>
<td>N/A</td>
<td>&lt;12 Average daily number of Patient’s awaiting discharge to a community setting</td>
</tr>
<tr>
<td>16</td>
<td>All</td>
<td>Discharges from VKH to Community</td>
<td>Number of discharges from VKH to community beds</td>
<td>N/A</td>
<td>40 community discharges per week (7 days) Number of discharges</td>
</tr>
<tr>
<td>17</td>
<td>All</td>
<td>Delayed Discharges</td>
<td>Average number of patients awaiting social care placement or package of care</td>
<td>N/A</td>
<td>40 admissions to social care each week (7 days) Average Number of Patients HHCP</td>
</tr>
<tr>
<td>18</td>
<td>HSCP</td>
<td>START Beds</td>
<td>Percentage of START beds occupied</td>
<td>N/A</td>
<td>&lt;24% Bed Occupancy Percentage HHCP</td>
</tr>
<tr>
<td>19</td>
<td>HSCP</td>
<td>START Waiting Time</td>
<td>Average wait for discharge from VKH after START package agreed</td>
<td>N/A</td>
<td>&lt;3 days Wait</td>
</tr>
<tr>
<td>20</td>
<td>HSCP</td>
<td>Social Work Assessment Units</td>
<td>Percentage of beds occupied</td>
<td>N/A</td>
<td>&lt;24% Bed Occupancy Percentage HHCP</td>
</tr>
<tr>
<td>21</td>
<td>HSCP</td>
<td>PPCS</td>
<td>Out of Time Home Visits greater than 4 hours</td>
<td>N/A</td>
<td>&lt;150 visits per month Number of Oddi Visits outside 4 hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total Number of Contacts</td>
<td>N/A</td>
<td>1200-1700 Total Number of Contacts</td>
</tr>
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</table>

---

**Note:** The above table provides a summary of key performance indicators and targets for the Winter monitoring period, with emphasis on discharge and admission rates, bed capacity, and patient waiting times. Each measure is categorized by its specific area (e.g., Emergency Department, A&I Assessment) and includes detailed definitions, targets, and expected performance metrics to guide hospital management and planning during the Winter season.
# Appendix 3

## Safety Huddle Sitrep for day before

<table>
<thead>
<tr>
<th>Site Position</th>
<th>Number of patients in VHK</th>
<th>Occupancy</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>514</td>
<td>0.0%</td>
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</table>

<table>
<thead>
<tr>
<th>Breaches &amp; Performance</th>
<th>Admissions against predicted EC</th>
<th>Discharges achieved EC</th>
<th>0</th>
<th>Before 1pm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Breaches &amp; Performance</th>
<th>Admissions against predicted PC</th>
<th>Discharges achieved PC</th>
<th>0</th>
<th>Before 1pm</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Total presentations to AA Ax U:</th>
<th>Total discharges from AA Ax:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Transfer profile from AU1:</th>
<th>08:00 - 13:00</th>
<th>13:00 - 20:00</th>
<th>After 8pm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

## Hospital at Night

<table>
<thead>
<tr>
<th>Total contact activity:</th>
<th>Number of falls reported:</th>
<th>Any expected deaths:</th>
<th>Any unexpected deaths:</th>
<th>Patients who require early review:</th>
<th>Number of cardiac arrests:</th>
<th>Patients with delirium who require review:</th>
</tr>
</thead>
</table>
### Safety Huddle Sitrep for current morning

**TUCSON HOSPITAL SAFETY HUDDLE - FLOW**

<table>
<thead>
<tr>
<th><strong>Date</strong></th>
<th><strong>Day of the week</strong></th>
<th><strong>Shift</strong></th>
<th><strong>Times</strong></th>
<th><strong>Prepared By</strong></th>
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<tbody>
<tr>
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#### EMERGENCY CARE

<table>
<thead>
<tr>
<th><strong>Bedroom</strong></th>
<th><strong>Speciality Bed Ward</strong></th>
<th><strong>Electrical Flow</strong></th>
<th><strong>Exposed Equipment</strong></th>
<th><strong>Discharge Before Disposal</strong></th>
<th><strong>Adverse Events</strong></th>
<th><strong>Patient No Show</strong></th>
<th><strong>Triage</strong></th>
<th><strong>Prepared</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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#### FLUID CARE

<table>
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<th><strong>Exposed Equipment</strong></th>
<th><strong>Discharge Before Disposal</strong></th>
<th><strong>Adverse Events</strong></th>
<th><strong>Patient No Show</strong></th>
<th><strong>Triage</strong></th>
<th><strong>Prepared</strong></th>
</tr>
</thead>
<tbody>
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#### TOTALS

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<th><strong>Discharge Before Disposal</strong></th>
<th><strong>Adverse Events</strong></th>
<th><strong>Patient No Show</strong></th>
<th><strong>Triage</strong></th>
<th><strong>Prepared</strong></th>
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<tbody>
<tr>
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### FLOW

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<th><strong>Discharge Before Disposal</strong></th>
<th><strong>Adverse Events</strong></th>
<th><strong>Patient No Show</strong></th>
<th><strong>Triage</strong></th>
<th><strong>Prepared</strong></th>
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</thead>
<tbody>
<tr>
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### BAC

<table>
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<th><strong>Exposed Equipment</strong></th>
<th><strong>Discharge Before Disposal</strong></th>
<th><strong>Adverse Events</strong></th>
<th><strong>Patient No Show</strong></th>
<th><strong>Triage</strong></th>
<th><strong>Prepared</strong></th>
</tr>
</thead>
<tbody>
<tr>
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### ADDITIONAL CAPACITY

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<th><strong>Adverse Events</strong></th>
<th><strong>Patient No Show</strong></th>
<th><strong>Triage</strong></th>
<th><strong>Prepared</strong></th>
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</thead>
<tbody>
<tr>
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### Number of ORs in Frame List

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<tr>
<th><strong>ORs</strong></th>
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### ORS

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### PATIENTS

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<th><strong>0</strong></th>
<th><strong>0</strong></th>
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### Triage

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<tr>
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### Total

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**Appendix 4**
## Cumulative Discharge model Tracker

### Long Term Care

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Transfer to DSB</strong></td>
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<td>Planned</td>
<td>19</td>
<td>33</td>
<td>33</td>
<td>33</td>
<td>28</td>
<td>146</td>
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<tr>
<td>Actual</td>
<td>0</td>
<td>18</td>
<td>8</td>
<td>19</td>
<td>12</td>
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<td>-33</td>
<td>-33</td>
<td>-33</td>
<td>-28</td>
<td>-126</td>
<td></td>
</tr>
<tr>
<td><strong>DSB Percentage Achieved</strong></td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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</tr>
</tbody>
</table>

### Discharge Model - Social Care Placements

#### Long Term Care

<table>
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<tr>
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<td>8</td>
<td>19</td>
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</tr>
<tr>
<td><strong>Variance</strong></td>
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<td>-3</td>
<td>-5</td>
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#### Home Care (Internal & External)

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<tr>
<td><strong>Variance</strong></td>
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<td>-1</td>
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### START

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<td><strong>Variance</strong></td>
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### Assessment Beds

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<tr>
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<td>3</td>
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<tr>
<td><strong>Variance</strong></td>
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### STAB

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<td><strong>Planned</strong></td>
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<td>5</td>
<td>2</td>
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### Social Care Planned - Subtotal

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<td>Planned</td>
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<td>35</td>
<td>35</td>
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<tr>
<td>Social Care Percentage Achieved</td>
<td>64%</td>
<td>136%</td>
<td>97%</td>
<td>100%</td>
<td>179%</td>
<td>118%</td>
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### Discharge Model - Rapid Discharge Routes / Placements

#### Re-Start Care Packages

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#### Front Door Supported Discharge Model

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### ICASS

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### Other Models Planned - Subtotal

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### Total Planned

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