Fife Winter Plan
2016 – 2017
1. **Introduction**

Health and Social Care Providers have a key responsibility to undertake effective planning of capacity to ensure that the needs of vulnerable and ill people are met in a timely and effective manner despite increases in demand on services or a mismatch between demand and supply of services. This can happen at any time of the year but commonly in winter activity rises, there is increased risk of infection (Norovirus in particular), the weather conditions can be adverse and influenza is more likely than at other times of the year.

NHS Fife, Fife Council and the Health and Social Care Partnership share the challenges of managing service delivery in the context of demographic change across primary, secondary and social care. The organisations are collectively responsible for managing the local health and social care system. This includes managing information and intelligence; assessing needs and working with community partners to ensure that services are fit for purpose; they meet the needs of patients; and are cost effective despite the pressures described above. The purpose of this document is to describe the arrangements put in place by NHS Fife, Fife Council, the Health and Social Care Partnership and partner organisations so that throughout the year, but particularly over the winter (including the Christmas and New Year holiday), the following are maintained:

This plan is supported by:

- Pandemic Flu Plan
- Major Incident Plan
- Business Continuity Plan

A Pandemic Influenza will require additional measures/plans due to the population group likely to be affected, i.e. children and adults of working age. The impact on health and social care provision being greatest in relation to the provision of critical care facilities for children and in the number of staff likely to be affected; features not present in previous pandemic flu outbreaks. Although generic references to pandemic flu responses are referred to within this plan, it does not outline specific operational responses. For specific information please refer to the NHS Fife Pandemic Influenza Plan and the Fife Council Pandemic Influenza Plan.

2. **National Unscheduled Care Programme: Preparing for Winter 2016/17**

2.1 This national guidance DL(2016)18 recognises that there is increased activity and, therefore, the need for increased capacity over the winter months across NHS Scotland and that this increased prolonged pressure plus increased pressure from delays in discharge will, without any mitigating action, have an impact on our ability to deliver the 4 hour Accident & Emergency access target throughout the winter months.

2.2 Boards are asked to take a balanced approach to the effective planning and scheduling of elective and unscheduled care activity.
2.3 The work undertaken as part of the 6 Essential Action Improvement Programme Developing Our Basic Building Blocks Model provides a baseline to understand our whole system in Fife. Appendix 1 outlines how the Unscheduled Care agenda is managed in Fife. Appendix 2 outlines the NHS Fife Winter Plan initiatives for 2016/2017 aligned to the 6 Essential Actions to Improving Unscheduled Care.

3. **Overall Operational Resilience**

As part of their duties under the Civil Contingencies Act 2004, NHS Fife, Fife Council and partner agencies have robust resilience arrangements in place that focus on being prepared for any disruptive event and its consequences. These arrangements are regularly reviewed and updated to ensure they remain relevant and fit for purpose. These arrangements were tested fully in December 2015 with the closure of the Forth Road Bridge with minimal disruption to the delivery of health services.

NHS Fife and Fife Council’s Business Continuity Plans identify personnel considered to be essential to maintaining, both frontline and supporting services, and cover key disruptive risks such as cold weather and storm damage; loss of access to premises; disruption to utilities (e.g. gas, oil) and the supply chain (e.g. oxygen, blood); transport disruption; and staff movement/absences. Business Continuity Plans mitigate and manage these risks/critical activities and build on the lessons learned and practices adopted during previous periods of severe winter weather. NHS Fife’s Business Continuity Manager is fully involved in all aspects of winter planning so that business continuity management principles are embedded within NHS Fife’s winter plans.

In the event of severe weather impacting on travel during the coming winter, NHS Fife has ensured that HR policies are in place so that appropriate travel advice messages and communications are provided to staff and the public. NHS Fife is an integral part of East of Scotland Regional Resilience Partnership (ESRRP) and Fife Local Resilience Partnership (Fife LRP). Through the relevant Resilience Partnership, partner agencies work closely together to ensure that messages to the public are clear and consistent and ensure that communications with vulnerable groups are appropriate and consistent.

Mutual aid arrangements (which will be implemented throughout Fife LRP) are in place within the relevant Resilience Partnership, to ensure that access to resources, including staff, equipment and vehicles on a 24 hour basis, is maintained. Safe transportation to and from work for essential staff using 4x4 vehicles has been particularly effective during previous periods of severe winter weather.

Although the new Fife Health and Social Care Partnership is not yet considered as a Category One responder under the Civil Contingencies Act, they are currently developing resilience arrangements in line with other partner agencies.
4. Severe Weather

Over the past few winters we have seen periods of severe weather that have led to business continuity pressures for all organisations.

Weather conditions such as severe ice, snow, gales or heavy rainfall resulting in flooding can lead to consequences such as:

- Staff unable to travel and/or reach places of work or individuals
- Patients unable to attend appointments
- Ambulance services requiring support to reach individuals
- An increase in slips, trips, falls and fractures
- Family/dependent emergencies due to school closures or other carer demands
- Salt/grit supplies running low making site access hazardous

NHS Fife and Fife Council are integral members of Local Resilience Partnership and are involved in the planning and maintaining of multi-agency plans. Such as the LRP Severe Weather and Flooding Plan.

4.1 Our mitigating actions for severe weather include:

- Organising an Incident Response Team to manage the severe weather consequences, in particular the response to a very prolonged incident of adverse weather and plans to manage the recovery and 'catch up' phase of the incident without causing a rise in escalation status.
- Have plans in place to access or increase 4x4 vehicles to support moving staff both in to work and out to vulnerable patients.
- Consider internal resources such as stock suppliers and contractors. Check contracts as necessary to assure the business continuity procedures of any vital resources or suppliers.
- Encourage staff to consider their own personal resilience strategies, i.e. alternative transportation methods, other suitable sites from which to effectively work and child care or other dependant back up plans.
- Ensure fair and transparent policy and procedures are in place regarding relevant issues i.e. severe weather policy, special leave and where possible share this information across partner agencies to ensure an equitable approach.

Further information on major Incident procedures can be found within the VHK Major Incident Operational Plan and Fife Council Continuity Plans.

5. Norovirus

Outbreaks of diarrhoea and vomiting are common, widespread and can often be prolonged. In recent years Norovirus has seen repeated outbreaks causing disruption and ward closures for several months at a time.

- Information is essential to early awareness and action. Health Protection Scotland (HPS) circulated updates are helpful, however they can only
cascade the information they receive and hence tend to support retrospective analysis rather than forward planning. The importance of two-way sharing of information (via Health Protection) with others such as Nursing or Residential Homes will help improve the overall community picture of infection.

- It is essential to nurture a culture of joint collaborative working between providing organisations with transparent, clear and mutually agreed infection control guidelines, based on the National Infection Prevention and Control Manual, for managing patients on closed wards. The following infection control principles are suggested:
  - Staff responsible for the discharge management of the patient to provide a full patient history including movements from previously closed wards, or wards that have closed since the patient was moved (especially inter-board transfers)
  - Ensuring that a patient situated in a closed ward or bay, who is well, is assessed in a timely manner so that the patient outcomes are not compromised.
  - Utilising electronic communication systems, telephone and teleconference to ensure that all organisations are represented during the management of both individual cases and outbreaks.
  - Agreeing to urgently prioritise a delayed patient as soon as a ward re-opens.
  - Receiving a well but potentially exposed patient into a side room until the Norovirus incubation period has passed.
- The consideration of all available guidance and evidence from HPS and the Health Protection Agency (HPA) currently available. If evidence of repeated infections is apparent, this information may be critical to consequences of making a decision to cohort affected patients.
- The consideration of a pro-active public health message which raises awareness of the impact of Norovirus. Emphasis could be made on the amount of time and planning that a hospital puts into managing outbreaks and more importantly the detrimental effect on the experience of patients.
- Extending the availability of onsite expert advice from the Infection Control Team to include on site weekend cover may assist during large outbreaks. Weekend on-call cover is provided year-round, but current establishment of the Infection Control Service would not allow on-site weekend cover for more than very short periods.
- Stopping or limiting visitors. Providing organisations to work to the key principles and process developed by HPS and Scottish Government for closure of wards or hospitals to visitors.

Following the winter Norovirus season 2015-2016, shared learning has facilitated a review of all systems and processes which support patient safety during suspected and confirmed Norovirus outbreaks. In order to further strengthen the governance structure around reporting of outbreaks and the closure or cohort restrictions/bay closures in affected wards, a schematic of escalation has been developed.

Additional measures have been introduced this year to ensure our staff are appropriately prepared for Norovirus season 2016/2017.
• Winter debrief meetings with both the Acute and H&SC Divisions to assess the effectiveness of the management of the norovirus patients and outbreak wards
• Assurance of availability of staff and attendance at norovirus outbreak management update training in both Acute and H&SC Divisions planned to commence from September 2016 onwards.
• Multidisciplinary table top exercise on the management of norovirus outbreaks for both Divisions to take place in late September/early October 2016.
• Facilities Team to plan availability of domestic hit squad for outbreak terminal cleans across the Acute Division.
• Management of Norovirus Guidance updated to reflect extant national guidance.

6. Pandemic Influenza

Following the H1N1 Pandemic of 2009 an NHS Fife robust Pandemic Influenza Response plan was developed and is in place, which is regularly reviewed and updated by the NHS Fife Strategic Pandemic Flu Group.

Anticipated consequences may include:

• A higher than normal rate of seasonal flu activity from a virulent strain resulting in additional pressure on both community and acute services.
• Vulnerable members of the population suffering more severe or complex symptoms and requiring critical care treatment.
• Media interest and public concern with worried well members of the public presenting.
• Vaccination uptake this year, as in previous years, remains a key priority throughout all health and social care organisations. Lessons learned from planning and delivery of our programme has been done. Engage with Occupational Health early and action plans to encourage a high profile and accessible vaccine programme for staff.
• This full programme for staff vaccination is currently in place across the health and social care system. Our programme is being offered to a full range of staff across all services including social care providers and independent primary care providers. This programme is supported and is being delivered in local venues at different times through the working week with a communication plan supporting to encourage better uptake.

7. Capacity & Escalation Structure

7.1. Since June 2015 a daily patient safety huddle is held in NHS Fife which involves all appropriate staff meeting every morning for 30 minutes to focus on patient care, patient experience along with a capacity and flow plan for the day. The safety huddle focuses on the deteriorating patient (via Patientrak), what actions require to be taken to keep our hospital safe and also allows us to identify and progress any barriers for discharge each day.
The morning huddle is supplemented by 1100 a.m. huddles in Emergency Care and Planned Care to focus on capacity throughout the day. A 3.30 p.m. huddle takes place to focus on overnight and the following morning staffing issues.

7.2. Managing hospital capacity forms part of this discussion and during the winter months will continue to support our planning system.

7.3. This huddle model, along with our Emergency Access Report, (See Appendix 3) will be used to measure pressure across our healthcare system.

7.4. Operational planning meetings will be held each Thursday afternoon to predict and plan for both Elective and Emergency Activity for the coming weekend along with the following week and to discuss and agree any contingencies that require to be put in place.

7.5. Daily conference calls will be instigated, if necessary, if excessive pressure is experienced on our Acute site.

8. **Self Assessment Checklist – Preparing for Winter**

The self assessment checklist which measures our readiness for winter across six domains will be utilised as a local guide to assess the quality of winter preparations. These six domains are:

- Resilience
- Unscheduled/Elective Care
- Out of Hours
- Norovirus
- Seasonal flu and
- Respiratory Pathway

A detailed review of plans in these six areas will apply a Red, Amber, or Green status:

- Business continuity plans tested with partners
- Escalation plans tested with partners
- Safe and effective admission/discharge continues in the lead-up to and over the festive period and also into January
- Strategies for additional surge capacity across Health & Social Care
- Whole system activity plans for winter: post-festive surge/ Respiratory pathway
- Effective analysis to plan for and monitor winter capacity, activity, pressures and performance
- Workforce capacity plans & rotas for winter/festive period agreed by October
- Discharges at weekends and bank holidays
- The risk of patients being delayed on their pathway is minimised
- Communication plans
- Preparing effectively for norovirus
- Delivering seasonal flu vaccination to public and staff
The Fife Partnership are confident that systems and processes are fully in place.

9. Preparing for Winter

This plan describes actions being taken forward across the NHS Fife Acute Services Division (ASD) and Fife Health & Social Care Partnership (H&SCP) to optimise our service resilience during the winter months and beyond.

10. Key Pressures

There are a number of key pressures that are prevalent over the winter period and which affect our ability to optimally manage flow and capacity in Fife’s main acute hospital site - the Victoria Hospital (VHK). History tells us that these include:

- increased clinical needs of patients
- increased conversion rate from A&E attendance to admission
- increase in (medically-fit-for-discharge) patients in delay
- decreased resilience within the workforce (school holidays, bank holidays, sickness/absence)
- an inability to scale-down scheduled care activity due to waiting time obligations
- having appropriate levels of community capacity to accommodate demand from across the health and social care system.

In addition to the above, NHS Fife anticipate an additional capacity pressure with the reduction in bed complement of 12 beds at Victoria Hospital in an effort to achieve financial efficiencies.

11. Acute Services

We know that the winter months see:

- decreased attendances at the ED (driven by a significant decrease in self-referrals)
- increased clinical acuity/complexity/dependency and increased conversion rate from Emergency Department (ED) attendance to admission

We know that we have extant issues with:

- medically fit patients who’s discharge from hospital is delayed
- discharges from VHK at weekends

12. Winter 2016/2017

The plan for Acute Services for Winter 2015/16 was fully implemented. The plan provided alternative solutions which included measures to reduce the number of emergency admissions, measures to increase capacity to provide rapid assessment and early supported discharge (with appropriate support from
community services where required), or to provide clinically acceptable alternatives to inpatient care. These initiatives delivered the following benefits and are now embedded into daily clinical practice:-

- An increase in early supported discharge at our front door through the frailty service for up to 40 patients per week
- A 30% increase in patients accessing ambulatory care (although a minority of these patients will require admission)
- 40 same day discharges through the assessment trolleys in AU1 per week where early senior clinical assessment is available
- 10-15 patients discharged from the front door via a supported discharge model to prevent an in patient episode for non-clinical reasons

13. Summary (Acute Services)

NHS Fife will focus this winter on delivering an improved clinical model which follows defined patient pathways rather than continuing with suboptimal processes and finding more physical space to put patients into.

This will include:
- Increasing the rate of frailty screening in ED and introduce within AU2
- Improving use of QMH 23 hour stay surgical unit
- Review and improvement of the Advanced Nurse Practitioner model at the front-door
- Consider redesign of the AU1 Assessment unit to eliminate non-added clinical value use, decrease spikes of overcrowding and medical model.
- Specialty “pull” model from AU1
- Test direct to specialty GP calls and introduction of a Referral Decision Tree (Appendix 4)
- Explore point of care testing within Ambulatory Care
- Improving response to trauma in ED
- Continued work with Radiology to improve the logistics which would support reduced numbers of patients awaiting in-patient imaging.
- Introduce specialty pathways from front door, clarifying optimal destinations for high volume presentations.
- Further increase the number of patients attending ECAS, with particular focus on ED patients
- Redesign of the Discharge Lounge
- Redesign of the Transport Hub
- Introduction of the E-IDL to replace

14. Community Services

The Health and Social Care Parnership (H&SCP) component of the plan seeks to provide alternatives to hospital based care to prevent admission and support discharge in a range of community settings.

Plans for H&SCP community-based services include:
• Increasing capacity in the Short Term Assessment and Review Team (START) to support discharges from hospital and prevention of admission for those who need care at home.
• Consistent use of Social Work Assessment Unit capacity to support care and assessment out with the hospital setting for those requiring long term care.
• Reducing the number of patients delayed in community hospitals through use of community models of care.
• Flexible use of the available community hospital in-patient bed base to cope with demands as required.
• Maintaining and increasing capacity through Hospital at Home and Intermediate Care.
• Continued support of the Frailty pathway and work of the frailty team in the VHK A&E and AU1 through the commissioning and monitoring of a home support model to avoid admissions due to non-medical reasons.
• Development of the Short Term Assessment and Re-ablement (STAR) bed model to provide intermediate care in nursing and residential home settings across Fife.

[Note - this paper does not describe plans for other community services, for example, District Nursing, although this will be incorporated when available.]

14.1 Short-Term Assessment and Review Team (START)

The Short Term Assessment and Review Team (START) is a home care service that supports discharge from hospital. The model is designed to facilitate discharge from hospital within 72 hours of referral. Following an initial assessment in hospital individuals are discharged with a care package which is adjusted as they are assessed more fully at home and as their needs change. Over Winter 2016/17 this model will be available across Fife.

14.2 Social Work Assessment Units

People are often delayed in hospital whilst they are considering the most relevant long term care facility and the availability of a vacancy therein. At present Social Workers assess each individual’s requirements whilst they are in hospital; as part of new models of care this assessment will now be concluded within a care setting rather than a hospital setting. Assessment units (16 beds in total) are now on stream and discussions are ongoing with care homes to identify care establishments across Fife who may be willing to consider this model. We are aiming to have a total of 40 beds for this purpose across Fife.

14.3 Community Hospitals

Our community hospitals in Fife provide a wide range of services, which include GP admissions, rehabilitation, medical assessment and ongoing care. The operational plan for winter 2015/16 included access to community hospital beds directly from AU1 and access to community hospital beds for H@H, thus preventing admission to VHK wards. This access will also be valuable for Winter
2016/2017. This flexible use of community hospital capacity will be supported through reducing the number of patients in delay.

14.4. Hospital at Home (H@H) and Intermediate Care

In Winter 2015/2016 we increased capacity and flow in H@H by improving the interface between H@H, District Nursing and Intermediate Care Teams. H@H will retain overall case management but appropriate care elements will be delivered by the most appropriate team. This flexible, responsive model of care will be provided again in Winter 2016/2017.

14.5 Supported Discharge from the Front Door of Victoria Hospital

The Integrated Assessment Team has further developed the frailty model in advance of winter 2016/2017 with the introduction of trainee Frailty Nurse Practitioners to support decision making around pathways for frail people. From October 2016 there will be Medicine of the Elderly Consultant presence for 5 sessions per week in the Emergency Department (ED), Acute Medical and Acute Surgical Units.

The front door Discharge Support Model has been reintroduced from July 2016 following a successful impact evaluation during winter 2015/2016. It is expected that the service, provided by an Independent provider, will discharge 10-15 patients per week for a maximum of 3 weeks. Suitable patients are those requiring minimal but necessary support at home whilst they recover from an acute illness and would otherwise remain in hospital for non-clinical reasons. Patients are identified for the front door model as part of the Integrated Assessment Team (IAT) frailty model in the ED, Acute Medical and Acute Surgical Units.

In February 2016, NHS Fife introduced a process for early identification of frailty and potential complexity. Patients identified as frail and who are admitted to Medicine of the Elderly are referred to the Discharge Hub by IAT. The Discharge Hub monitors the patient daily and as soon as the patient is medically fit, they are assessed by the Discharge Hub for discharge requirements. Early identification and early intervention by the Discharge Hub has resulted in earlier referral to community services and earlier discharge.

14.6 Short-Term Assessment and Re-ablement (STAR) Beds

The Short-Term Assessment and Re-ablement (STAR) bed model provides intermediate care in nursing and residential care home settings across Fife. Within the units people are assessed and supported to maximise their functional independence. Ahead of winter the HSCP plans to expand and consolidate the STAR model, with a revised case management structure and a focus on reducing length of stay in order to:

- Prevent permanent admission to long-term care
- Prevent unnecessary admission to the acute hospital
- Facilitate discharge from acute and community hospitals for patients requiring intensive supported re-ablement.
• To ensure in depth assessment and alternative intervention exploration to prevent delays in hospital.

15. Operational Planning Assumptions & Escalations

NHS Fife have no plans to open a surge ward over the winter period. However, there will be opportunities to flex capacity on a temporary basis, when required. This decision is based on our confidence in NHS Fife’s ability to deliver each component part of the winter plan, ensuring:

- delivery of the 4 hour performance target
- minimal boarding
- no increase in crude winter mortality when compared with 2015/16 levels

Escalation to multi-Director level will occur at the weekly Executive Directors Group (Monday morning) which is chaired by the Chief Executive. There are a number of processes which support operational escalation during the working day and in the out-of-hours periods.
UNIVERSITY OF FIFE

WINTER PLAN 2016–2017

Date of Issue: August 2016

Originator: Chief Operating Officer/HSCP Director

Version 5

Date of Review: August 2017

APPENDIX 1 – BUILDING BLOCK MODEL

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<th>Acute Care Quality Standards</th>
<th>VHK Preparedness for Winter 2016/17</th>
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Unscheduled Care Programme Board

Draft Programme Structure

• Enlarged Ambulatory Care service – 30% increase in activity
• Creation of assessment unit in AU1 – 40 same day discharges achieved
• Clinically driven capacity management
• Reduce duplication in clinical documentation
• Early supported discharge at the front door – up to 40 patients per week
• Supported discharge model – 10-15 patients
• Specialty pathways for ambulatory and admitted patients
• Clinically focused and empowered hospital management
• Hospital capacity & patient flow realignment
• Patient rather than bed management operational performance
• Medical & surgical clinical processes arranged to pull patients from ED
• 7 day services
• Ensuring patients are cared for in their own homes
• Delayed discharges Fife-wide/VHK
• Social care placements per week
• NHS Tayside patients awaiting community bed
• ICASS patients awaiting mainstream homecare
• STAR beds occupancy/ average LoS
• Community hospitals midnight bed occupancy/ beds occupied by patients in delay/average LoS
• PCES response time
• Discharge hub time to first assessment /no. on caseload/ time from assessment to discharge
• Frailty & H@H teams facilitated discharges
• ED Attendances/conversion rate to admission
• Admission Units conversion rate to downstream V4 admission
• AU1 Assessment trolley activity/ direct discharges/ average LoS
• Ambulatory trolley activity
• VHK transport availability for same day discharge/ clinical acuity – dependency, complexity/ boarders/ cancelled electives due to bed availability/ midnight bed occupancy/ average LoS
• Extend discharge lounge to include transport hub
• Increase frailty screening in ED and introduce in AU2
• Improving use of QMH 23 hour stay surgical unit
• Review of ANP role at front door
• Redesign of AU1 Assessment
• Direct to specialty GP calls and Referral Decision Tree
• Explore Point of Care testing in Ambulatory Care
• Improve trauma response in ED
• Access to diagnostic modalities which support assessment, ambulatory care and admissions
• Increase ECAS attendances further
• Introduction of e-IDL
### APPENDIX 2 - WINTER PLAN 2016/2017

#### Unscheduled Care

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<th>Essential Action 1 – Clinically Focussed and Empowered Hospital Management</th>
<th>Essential Action 2 – Hospital Capacity and Patient Flow (Emergency and Elective Realignment)</th>
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| - Designated Site Directors now in place for Victoria Hospital and Queen Margaret Hospital.  
- On-Call Senior Manager scheme is in situ (7 day support)  
- 24/7 Clinical Co-ordination in place on the Victoria Hospital with embedded escalation processes. Out-of-hours the Clinical Co-ordinators assume the role of Site Manager.  
- Staffing review daily at 3.30 p.m. (Monday-Friday) to ensure safe staffing in the overnight period, supported by a Duty Charge Nurse rota (7 day coverage). | - An exemplar Safety Huddle has been introduced on both acute sites. The main focus is on patient safety, safe staffing levels and a plan for capacity for the forthcoming 24 hour period.  
- Brief Capacity Huddles are held (Monday-Friday) within Emergency Care and Planned Care.  
- A Daily Emergency Access Report is produced with provides a daily RAG status based on key capacity measures across a broad range of primary and secondary care services.  
- A Weekly Emergency Access Report is produced which focuses on key information pertaining to capacity and flow, both within and external to the hospital  
- A number of additional general surgery procedures will now be performed at the Queen Margaret Hospital, improving the utilisation of the 23-hour stay facility releasing in-patient bed days on the Victoria Hospital site |

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<tr>
<th>Essential Action 3 – Patient Rather than Bed Management – Operational Performance Management of Patient Flow</th>
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| - 24/7 Clinical Co-ordination ensures that patients are timeously transferred to specialty wards following emergency admission, including patient repatriation and step-down from critical care beds.  
- Morning discharges are encouraged with timely transfer of patients to the Discharge Lounge.  
- The aim is for the Discharge Lounge to be co-located with a Transport Hub which will be supported by a PTS Scheduled Care Co-ordinator and NHS Administrator to improve planning and optimisation of PTS resource.  
- Increase spread and consistency of Board rounds to support improved and co-ordinated discharge planning.  
- Work with Radiology to improve the logistics which would reduce the waiting times/numbers waiting for in-patient imaging.  
- Point of Care Testing – explore benefits of POCT within ECAS.  
- Flexible use of the available community hospital in-patient bed base | - Assessment area introduced within the Acute Admissions Unit (AU1) to provide timely assessment and triage of patients. Since its introduction in October 2015, the Assessment Unit is successfully discharging 30% of patients on the day of admission.  
- Update on AU1 Assessment Unit redesign observations  
- The Ambulatory Care Service has been enhanced to accommodate a wider range of interventions and can provide an alternative to hospital admission. The focus is to further increase patient attendances, with particular focus on patients from ED.  
- Trauma pathway now introduced within ED  
- Progress specialty pathways from the front door clarifying the optimal destination for high volume presentations.  
- Test direct-to-specialty calls and introduce a Referral Decision Tree across General Practice  
- Review and improvement of the Advanced Nursing Practitioner |
- Flex acute bed capacity on a temporary basis, when required.

**Essential Action 5 – Seven Day Services appropriately targeted to reduce variation in weekend out of hours working**

- Augmentation of the hospital frailty team
  - Staff now providing seven day cover. Team has been augmented with the appointment of Nurse Practitioners and Assistant Frailty Practitioners.
- Provision of frailty screening in ED, AU1 and AU2
- Focus on improvement work to improve weekend and early in the day discharges.
- Weekend cover from both Physiotherapy and Occupational Therapy staff to the Orthopaedic wards and within the Integrated Assessment Team at the front door.
- On-call Physiotherapy cover for respiratory overnight and at weekends.
- Priority AHP service provided over the Public Holidays to all in-patient areas.

- Augmentation of the MOE and Acute Medical Occupational Therapy Teams.
- Continued support of the Frailty pathway and work with the Frailty Team in ED, AU1 and AU2

**Essential Action 6 – Ensuring patients are optimally cared for in their own homes or homely setting**

- Supported discharge model from the front door at Victoria Hospital
- Maintaining and increasing capacity through Hospital at Home and Intermediate Care
- Continuation of the discharge to assess model of care facilitating patient’s early supported discharge by providing a detailed OT functional assessment within the patient’s own environment. An alternative pathway for patients through the provision of a rapid response outreach service.
- Increasing capacity in START to support discharges from hospital and prevention of admission for those who need care at home
- Consistent use of Social Work Assessment Unit capacity to support care and assessment out with the hospital setting for those requiring long term care
- Reducing the number of patients delayed in community hospitals through use of community models of care.
- Development of the STAR bed model to provide intermediate care in nursing and residential care home settings across Fife
## APPENDIX 3 - DAILY ACCESS REPORT

### Daily Access Report

<table>
<thead>
<tr>
<th>Status</th>
<th>Number of Triggers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>2</td>
</tr>
</tbody>
</table>

#### Acute Capacity at 0800hrs

<table>
<thead>
<tr>
<th>Number of patients in A&amp;E at 0800hrs awaiting beds</th>
<th>Longest wait in A&amp;E</th>
<th>Number of empty beds in VH at 0000</th>
<th>Number of patients on Trauma list</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ECM</strong></td>
<td><strong>PC</strong></td>
<td><strong>Ortho/Trauma</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Boarding

<table>
<thead>
<tr>
<th>Additional Capacity in use</th>
<th>Ward</th>
<th># of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Boarders [Excluding Ward 12]</td>
<td>Ward 34</td>
<td>Ward 12</td>
</tr>
<tr>
<td>Surgical Boarders</td>
<td>Ward 10</td>
<td>5 FNT</td>
</tr>
<tr>
<td>Orthopaedic Boarders</td>
<td>Ward 19</td>
<td>Ward 32</td>
</tr>
<tr>
<td>Total Number of Patients Boarding</td>
<td>Ward 6</td>
<td>Total 0</td>
</tr>
<tr>
<td>Medical Patients - Ward 12</td>
<td>Ward 12</td>
<td></td>
</tr>
<tr>
<td>Emergency Patients boarding in another area</td>
<td>Ward 12</td>
<td></td>
</tr>
<tr>
<td>Start date of longest boarding patient</td>
<td>Ward 12</td>
<td></td>
</tr>
<tr>
<td>Length of longest boarding period (days)</td>
<td>Ward 12</td>
<td></td>
</tr>
</tbody>
</table>

#### Predicted Demand Today

<table>
<thead>
<tr>
<th>Predicted Emergency Demand Today</th>
<th>Number of predicted discharges (from Predictor)</th>
<th>Elective Admissions</th>
<th>Predicted bed balance until 0000 tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
<td>Planned</td>
<td>Planned Care Actual</td>
<td>Planned Care on Oasis</td>
</tr>
<tr>
<td>Total</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Specialty Demand from AUI Today

<table>
<thead>
<tr>
<th>MOE</th>
<th>Resp</th>
<th>Cardio</th>
<th>GI</th>
<th>Stroke</th>
<th>ID</th>
<th>Renal</th>
<th>Haem</th>
<th>Neurology</th>
<th>General Medicine</th>
<th>Palliative Medicine</th>
<th>Urology</th>
<th>H&amp;H</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Longest medical specialty waits AUI / AU2 Today

<table>
<thead>
<tr>
<th>Date of Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### Additional moves affecting Capacity

<table>
<thead>
<tr>
<th>Number of patients awaiting tertiary care from VH</th>
<th>Any Acute Wards closed due to infection</th>
<th>Number of patients moved after 8pm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Originator: Chief Operating Officer/H&SCP Director  Version 5  Date of Review: August 2017
### Planned Community Capacity

<table>
<thead>
<tr>
<th></th>
<th>Total number of vacant community beds at 0900</th>
<th>Number of patient discharges from community beds today at 0900</th>
<th>Number of patients transferring to community beds today from other areas</th>
<th>Number of patients transferring to community beds today from other areas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>From To (CHF) Number</td>
<td>From To (CHF) Number</td>
</tr>
<tr>
<td>DHMF</td>
<td></td>
<td></td>
<td>Total 0</td>
<td>Total 0</td>
</tr>
<tr>
<td>GANEF</td>
<td></td>
<td></td>
<td>Total 0</td>
<td>Total 0</td>
</tr>
<tr>
<td>KIL</td>
<td></td>
<td></td>
<td>Total 0</td>
<td>Total 0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>Total 0</td>
<td>Total 0</td>
</tr>
</tbody>
</table>

**Any comments regarding Community Transfers**

### Delayed Discharge Community Capacity required

<table>
<thead>
<tr>
<th></th>
<th>Total number of patients on downstream beds and</th>
<th>Patients ready on Edison in Fife (excluding mental)</th>
<th>Top 3 reasons for patients being in delay (On Edison)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICASS</td>
<td>VHMK</td>
<td>Codes</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMHN</td>
<td>Admissions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CAMAR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>GREN</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>MRMH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>SACH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (incl Tayside Repatriation)</td>
<td>0</td>
<td>Total in Fife</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Admissions more than discharges (2 days behind)** ECG FC Total 0

### 4 hour Standard Performance

**Daily**

- No 12 hour breaches for days

**Monthly**

- No 0 hour breaches for days

### ASE Performance Yesterday

<table>
<thead>
<tr>
<th>% Patients breached 4 hours</th>
<th>Breakdowns by Flow</th>
<th>Total no. patients &gt; 4 hours</th>
<th>No patients &gt; 8 hours</th>
<th>No patients &gt; 12 hours</th>
<th>Flow 1 - Minors who leave the dept without undergoing any diagnostic/further investigation but ultimately are sent home.</th>
<th>Flow 2 - Minors who required a diagnostic or further investigation but ultimately are sent home.</th>
<th>Flow 3 - Patients who are subsequently admitted to a medical ward.</th>
<th>Flow 4 - Patients who are subsequently admitted to a surgical ward.</th>
<th>Flow 5 - Patients who do not fall into any of the above categories due to ambiguity or lack of data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Flow 1</td>
<td>Flow 1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flow 2</td>
<td>Flow 2</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flow 3</td>
<td>Flow 3</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flow 4</td>
<td>Flow 4</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flow 5</td>
<td>Flow 5</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Patients who present at ASE before midnight and who go onto breach after midnight will not show in the attached report. These patients will only show in the report tomorrow but for the correct date of arrival. We are currently looking to see how we can move to live reporting which will resolve this issue.

The total number of breaches for each day is that shown in the 4 hour column of the attached report.
### Acute Medicine Referral Decision Aid

**APPENDIX 4 – ACUTE MEDICINE REFERRAL DECISION AID**

#### Acute Medical Referral Decision Aid - For Adults ages 16 and over

**NIH- For frail/elderly patients please see Medicine for the Elderly Decision Tree**

<table>
<thead>
<tr>
<th>Typical Conditions</th>
<th>Typical Conditions</th>
<th>Same Day</th>
<th>Next Day</th>
<th>Patients with possible leg DVT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
<td>Unstable Anaphe</td>
<td>Pleuritic Chest Pain</td>
<td>Unexplained Anemia</td>
<td>Deterioration of chronic condition needing urgent assessment</td>
</tr>
<tr>
<td>Acute GI Bleed</td>
<td>Acute Coronary Syndrome</td>
<td>CURB 1 or 2 Pneumonia</td>
<td>Low risk PE</td>
<td></td>
</tr>
<tr>
<td>Acute Renal Failure</td>
<td>Unstable Heart Failure</td>
<td>AF</td>
<td>Mild Heart Failure</td>
<td>Low risk GI bleeding</td>
</tr>
<tr>
<td>Severe D+V</td>
<td>Unstable Arrhythmia</td>
<td>High risk TIA</td>
<td>Minor Stroke</td>
<td>Acute Headache</td>
</tr>
<tr>
<td>Altered Consciousness</td>
<td>Delirium</td>
<td>Unexplained Collapse</td>
<td>Low risk chest pain</td>
<td>Unexplained Collapse</td>
</tr>
<tr>
<td>Acute Asthma</td>
<td>Acute COPD</td>
<td>Jaundice - without pain/ sepsis</td>
<td>Cellulitis</td>
<td></td>
</tr>
</tbody>
</table>

**Direct Referrals**

- **M-F**
  - 9am to 4pm only
  - Advice available on Ext 21891
- **After 4pm**
  - All Cardiac referrals will be assessed in AU1

**Acute Stroke - 999**

- Ambulance to ED if within 4 hours

**Acute Medical Advice**

- Available via Duty Acute Physician: Monday to Friday 9am to 6pm on 24223 or via email Fife-UMB.AcuteMedicineConsultants@nhs.net (emails will be check every 24 hours M-F)

**Out of hours advice**

- Available via on-call medical registrar via Switchboard

**Treatments given in ECAS**

1. Daily IV Antibiotics for soft tissue infection/ occasional deep seated infection
2. Urgent Blood transfusion
3. High risk infusions, including Magnesium and Biologics.

<table>
<thead>
<tr>
<th>How to refer</th>
<th>How to refer</th>
<th>How to refer</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>8am - 7.30pm</td>
<td>8am - 7.30pm</td>
<td>9am-5pm</td>
<td>5pm-5pm</td>
</tr>
<tr>
<td>AU1 Nurse Practitioner</td>
<td>AU1 Nurse Practitioner</td>
<td>Duty Acute Physician</td>
<td>DVT nurse</td>
</tr>
<tr>
<td>01383 627000 ext 21890</td>
<td>01383 627000 ext 21890</td>
<td>01383 627000 ext 24223</td>
<td>01383 627000 ext 21140</td>
</tr>
<tr>
<td><strong>after 7.30pm ext 27902</strong></td>
<td><strong>after 7.30pm ext 27902</strong></td>
<td><strong>Last patient assessed at 4pm</strong></td>
<td><strong>After 5pm as per AU1</strong></td>
</tr>
</tbody>
</table>

**Created by**

Dr Chris McKenna 09/16