Item 5.3

Report

Winter Plan 2017-18

Edinburgh Integration Joint Board

15 December 2017

Executive Summary

1. Scottish Government DL (2017)19 guidance on Preparing for Winter 2017/18 requires the Edinburgh Health and Social Care Partnership to produce an action plan to ensure health and social care services are well prepared for winter. The plan should provide safe and effective care for people using services and ensure sufficient capacity and funding are in place to meet expected activity levels. This will support service delivery across the wider system of health and social care over the winter months and during festive public holidays.

2. The winter plan is the result of a collaborative approach to planning across local partners, building capacity for out-of-hours services, reducing unscheduled admissions to acute hospitals and supporting the early discharge of people who are admitted, if appropriate. It has involved, for the first time, input from all agencies contributing to the care of residents during the winter months, resulting in a more all-encompassing action plan for 2017/18.

3. The winter plan also focuses on addressing additional pressures, such as potential surges in respiratory and admissions over the winter, incidence of norovirus and influenza, and seasonal business continuity challenges.

4. This report provides a summary of actions being taken in relation to the critical areas outlined in the guidance. The winter plan is attached at Appendix 1.

Recommendations

5. The Integration Joint Board is asked to:

    a) note progress with winter planning for 2017/18

    b) approve the action plan set out at Appendix 1 as far as it relates to issues under the authority of the Board

Background

6. Planning for winter is an important part of year-round service delivery, given the additional pressures placed on local systems from seasonal influenza, norovirus, severe weather and public holidays. Earlier this year, the Scottish Government supported local systems to undertake a review of pressures and several national events to consider priority areas and initiatives to support local health and social care systems to prepare effectively for winter.

7. Scottish Government DL (2017)19 guidance on Preparing for Winter 2017/18 was released in August 2017. It sets out the critical areas, outcomes and indicators of success that should be included as part of local planning. These are aligned to the unscheduled care 6 Essential Actions and include:

    - business continuity plans tested with partners
    - escalation plans tested with partners
    - safe and effective admission/discharge in the lead-up to and over the festive period and into January
    - strategies for additional surge capacity across health and social care services
    - 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 and rota's for winter/festive period agreed by October
    - discharges at weekends and bank holidays
    - the risk of people being delayed on their pathway is minimised
    - communication plans
    - preparing effectively for Norovirus
    - delivering seasonal flu vaccination to public and staff.

8. The Winter Planning Group, which includes multi-agency and multi-disciplinary representation has led on the Development of the Winter Plan 2017/18. The group meets monthly, and has taken account of the findings of a review of performance in winter 2016/17.

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Performance management and improved understanding of flow

9. Performance management tools are in development to support greater understanding of the demands being placed on the system at any time. This will help inform decision-making on resource allocation. It includes a new hospital dashboard for analysing activity, flow in key areas, particularly in relation to people over 65, and trends to support local planning. It draws data from NHS TRAK and will include Council data when available. Locality teams are being trained in its use to ensure greatest effect.

10. Performance reporting is being put in place for new and enhanced services to demonstrate the return for the investment. Measures of success are being agreed and baselines established to ensure that the necessary data is available to allow ongoing monitoring and evaluation at the end of winter.

Prevention of hospital admission and supporting facilitated discharge

11. The Winter Plan promotes proactive management of individuals known to be at risk of admission and vulnerable adults in the community through the Locality Hubs.

12. Multi-agency triage teams will review cases of acute admission and delayed discharge, and the position of people known to be at risk of admission, linking with partners to provide home support as appropriate. This will be extended to cover public holidays and weekends over the winter months, and include functions usually managed by the Service Matching Unit, ensuring referrals are processed in real time, with no batching of delays.

13. Winter funding is allowing for additional social worker, home care co-ordination and clinical support capacity, and occupational therapist and physiotherapist input to each locality hub, with recruitment underway to fill these posts. Extending this service will aid the ongoing development of locality hubs into a seven-day service, as a test of change.

14. To increase hospital presence by hub staff and foster closer working relationships, weekend teams are being co-located in discharge hubs at the Royal Infirmary of Edinburgh and Western General Hospital. They will work alongside Home First practitioners, acute hospital staff, unscheduled care services, and carer support agencies, enabling discharges to take place over the festive holidays and weekends.

15. Intermediate Care Services at Liberton Hospital are also being enhanced through increased occupational and physiotherapy staffing for the 60-bedded service during the winter period. This increase in capacity will support Edinburgh residents who are medically stable but need reablement/ rehabilitation to return home and those for whom discharge has been delayed, to reduce their stay in hospital.

16. Established links are already in place to support the management of people in care homes, individuals known to be at risk of falls, and those with chronic respiratory illness, where there is an increased risk of admission over the winter months.

17. In addition, dedicated nurse liaison posts are being introduced in each locality to act as an interface with the hubs. They will support care home staff with anticipatory care planning and reviewing admission referral pathways. Looking for alternatives to admission will enable staff to maintain residents in their care home and improve their experience.

18. The Community Respiratory Team will continue to support the respiratory pathway, preventing avoidable admissions for people with chronic obstructive pulmonary disease. During the winter period, however, their referral criteria are being widened to include frail or older people with acute respiratory infections. At present, these individuals would potentially be admitted to several acute services, but the Acute Medical Unit at the Royal Infirmary of Edinburgh. The specialist skills of the team will enhance the existing management of this group and provide an alternative to admission where they are able to remain at home with additional support.

19. The team will also link with Hospital at Home services to complement their management in the community of people who are acutely unwell with respiratory conditions, and support the early discharge of those who do require an inpatient stay.

20. The Hospital at Home service provides a valuable service in South Edinburgh, and for the duration of winter, it will be extended to include North East Edinburgh. This allows for an alternative to hospital admission older people in the locality. Individuals will be able to remain in their own home while receiving, through multi-disciplinary team input, the same access to investigations, medication management and additional care as those in an acute hospital setting.

21. The success of the Patient Experience and Anticipatory Care Team (PACT) is being built on by targeting anticipatory care planning to an increased number of people known to be at the highest risk of hospital admission. At present, 0.25% of the Lothian population meets the criteria for team intervention. This will be increased to 2% in two GP clusters in North Edinburgh. This team will work closely with practices to improve patient care and reduce hospital demand. The top 2% account for approximately 77% of unscheduled admission bed days and the team expects to be able to reduce hospital attendance and admission by up to 35% in this area.

22. Since September 2017, anyone presenting to the emergency department with a Key Information Summary (KIS) in place is being highlighted on ehealth systems. This builds on primary care initiatives to ensure individuals at high risk of admission are identified, their wishes are known and shared, and unnecessary admissions avoided. Through collaboration with the Scottish Ambulance Service, a test of

change is underway to provide access to KIS for high risk individuals and reduce instances of unnecessary transfer to hospital.

23. Continuing to build on previous successes, residents and visitors in need of urgent primary care, minor injuries treatment and wider social care support will be able to attend a walk-in clinic located at Chalmers Hospital in the city centre. This clinic builds on experience from the Festival Practice, which is open to visitors to the city during the summer festivals. The clinic will be open on public holidays at both Christmas and New Year, offering a combination of pre-booked and drop-in appointments, providing an alternative to accident and emergency, unscheduled care and mental health services for residents and visitors.

Business continuity and resilience

24. City of Edinburgh Council and NHS Lothian Business Continuity plans are in place, with joint procedures being developed where possible to ensure a fully integrated response. Resilience is being devolved to localities and is on the agenda for locality meetings. The priority is to ensure new managers are familiar with both NHS Lothian and Council resilience systems until new integrated plans are agreed.

25. The severe weather plan for the Edinburgh Health and Social Care Partnership is being reviewed and will be communicated widely. It includes priority locations for road clearance and gritting, information sharing between Council and NHS Lothian to identify vulnerable people in the community, plans for distribution of emergency supplies, and arrangements for the deployment of four-wheel drive vehicles, if required.

26. The flu vaccination programme has been rolled out with a designated lead identified in each locality and key clinical areas. Additional emphasis is being placed on ensuring eligible staff in a social care setting are included, along with carers and people who are house-bound. Data on uptake by the various groups is being collected for the first time. This will allow targeting of areas where uptake is particularly low. Inpatients eligible for vaccination across the acute hospital sites have been identified and are being targeted.

27. In keeping with national guidance, local protocols are in place to ensure compliance with infection control procedures to reduce the risk of Norovirus in hospitals and care homes. The infection control policy and advice for inpatient areas are available to staff on the NHS Lothian intranet. The Health and Social Care Partnership Quality Improvement Advisory Group will monitor performance.

Key risks

28. Key risks include:

- potential surge in unscheduled admissions during and after the festive period, particularly in relation to respiratory and circulatory conditions
- impact of disruptive adverse weather conditions
- impact of Norovirus and Influenza incidence; services in England are already on high alert following reports of double the number of flu cases in some parts of the world
- challenges recruiting required additional staff; alternative solutions, such as varying staff skills mix, are being used to ensure there is flexibility to deploy staff where needed most and to limit potential impact.

Financial implications

29. Successful applications totaling £526,742 have been made to the Unscheduled Care Committee for a range of initiatives to support the winter plan 2017-18 including:

- enhanced locality hub for 2 areas for weekend and public holidays – £158,431
- enhanced allied health professional capacity at Liberton Hospital to maintain flow – £28,310
- care home liaison nurses in each locality – £57,376
- extension of the Pan-Lothian Admission Avoidance Network, reducing avoidable hospital admissions – £43,059
- enhanced Community Respiratory Team role – £71,513
- extension of Hospital at Home to the North East Edinburgh – £117,233
- walk-in clinic at Chalmers Hospital – £50,820

Implications for Directions

30. We recommend that the IJB issues a Direction to implement the Winter Plan in order to achieve the outcomes set out within the plan, with performance being monitored using the described indicators.

Equalities implications

31. An integrated impact assessment will be completed to consider both positive and negative outcomes for people with protected characteristics and other groups. Any recommendations arising from the assessment will be included in future service planning.

Sustainability implications

32. The proposals in the winter plan will help protect those most vulnerable to the effects of winter weather whilst managing the impact on the health and social care system in a sustainable way.

Involving people

33. Winter plans have been developed in close consultation with relevant parties through the Winter Planning Group.

34. A communication plan is being developed for the Partnership to ensure that staff in health and social care, partner organisations, the public and visitors to the city are aware of the services available over the festive period and how to access these. Additional guidance will encourage people to keep healthy, plan if they have any health care needs, and signpost individuals to the most appropriate service to ease pressure on emergency services. A range of tools and channels will be used, dependent on the needs of the target group

35. The key target groups are people using the largest proportion of health care resources, primarily vulnerable older people, people who receive a care at home (approximately 3,500), people with long-term health conditions, and unpaid carers.

36. The Edinburgh communication plan complements the wider NHS Lothian plan, which includes poster distribution to all GP practices and other key locations, a bus campaign covering 20 routes, running for eight weeks from mid-November, and accompanying social media campaign. The emphasis will be on encouraging residents to present at the most appropriate location, based on their needs. A sample poster is attached at Appendix 2. Staff will be signposted to winter service availability, flu and infection control advice through an interactive intranet site. The impact of the campaign will be measured by monitoring hospital attendance levels for the duration of the campaign and tracking visitor numbers to the various social media channels.

Impact on plans of other parties

37. Winter plans have been developed in close consultation with relevant parties through the Winter Planning Group.

Background reading/references

Scottish Government DL (2017)19 guidance on Preparing for Winter 2017/18

6 Essential Actions to Improve Unscheduled Care

Introduction and monitoring of the HPS Norovirus Outbreak Guidance (2016/2017)

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Appendices

Appendix 1	Edinburgh Health and Social Care Partnership Winter Plan 2017-18
Appendix 2	Sample of winter advertising campaign

Edinburgh Health and Social Care Partnership
Winter Plan 2017/18

38. 1. Business continuity plans tested with partners			
Outcome: The partnership has business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather.		**Indicators:** Progress against any actions from the testing of business continuity plans.	
Action	**Owner**	**Status**	**Complete**
All business continuity management arrangements to be reviewed and tested	P Wynne	• Regular updating of arrangements with all partners involved through local winter planning meetings. • NHSL and CEC policies and plans in place. Work has been ongoing with EHSCP Resilience Committee with regular meetings to develop joint NHSL CEC procedures to allow fully integrated responses. Resilience is in process of being devolved to localities. • Action for winter 2017/8 is to familiarise all new managers with both resilience systems until integrated system and new integrated plans are ready. Resilience is on the agendas for Locality Meetings. • CEC Severe weather plan well developed and communicated outlining plans for capacity and recruitment, prevention and responding to emergencies. CEC Plan for Severe weather includes a plan for EHSCP including priority sites for road clearance and gritting, information sharing between CEC and NHSL systems to identify vulnerable people in the community, plans for distribution of emergency supplies in the community and arrangements for the deployment of 4 wheel drive vehicles.	Ongoing

		• BC Operational Plans on shared drive for all essential services available to Senior Management and Clinical Managers.	
Action	**Owner**	**Status**	**Complete**
Severe weather plans reviewed each year and updates implemented when they occur	P Wynne	• Close connection and contact with NHS Lothian and CEC Resilience Leads. NHSL policy and FAQs on Intranet under HR Online.	Complete and ongoing
Norovirus outbreak plans in place	P Wynne	• Clinical Nurse Managers to ensure HAI protocols in place. • Ensure care home managers are aware of and implementing infection control procedures across care settings. • For Care Homes, this comes under NHSL Health Protection. • For inpatient areas, all Infection Control policy and advice is on NHSL Intranet and there is link to Advisor. • Ensure compliance with all infection control procedures. • Have access 7 days to advisor via duty Infection Control Nurse. • Monitored through EHSCP Quality Improvement Advisory Group. • NHSL have a short life working group currently meeting and outcomes will be communicated to all staff across Lothian.	Ongoing

39. 2. 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 and locality management team with clear parameters on whole system escalation processes.		**Indicators:** 1. Attendance profile by day of week and time of day managed against available capacity; 2. % occupancy of ED 3. utilisation of trolley/cubicle 4. % patients waiting for admission over 4,8,12 hours 5. Admission profile per locality by day and by week	
Action	**Owner**	**Status**	**Complete**
Escalation plans for partnership hospitals, HBCCC facilities and Local Authority Care Homes	S Muir (Liberton/ HBCCC) N Conway (Comm / Care Homes)	• Liberton Hospital will have internal escalation procedures with clear trigger points and actions. • Liberton Hospital has some capacity for flexible use and the potential to scale up its intermediate care functionality with additional AHP support. Rehab wards also have some capacity for flexible use and this is currently being reviewed for Liberton and Rehab. Flexible use includes reviewing respite care demand in HBCCC wards. • HBCCC wards different as turnover is usually by patient death rather than discharge though not exclusively. • Community-wide escalation procedures will be agreed with clear triggers and actions. A de-escalation process will be agreed likewise. • Ongoing work with Care Homes to ensure timely assessment and discharge from hospital.	In place and ongoing monitoring

3. Safe and effective admission/discharge continues in the lead-up and over festive period and also in to January			
Outcome: Emergency and elective patients are safely and effectively admitted and discharged throughout the month of December and up until the 24th and over the festive holiday period including the 2 public holiday breaks. The partnership should ensure that delayed discharge patients are effectively discharged up until the 24th December, and from the 26th December onwards including transfer into care home, new packages of cares and restart packages of care. This will help ensure that patients do not have unnecessary stays in hospital, medical boarding into surgical wards is reduced and hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.		**Indicators:** • Delayed discharge patients continue to discharge from the acute hospitals up until the 24th December and throughout the festive period weeks. Including over the PHs and weekend periods: - New package of care; - Restart package of care; - Transfer to care home - Transfer to HBCCC; - Transfer to Intermediate Care at Liberton • Levels of medical boarding into surgical wards are reduced. • Delayed discharge quotas and trajectories on target. • Bed occupancy is reduced and around 85%.	
Action	**Owner**	**Status**	**Complete**
a. Prevention of hospital admissions where appropriate b. Facilitate early discharges and reduce occupied bed days c. Staffing and resources appropriate to meet demand	N Conway M Green P Jackson A Lindsay (Localities) S Muir (Hospital)	**Hub and Cluster Capacity and Flow Realignment** • We will establish and then utilise appropriate performance management and trend data to ensure that the correct resources are applied at the right time, right place and in the right format. • We are creating a daily and weekly suite of flow activities that will support the Locality Hub in understanding the trend data in relation to flow and support the key decision-making in relation to allocation of service. • This will include: - Daily Multi Agency Triage Team (MATT) Huddle; - Daily UCC Debrief on day before performance; - Whole System Capacity Link via Teleconference; - End of Day Rapid Run Downs; - Star Chamber Delayed Discharge Review; - Links to Hospital Emergency Access and Winter Planning Meeting; - Frailty Programme Board;	Ongoing (as part of Essential Action 2)

		- Performance Meetings in Locality and via SMT. • The initial work will establish a current footprint of flow into, through and out of the hospital to identify where capacity meets or does not meet demand. This will include key aspects of flow surrounding >65 years, >75yrs, >85yrs. • We plan to conduct demand and capacity analysis (DCAQ) at cluster and locality level to establish capacity gap in a range of capacity including Care Homes, Dementia Care, Young People's Care, Intermediate Care Services including any bed based model, Reablement, Home Care and HBCCC. • Use DCAQ analysis to inform options analysis on options for increasing capacity at locality level. • Proactive management of patients at risk and vulnerable adults in the community through winter bid to extend Hospital at Home to the NE of Edinburgh in the first instance through IOPS. • CRT proactively preventing avoidable COPD admissions. • Falls - screening for patients falling at home, admitted with fall, or deemed at risk of future falls. System in place through Community Alarm and Telecare Service for uninjured fall patient. Developing improved onward referral pathways for winter 2017 with localities. This will be part of the Hub response for winter. • GP Anticipatory Care Plans for nursing home residents/identified patients at risk. • Closer working with Care Homes to avoid unplanned admissions to acute settings.	

40. 4. Strategies for additional surge capacity across Health and Social Care Services			
Outcome: The risk of increased admission into hospital, and the associated capacity blockages this causes due to community capacity gap in resources is minimised. The staffing plans for additional surge capacity across health and social care services are agreed in October. This surge capacity is related to addition therapy staff to support long terms conditions, manage the length of stay from the acute hospitals and prevent unnecessary hospital admission. The planned dates for the introduction of additional acute, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person-centred environment.		**Indicators:** • Additional staff in place to support: a. chronic conditions and people at risk; b. management of hospital LOS and DC c. additional intermediate beds in the community and the planned date of introduction of these beds; d. Levels of boarding. e. Planned number of extra care packages f. Planned number of extra home night sitting services g. Planned number of extra next day GP and hospital appointments	
Action	**Owner**	**Status**	**Complete**
a. Prevention of admission b. Escalation and business continuity procedures c. Anticipatory Care Planning (ACP) d. Supporting GP Capacity	A Lindsay	• Proactive management of patients at risk and vulnerable adults in the community through Locality Hubs along with - immediate assessment and proactive management of patients at risk of admission; • Falls - screening for patients falling at home, admitted with fall, or deemed at risk of future falls; this should improve falls admissions rate through pathways to be implemented for winter for those at high risk of falling. • Increased capacity of falls co-ordination post. • Closer working with Care Homes to avoid unplanned admissions to acute settings. **Winter Bids that have been funded for EHSCP are**: - a. **Chalmers bid** – provision of a city centre walk in clinic for the four public holidays over the festive period will run as a test of change. Will avoid presentations at A and E, LUCS and IHTT	Ongoing

		b. **CRT+** - will have a broader referral criteria for winter to encourage GPs to refer acutely unwell respiratory patients with the aim of prevention of admission or attendance to Secondary Care. We will look to reduce attendances at MAU/AMU at RIE/WGH by 20%. Secondary Care will also have the ability to refer patients for supported discharges; aiming to reduce LOS in non-respiratory specialist wards. c. CRT will also collaborate with both H@H in the North and South by taking clinical ownership of their acute respiratory caseload. This in turn will release capacity in H@H. We will work together to ensure GPs have clear communication as to the collaboration and the appropriate service to refer to. d. **Enhanced Locality Hub** working – weekend and Public Holiday operation to allow 7-day pull models from all 4 locality hubs. e. **Extend Hospital at home** - cover all of NE Edinburgh (South Edinburgh already covered). This would be incorporated in Leith CTC in with OPRA. There are ongoing discussions with regard to recurring funding. f. **Liberton** – enhanced AHP capacity for Intermediate Care service for patients who are medically stable but require reablement. EHSCP took over Liberton on 1.7.17 with the aim of providing an Intermediate Care Service. g. **Care Home Liaison** – to prevent admissions from care homes and provide and interface with community team and support anticipatory care plan. h. **PLAAN** - Test of change: admission avoidance – to provide targeted anticipatory care planning support in two GP clusters in North Edinburgh: clinical review of and care planning for those individuals most at risk of hospital admission (top 2% of population) with multi morbidity and/or complex care needs. This cohort currently account for 77% of unscheduled bed days. **i. Care Homes -** provide support to six care homes to develop a robust anticipatory care process j. Develop an ACP training toolkit tailored for variety of health and social care staff	

		k. Improve quantity and quality of Key Information summaries**.** **l.** **Training and education** - Delivery of training to locality health and social care teams (city wide) and GP Practice teams (South Edinburgh) around: • Anticipatory Care Planning (ACP) including Key Information Summaries (KIS) and consent process • Test of Change: GP Practice project/administrative support to bridge the identified gap of 'stand-alone' anticipatory care plans written by specialist teams but not currently shared with healthcare professionals, out of hours teams or Scottish Ambulance Service via KIS. • Improve access to Key Information Summaries (KIS): ensuring high risk individuals are identified, their wishes are known and shared and unnecessary admissions avoided • KIS icon in TRAK is live from 6/9/17 to identify individuals who arrive at emergency department who have anticipatory care plan • Test of Change: Collaborative with Scottish Ambulance Service to 'open every KIS' for high risk individuals with a view of reducing unnecessary conveyance to hospital. • Implementation of additional staffing to support Primary Care through Primary Care Transformation Fund.	

41. 5. Whole system activity plans for winter: post-festive surge/respiratory pathway			
Outcome: The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. The hospital models will include flows between front doors, receiving units, and downstream wards. The partnership must respond accordingly to support delivery of the daily quotas of discharge from the acute hospital and to ensure as far as possible, as many high risk respiratory patients are managed safety at home.		**Indicators:** • Respiratory presentations to the acute hospital • Respiratory admissions to the acute hospitals • Respiratory boarding patients out with the acute respiratory bed bases • Daily number of cancelled elective procedures • Number of respiratory admissions and variation from plan • Numbers of respiratory patients under the management of CRT 44.	
Action	**Owner**	**Status**	**Complete**
Flow activity to be managed through the partnerships range of services and supports	N Conway M Green P Jackson A Lindsay	• Daily MATT Huddle with specific focus on the older patient and respiratory admissions to hospital, notably those patients with ACP. • 9.30am System Teleconference with the Acute Hospital with specific focus on patients who are able to discharge with support from CRT or other Hospital at Home Services. • Ongoing weekly senior manager meeting to review and address all delays involving patients at weekly partnership wide Delayed Discharge meeting. Plus, in the hospital sites there are weekly meetings to review all delayed discharges. • Increased support within Care Homes to review pathways and reduce hospital admissions through improved local care and decision making – Anticipatory Care Planning • Monitoring of care at home providers to ensure maximum contracted hours are being delivered	Plan in place to be regularly reviewed and updated

	E McGuire (Festive Practice)	and that appropriate level of care is being delivered particularly over the festive period. • We will be conducting a demand and capacity analysis (DQAC) at locality level to establish capacity required for the weekends and any potential gaps. This will also inform options analysis for increasing capacity at locality level. • Bids for winter funding have included 7 day working • CRT+ Team will be working with Acute Respiratory Services to mirror their January model of delivery. • Synergies between Service Matching Unit and Hubs to be determined in advance of winter. • Admin and Business support for Hubs to be in place for winter. • Up scaling telecare deployment to over 65s. • Chalmers – provision of a city centre walk in clinic for the four public holidays over the festive period which will run as a test of change. Will avoid presentations at A&E, LUCS and IHTT.	

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. The partnership should use this available intelligence and with support from Strategy and Insight teams, to plan and monitor winter activity.		**Indicators:** • Agreed and resourced analytical plans for winter analysis. • Daily analysis via the Hub Managers • Weekly analysis via Locality Performance review of hub services	
Action	**Owner**	**Status**	**Complete**
Data analysis to respond to increased demand	E Cunningham A Jackson	• Partnership working with ISD, health and council data reporting to provide the analysis and projections to respond to demand appropriately resulting in a Dashboard which is new for this winter 2017	Systems under development

		• Specific output and measures associated with funding proposals.	
7. Workforce capacity plans and rotas for winter / festive period/ agreed by end of October			
Outcome: Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective admission and discharge of emergency and elective patients. This should encompass all relevant health and social care services. Maintain discharges at normal levels over the two 4 day festive holiday periods		**Indicators:** By locality: a. Workforce capacity plans and rotas for winter / festive period agreed by October; b. Effective local escalation of any deviation from plan and actions to address these; c. Extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements. d. Number of discharges on each of the 4 day festive holiday periods compared to number of normal daily discharges	
Action	**Owner**	**Status**	**Complete**
Festive period and public holidays	All operational managers E McGuire (Festive Practice)	• Rostering appropriate staffing and resources to maintain services through the festive period. • Managers will ensure leave is appropriately managed to ensure sufficient capacity to cope with winter demands. A revised process had been agreed by CEC and NHSL human resources • On call rota for duty managers and clinical service leads are in place. • District nurse service runs 365 days a year with system to cover all weekends and public health across the year. • Emergency Social work service will continue to provide an emergency social work response to situations that occur out with core hours including public holidays throughout the winter period. • Enhanced hub capacity will facilitate weekend and bank holiday discharges. • Pan city review of care home agency utilisation. • Chalmers bid – provision of a city centre walk in clinic for the four public holidays over the festive	Protocol in place

		period will run as a test of change. Will avoid presentations at A&E, LUCS and IHTT.	

45. 8. Discharges at weekend and bank holiday			
Outcome: Patients are discharged at weekend and bank holidays to avoid unnecessary stays in hospital, minimise boarding of medical patients into surgical wards and to improve flow through the hospital. There is reduced hospital occupancy over the 7 days and earlier discharge in the day.		**Indicators:** • % of discharges for weekends and public hospitals are consistent with week day [patterns • Boarding numbers are minimised in surgical wards • Daily discharge quotas are delivered	
Action	**Owner**	**Status**	**Complete**
Enhanced staffing within the locality Hubs will facilitate additional discharges at weekends and bank holidays.	A Walker	• Weekend hospital discharges can be arranged at any point. This winter plan creates capacity for discharge planning to be undertaken at weekends, increases the support available to enable weekend discharges to happen and will provide a hospital presence to support active criteria led discharge at weekends and on public holidays. • Winter Funding will enable Hub Services to be enhanced on Saturdays, Sundays and Public Holidays between. Recruitment underway. • Plans are in development to provide on a North and South Hub on weekends providing an integrated Hub response 8.30 – 4.30 Saturdays, Sundays. A combined north (NE/NW) and South (SE/SW) MATT will take place on Saturdays, Sundays and public holidays, and will link with hospital discharge hubs, flow centre and LUCS to deliver integrated care pathways to support a non-bed based winter model. The MATTs will review acute admissions, delayed discharges,	Ongoing

		and situations of people at risk of hospital admission (linking with relevant Hospital at Home services as appropriate) Social Workers will be based in the acute hospital at weekends and on public holidays. They will support clinical staff to make appropriate plans around the discharge of people who present in ED, AMU and MAU but do not require hospital medical care. • Hospital based social workers will liaise with the North and South Hub therapy staff, home care coordinators and Emergency Social Care staff team to maximise the opportunities for discharge.	
47. 9. The risk of patients being delayed on their pathway is minimised			
Outcome: **SYSTEM BAROMETER FOR FLOW:** • Crowding in the Emergency Department or Acute Receiving Unit is avoided due to available hospital bed capacity at any one time. • Cancellation of elective surgery is avoided due to available hospital bed capacity at any one time.		**Indicators:** • Crowding at any one point in the ED and ARAUT (RIE 35 cubicles and ARAUT 18 cubicles). This level of information can be accessed via the Acute Site Daily UCC Debrief. • Cancellation of Elective Surgery • % of discharges before noon • Levels of boarding medical patients in surgical wards	
Action	**Owner**	**Status**	**Complete**
Ensure there is effective community capacity daily to support the essential discharge quotas from hospital for every patient, including those high-risk patients.	D Arundel S Latona F Stratton A Walker	**DAILY FLOW ACTIVITY:** • MATT Huddles of all hospital delays daily and facilitate timely provision of community supports. • UCC Debriefs to review previous day activity and escalation markers. • Teleconferencing across sites re beds twice a day Monday – Friday. • Single point of contact between Localities/Hubs and RIE Discharge Hub. Hospital in-reach to liaise daily with the Discharge Hub; 48. W**EEKLY**	In place with ongoing monitoring

	N Conway A Fox (Falls)	• Weekly Partnership meeting focused on delayed discharges and weekly whole system teleconference. • Ensure availability of multi-disciplinary team for patients returning from hospital and those being managed at home via the Hubs; **OTHER** • Continuity planning for Care Provider organisations, carer support organisations and the community and voluntary sector. • Work underway to implement referral pathway from Social Care Direct to Locality Hubs and inter referrals between flow centre and the Hubs. • Implementing Carer Discharge Support Workers within each locality hub. • Pathways into Hubs and from Hubs to other services to be reviewed to ensure accessibility and to remove duplication. • Falls – priority actions identified for winter period: • Proactive identification of people at risk or falls within localities – development of fall 'hotspots' map. Prioritise training and falls assessments. • Engagement with hub and cluster teams: Falls Pathways education. • Review referral routes to locality hubs – Social care direct. • Review Falls Co-ordinator support within MATTs. • Test of change: SAS pathway – Fallers attended by SAS but not conveyed to hospital: use SAS non-conveyed data to trigger urgent falls assessment by locality falls practitioner (intermediate care) • Test of change: Fire and Rescue Service completing level 1 falls assessments in NE locality as part of home safety checks	

		• Targeted falls prevention training within care homes – use of SAS conveyance data and falls admission data to identify high risk care homes • Review of Fallen Uninjured Person Pathway (FUPP) (hosted by CATS) test of change: extend scope to fallers at home alone. • Review falls pathways for people referred to Day hospital - ensuring seamless information flow to/from hubs and GPs	
49. 10. Communication Plans			
Outcome: The public and patients are kept informed of winter pressures, their impact on services, and the actions being taken.		**Indicators:** • Daily record of communications activity • Early and wide promotion of winter plan	
Action	**Owner**	**Status**	**Complete**
Information Management	A Duff / E McGuire	• Briefing and copy of winter plan to all on call clinical staff and partner organisations. • Regular local winter planning meetings with key partners and feed into the Lothian Winter Planning meetings. • Communications is a standing item on EHSCP Winter Planning Group agendas. • A full Communications Plan has been drafted and complements the NHS Lothian overarching Communications Strategy for winter 2017/18. Priority groups will be those using the largest proportion of health care resources, primarily vulnerable older people, people who receive a care at home (approximately 3,500), people with long-term health conditions, and unpaid carers.	Ongoing

50. 11. Preparing effectively for norovirus			
Outcome: The risk of Norovirus outbreaks becoming widespread throughout a hospital or care home is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).		**Indicators:** • Number of wards and care homes closed to Norovirus • Application of HPS Norovirus guidance.	
Action	**Owner**	**Status**	**Complete**
Robust Norovirus outbreak management Introduction and monitoring of the HPS Norovirus Outbreak Guidance (2016/2017)	P Wynne	• Clinical Nurse Managers to ensure HAI protocols in place. • Ensure care home managers are aware of and implementing infection control procedures across care settings. • Links with Care Home Liaison and specific objective regarding infection control • Ensure compliance with all infection control procedures.	Complete and ongoing
51. 12. Delivering seasonal flu vaccination to staff and public			
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		**Indicators:** • % uptake for those aged 65+ and 'at risk' groups; • % uptake of staff vaccine by site and locality and variance from planned levels in line with CMO	52.
Action	**Owner**	**Status**	**Complete**
Seasonal Flu	P Wynne	• Carer vaccination to be encouraged by GP practices. Also, when vaccinating housebound, carers should also be vaccinated for care homes and community hospital long stay patients. • Ongoing active campaign to increase staff uptake of flu vaccination particularly front-line staff with patient contact and including the social care sector (care homes/care at home). Clarification to be communicated as to which Council staff are eligible.	Ongoing

		• The flu programme for housebound has been funded and is planned to commence earlier than last year. • Flu Lead to be identified for each locality, hosted services, HBCCC and rehabilitation services • Flu clinic dates feature on the Council Orb and clearly state who is eligible. Dates also on NHS Lothian Intranet • Private care homes and private care at home to be included. Process for obtaining consent in nursing homes has been confirmed.	

Appendix 2 - Sample of winter advertising campaign