Item 5.5

Report

Evaluation of 2017/18 Winter Plan and Winter Plan 2018/19
Edinburgh Integration Joint Board

28 September 2018

Executive Summary

Evaluation of the Winter Plan 2017/18

1. Scottish Government DL (2017)19 guidance on Preparing for Winter 2017/18 required the Edinburgh Health and Social Care Partnership (EHSCP) to produce an action plan to ensure health and social care services were well prepared for winter. This plan was presented to the Edinburgh Integration Joint Board on 13 October 2017 and 15 December 2017.

2. The plan focused on building capacity for out-of-hours services, reducing unscheduled admissions to acute hospitals and supporting early discharge. It addressed additional pressures such as potential surges in respiratory disease and admissions over the winter, incidence of norovirus and influenza, and seasonal business continuity challenges.

3. This report provides an evaluation of actions taken in relation to the critical areas outlined in the guidance for 17/18.

Winter Planning for 2018/19

4. The Winter Planning process for 2018/19 has commenced, and the Partnership was invited to submit requests for funding in late June. The Partnership's financial allocation was confirmed on 18 September 2018 and is further detailed in paragraph 81.

Recommendations

5. The Integration Joint Board is asked to:

   i. Review the outputs and lessons learned from winter 2017/18 and advise if there are any further actions the EHSCP Winter Planning Group should consider for 2018/19.

   ii. Note progress with winter planning for 2018/19

iii. Accept this report as a source of moderate assurance that EHSCP is developing a robust winter strategy in response to learning from winter 2017/18 as well as supporting new initiatives to continuously improve the winter planning processes

Background

6. Planning for winter is an important part of the Partnership's service delivery, given the additional pressures placed on local systems from seasonal influenza, norovirus, severe weather and public holidays.

7. For winter 2017/18, the Scottish Government supported local systems to undertake a review of pressures at several national events where consideration was given to priority areas and initiatives to support local health and social care systems to prepare effectively for winter. It would be fair to say that the focus at the events was still highly geared towards acute services.

8. Scottish Government DL (2017)19 guidance on Preparing for Winter 2017/18, which was released in August 2017, set out the critical areas, outcomes and indicators of success that should be included as part of local planning. These were aligned to the Unscheduled Care 6 Essential Actions and included:

    - 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 service
    - 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 rotas 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.

9. The Cabinet Secretary for Health and Sport Committee, wrote to the Chair of all Health and Social Care Partnerships on 31 August 2018 regarding preparing for winter 2018/19. The letter confirmed the amount that NHS Lothian has been allocated for 2018/19 and instructs Health Boards and Integration Joint Boards to use this allocation to specifically target the delivery of 3 priorities:

    - Demanding local improvement trajectories for weekend discharges rates to be agreed by the end of November.
    - Earlier in the day discharges, against local improvement trajectories.
    - Adequate festive staffing cover, across acute, primary and social care settings, to ensure that discharges can be maintained at required rates. This should include clinical staff, pharmacists, AHPs, auxiliary and domestic staff.

10. The letter also requested that Winter Plans are submitted by the end of October 2018. A supplementary checklist of winter preparedness: self-assessment was included for completion which is attached at Appendix 1.

11. A Regional Winter Planning Event was held on 13 September 2018.The EHSCP Winter Planning Group, which includes multi-agency and multi-disciplinary representation, leads on the planning and evaluation of the Winter Plans. Monthly meetings are scheduled for Winter 2018/19.

Main report

Funded Winter Bids 2017/18

Enhanced Locality Hubs – prevent avoidable admissions and support early discharge

12. The Locality Hubs were at a very early stage in their evolution and there were many winter challenges, in particular, care agencies picking up very little work from 20 December 2017 and over the holiday period. Agency staff flu levels were another mitigating factor.

13. In spite of this, Hub capacity was enhanced to include 7 day and Public Holiday working. Services for the North of the City were delivered from the North West (NW) Hub and for the South of the City from the South East (SE) Hub. 32 additional hospital discharges were facilitated, an average of 1.7 per weekend. 63 unnecessary admissions were prevented, an average of 3.3 per weekend.The

weekend Hub meant that in house services could be started on Saturdays and Sundays which had a knock on benefit to service provision the following week.

14. Recruitment, particularly to physiotherapy posts, was challenging and undoubtedly affected the ability to provide any additional community-based rehabilitation over winter 17/18.

15. In spite of pro-active weekend 'pull', contacts with acute site coordinators, e.g. Home First Practitioners at the Royal Infirmary of Edinburgh (RIE), little activity was generated in this way.

Respiratory Flow – enhancement of the Community Respiratory Team (CRT+)

16. CRT is a well established specialist respiratory team operating 7 days per week, providing a safe alternative to hospital admission.

17. The service widened the range of individuals supported to include the frail or elderly with acute respiratory infections as a test of change.

18. The team provided both primary and secondary care with an additional pathway for the management of patients with acute respiratory infections and supported an additional 157 patients. The majority of referrals were generated by General Practitioners (GPs). There were low levels of acute referrals.

19. At completion of the test of change, a protocol was developed for referral, assessment, supported management and continuation of care for patients with acute respiratory infections in the community, who will benefit from the services of the CRT

Expansion of Hospital at Home (H@H) to the North East (NE) of Edinburgh

20. Hospital at Home is a well established service in the South of Edinburgh. For the duration of winter 17/18 it was extended to include NE Edinburgh. This allowed an alternative to hospital admission for older people in the locality. Individuals were able to remain in their own home while receiving, through multi-disciplinary input, the same access to investigations, medication management and additional care as those in an acute hospital setting. In the first 10 weeks of the service, it cared for 58 patients saving 268 bed days with a saving of £71,550. Activity was lighter than anticipated due to unforeseen specialty doctor sickness during this period

21. The average length of stay for the NE H@H ward was 5.6 days, compared to 13 days in a Medicine of the Elderly ward.

22. Due to the success of the winter expansion and also endorsed by the Whole Systems Review on 7 March 2018, the Partnership has agreed a continuation of funding in NE until the end of the financial year. The Strategic Planning Group

approved a proposal for further expansion to NW to ensure that all residents over 65 across the City can benefit from this service. The full business case for extension is with the Partnership's Executive Team (ET) for consideration.

Enhanced Allied Health Professional (AHP) Capacity for Intermediate Care Service at Liberton Hospital to promote supported discharge

23. Intermediate Care Services were initially enhanced through additional Occupational Therapy and Physiotherapy capacity, based on aspirations to improve flow and increase capacity to support Edinburgh residents who are medically stable but require reablement/rehabilitation to allow for discharge home, and those for whom discharge has been delayed with the aim of reducing their length of stay in hospital.

24. The enhanced therapy service was premised on 60 beds, however, pressure on acute sites was significant and the Liberton bed base incrementally grew to 87. Rather than enhancing the Allied Health Professional (AHP) to bed ratio, the opening of additional beds to help with system flow effectively negated any impact but was, nevertheless, welcome.

Improving Anticipatory Care Planning (ACP) for High Risk Individuals in General Practice

25. Building on the success of the Patient Experience & Anticipatory Care Planning Team (PACT) and the Care Home ACP Programme, and focusing on a test of change in 1 GP Cluster in the NE of Edinburgh (8 GP Practices) the top 2% of people known to be at highest risk of hospital admission, using SPARRA data, were reviewed. Subsequent to that:

    - 28 patients who would benefit most had an intensive ACP review – previously none had benefited from this
    - 171 patients had a routine ACP review and Key Information Summary (KIS) updated or created.
    - The number of people in this cohort who did not have an up to date ACP reduced by 33%

26. Amongst many other outcomes, GPs found it useful to see patients when not in crisis and to be given sufficient time to and resource to explore the full range of issues that were important to the person.

27. Data analysis for GP Practice attendance; A&E attendance and hospital admissions is still awaited, it is anticipated this information is due in September 18.

Festive Practice – Primary Care Walk-in Centre

28. Continuing to build on previous successes, residents and visitors in need of urgent primary care, minor injuries treatment and wider social care support were able to attend a walk-in clinic located at Chalmers Hospital in the city centre. The clinic was 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 service for residents and visitors. The clinic saw 66 people over Christmas and New Year public holidays and the main benefit was felt by Lothian Unscheduled Care Service (LUCS) who had requested that the service be repeated at Easter.

29. Unfortunately the Easter service did not go ahead as LUCS had difficulty recruiting GPs to cover the Easter weekend. It was felt that the Easter service would become a pressure and a decision was taken not to go ahead at that time.

30. Valuable lessons have been learned about the service model and the staffing model will be refined to accommodate these for 2018/19.

Care Home Liaison

31. The Care Home Liaison Nurse project did not commence due to several challenges. Firstly and primarily, there was no suitable job description and the timescale for job evaluation, matching and recruitment was not possible within a three month timeline. Work has now been done to develop a job description for future use.

32. The likely cohort from which these posts would have been recruited is District Nursing and the Partnership was and still experiencing workforce pressures in this sector.

33. A previously successful care home liaison service (funded from the Older Peoples Change Fund) was disbanded and the organisational memory of that has yet to fade.

Generic Lessons Learned and Proposals for Improvement

34. In common with previous years, earlier agreement on funding allocation to allow recruitment to commence in the summer months is critical. AHP recruitment would benefit from a centralised collaborative approach.

35. Whilst it is recommended that Hub Services move to a seven day working model as business as usual, to support flow and prevent unnecessary admissions, this will require larger scale staff engagement, consultation and organisational change. Early work to enable this is underway through the Integration Challenge and Opportunities Working Group.

36. Where new services are developed, communication to key stakeholders (referees) needs to be targeted and sustained. The Winter Communication Plan needs to be initiated earlier in the season and an overarching communications plan for Resilience needs to be developed.

37. A clear Partnership incident management structure needs to be in place which specifies essential services and requires to have a more robust and proactive staff flu campaign and better data to support this.

38. Where things work well, demonstrate impact, and would contribute to community capacity building as outlined in the Strategic Plan, proposals/business cases should be developed as routine.

Pressures throughout Winter

39. The delayed discharge performance caused significant difficulties in achieving sustainable flow across each acute site. Difficulties associated with accessing packages of care, nursing home places and Guardianship cases further impacted performance.

40. All acute adult sites reported an impact resulting from influenza with the strain of influenza A (H3N2) among the most prevalent. This impacted on site capacity and flow as a number of wards throughout acute required to be closed / cohorted for safe containment of the infection.

41. Pressures for the Partnership included higher than usual staff sickness absence levels, including those of their partner providers, and staff vacancies.

Winter Bids 2018/19

42. Whilst the ambition remains to achieve a non-bed based winter model, it is recognised that Partnerships are not in a position to fully deliver this yet.

43. The 2018/19 winter planning process has evolved from the process used in 2017/18, with greater emphasis upon realising the impact of any funded winter scheme and clear metrics being considered alongside the rationale for funding. This year's approved approach has included:

    - Table top exercise with open discussion against each bid and application of a weightings framework to each bid against an criteria of:

        i. The Scottish Government 6 Essential Action Programme (see Appendix 2)

        ii. Ministerial Steering Group Indicators (see Appendix 3)

44. Areas of greatest impact/evidence to date:

- Application of live weightings to create a prioritised list of winter bids that fit within financial constraints/unscheduled care winter funding for 2018/19
- The forging of key linkages with resilience planning workstreams.

45. On 6 June 2018, EHSCP was invited to submit bids for winter funding. A communication was sent out at that time to a range of key stakeholders in the Partnership, including operational managers, locality managers, members of the EHSCP Winter Planning Group, Strategic Planning Manager's and the Chief Nurse, who were asked to liaise with staff and third sector partners to generate proposals.

46. The deadline for winter submissions was 25 June 18. EHSCP submitted 13 bids, which were discussed at a prioritisation meeting on 31 July. It was evident at the prioritisation meeting that the process required to be refined using improved weightings and a scoring system to make it fit for purpose. A list of essential areas, listed below, was produced at that meeting and will be included in the final winter plan:

- Festive Period Cover – ED/Festive Practice
- Infection Control – facilities
- Flu
- Respiratory
- Delayed Discharges
- Discharge to Assess
- ED Resilience
- Hospital at Home/Hospital to Home
- Prevention of Admission
- Ambulatory Care
- Enhanced staffing to improve flow in wards
- Additional Beds and Infrastructure
- Principles of prevention, earlier discharge

47. Firstly, system-wide must haves were agreed to be festive period cover, infection control and flu. Secondly, proposals with low or no evidence of impact were removed. Thirdly, it was agreed that each of the Partnerships should reconsider their submitted bids and reference them against the list of essential areas and to reprioritise by essential to least essential by each business unit/partnership.

48. Table one gives a breakdown of the Partnership submissions

Must Haves – already agreed			
ED005	Festive AHP Public Holiday Cover in AAH and Liberton	Relates to beds	Both proposals are discreet. No cross cutting. 100% linked to Festive Public Holiday cover
ED008	Festive Primary Care Model		
Priorities – in rank order, highest to lowest			
ED004	Community Respiratory Team +	Respiratory	
ED002	Discharge to Assess	Discharge to Assess	
ED001	AWI/Guardianship	Enhanced Staffing to improve flow in wards	
ED009	Hub – Hospital Social Work	POA/Delayed Discharge	
ED0101 & ED012	Hub – Enhanced Therapy & Hub Assistant Practitioners	POA/Delayed Discharge	
ED003	PLAAN Phase 2	POA	
ED006	Liberton Assistant Practitioners	Enhanced Staffing to improve flow in awards/Delayed Discharge	
ED007	ACP & Community Mental Health Teams	POA	
Removed			
ED011	Hub – Enhanced Discharge Facilitation		Offered up at de-prioritised at planning prioritization meeting on 31/07/2018
ED013	IMPACT District Nursing Brief Nursing Interventions		No evidence to support proposal. Unlikely to be able to staff

49. The essential bids in their totality will be further cross referenced against evidence to date and deliverability to create a final list of bids that will be funded, it is anticipated that funded bids would be confirmed by the end of August 2018. EHSCP submitted 11 bids totalling £379,698. 8 of these bids were successfully funded to a total of £286,043.

Unpaid Carers

50. The winter season and the festive period over Christmas and New Year, can be a difficult time for unpaid carers. Winter weather can make it problematic for carers and the person they look after to get around and seasonal reductions or disruptions in service provision, for both the carer and the cared for person, can amplify the loneliness and social isolation carers often experience.

51. The State of Caring Report 2017 by Carers UK advises "that carers who had felt lonely or isolated were almost twice as likely to report worsened mental (77%) and physical (67%) health" so the impact of this is an important consideration for winter planning.

52. Within Edinburgh for 2018/19, unpaid carers can access support and information from carer organisations throughout the winter period. However, during the two week festive period when many carer projects close carers can; access telephone support from the Edinburgh Carer Support Team on non-public holiday days; contact Social Care Direct at any time in relation to social care issues or queries about service provision in the event of adverse weather; and access specific opportunities that VOCAL Edinburgh plan to offer including; a series of drop-in sessions in their carers hub on specified dates offering company and emotional support from dedicated carer support staff; activities and trips out with other carers and dedicated staff; and telephone counselling.

53. All of these opportunities will aim to reduce isolation and loneliness and ensure carers are connected to support. The service being provided by VOCAL over Christmas is currently in the planning stages and will be widely promoted through a variety of platforms. This service will be funded through the Carer Information Strategy allocation to support carers' health and wellbeing over the festive period

Winter Weather Resilience Arrangements

54. The Partnership's 2017/18 winter resilience was robustly tested by the short, but eventful, visitation of the 'Beast from the East', which created severe snow and ice conditions between 28 February and 4 March 2018. The main impacts were transport, communications and staff and service user's welfare. This created a unique opportunity to introspectively look at incident readiness and response and, as a result of that, resilience arrangements have significantly changed.

55. In May 2018, the EIJB approved the Partnership's Overarching Resilience Arrangements, which includes winter resilience. Operational teams are currently finalising their own resilience plans for EMT sign off by the end of October 2018.

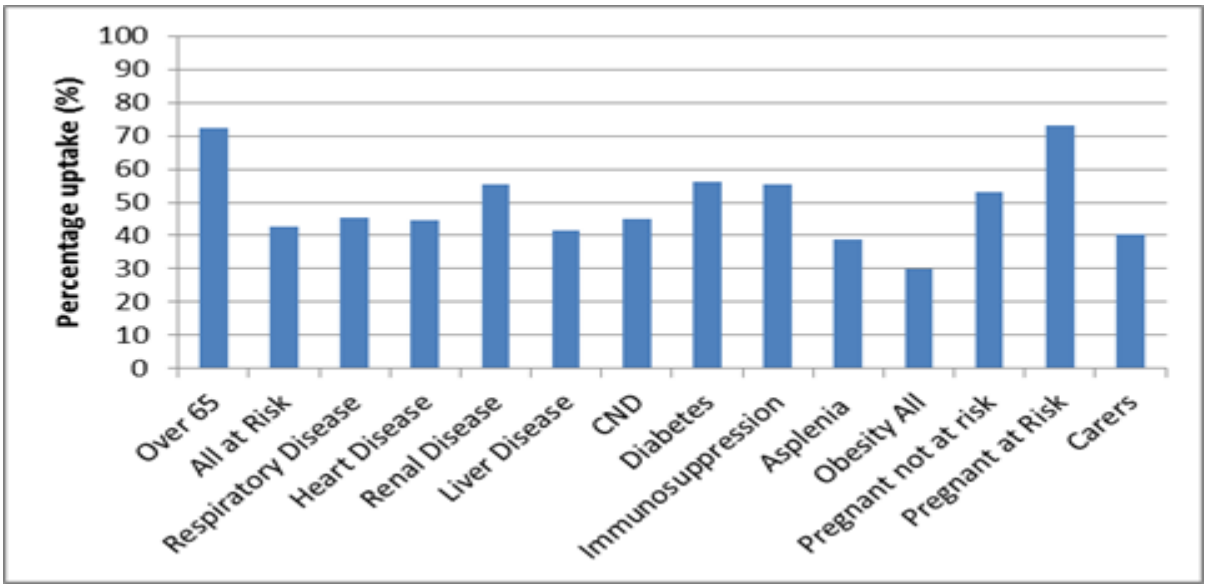
56. The full IJB Winter Weather Resilience Arrangements report is attached at Appendix 3.

Flu Vaccinations

57. Ensuring high uptake of flu vaccination among staff and patients is one of the key underpinning and most effective elements of winter planning. Prevention of flu in the community decreases the number of admissions and presentations, and prevention among staff decreases both nosocomial transmission and staff sickness.

58. NHS staff flu uptake increased enormously from 41% last year to over 51% this year. Nearly 16,000 vaccines were given in 495 clinics. This was above the Scottish average uptake of 46% and we have moved from bottom to 5th top mainland Board.

59. Getting data by locality on flu uptake is not possible currently. There is no data for the Council employed staff within the Partnership. Community flu uptake at last saw a reversal of the downward trend since 2013/14. The graph below outlines uptake of flu vaccinations in risk groups in GP Practices in Edinburgh.



60. This year saw the most significant seasonal flu activity since the post swine flu season of 2010/11. Early indications of a severe season in Lothian came from an early start with outbreaks in care homes from week 47. Altogether, 27 of the 110 care homes in Lothian reported outbreaks of influenza. It has not been confirmed how many of these were care homes in Edinburgh. The main season started from week 49, with prolonged high activity from weeks 52 – week 5 with a peak in GP consultations in week 2.

61. The Housebound Flu Vaccination Service was offered for the second year running to GP Practices and received positive feedback with 50 Edinburgh practices (68%) opting in.

62. A successful pilot took place utilising a smartphone application to trial real time collation of staff flu vaccination. Further work is required however on the best model and work will be considered in 2018.

63. The following are the key issues to be addressed around flu in 2018/19:

- **Uptake**: The welcome upswing in uptake in 2017/18 was only achieved late in the season after patients and staff came forward as a result of the publicity around the significant impact of flu at New Year. There needs to be a focus on continuing to improve uptake among the groups most at risk and in whom uptake is lowest. Across Scotland, uptake in all risk groups under 65 is still only 45% (in 2013/14 it was 57%)

- **New flu vaccines for 2018/19**: New adjuvanted and quadrivalent flu vaccines will be available for next season – with eligibility depending on age group for this first season. These new vaccines are very welcome, but there is a need to mitigate around potential confusion caused by different eligibility criteria. There is a supply restriction to over 75's only. By mid October 18 only 60% of the consignment will be available with the remainder available by early November. This may have an impact on GP clinics

- **Vaccination of in and outpatients**: Many patients miss their flu vaccination in primary care because they are in hospital or attending outpatients. The aim is to improve delivery of flu vaccination across all secondary care settings, both in and outpatients. By April 2021, as part of the Primary Care Transformation Programme, no flu vaccinations will be carried out by GPs or GP Practice staff. Improving delivery at point of care for those who are inpatients or frequent outpatient attenders will be an important first step to ensuring a new robust model of delivery of flu vaccinations.

- **Housebound Patients**: the new service over the last 2 years for housebound patients has been very much welcomed by GPs. The current model of using bank staff however is very challenging and a new model is recommended, led by HSCPs.

- **Staff flu vaccination**: The perennial issue of accurate recording of staff flu data remains. For 2018/19, data will include primary location/unit of work. There is a particular need to improve uptake among nursing and midwifery staff

Communication

64. The NHS Lothian Communication Team received funding for a Lothian-wide campaign aimed at the general public to signpost people to the most suitable

service for their health and social care needs. This involved printed communications, social media and advertising on Lothian buses. In addition to this many other groups and organisations, for example the Scottish Government and NHS24, were communicating winter messages.

65. The Partnership's communications for Winter 2017/18 focused on:

- Communicating with staff to provide advice to support service users
- Supporting the NHS Lothian public campaign, particularly on social media
- Supporting the NHS Lothian flu vaccine campaign for frontline staff

66. In addition to this there was a series of targeted communications to the most vulnerable groups, for example those with long term conditions.

67. The main learning from the 2017/18 communications was that we needed to start communicating earlier and better target key audiences with discreet messages. For Winter 2018/19 we aim to start communicating from week starting 22 October 2018, with a series of targeted communications for:

- High risk/frontline staff about getting the flu vaccine
- Care home staff about the importance of anticipatory care plans
- Social Care Direct staff to allow them to signpost callers to the right service
- Homecare staff on keeping themselves and clients safe and healthy over winter
- Those with long term condition
- Those most at risk of falling
- Unpaid carers

Key risks

68. Key risks include:

- Projects that have demonstrated good outcomes and meet targets will stop if further funding not agreed particularly:
    i. Hospital at Home North East Edinburgh
    ii. CRT+ will be further tested this winter with a view to permanency

- Challenges recruiting required additional staff for only a 12 week period. Some Partnerships are deciding to recruit to permanent contracts.

69. There is a risk that community infrastructure cannot meet demand, resulting in continued reliance on bed- based models, with associated risk to site flow, Emergency Department (ED) crowding and staffing.

70. There is a risk that if high levels of delayed discharge remain, this will impact on system wide flow.

Financial implications

71. A total of £412,000 was awarded to the 7 successful winter bids for EHSCP in 2017/18. Of this, £165,000 was spent by NHS and £95,000 by the Council, leaving an underspend of £152,000, for reasons previously outlined. The surplus was used to fund H@H beyond winter.

72. It is worth noting that the expanded H@H service for North Edinburgh scheme identified in the 2017/18 winter plan is already supported by the EIJB through additional non-recurrent investment in 2018/19.

73. NHS Lothian has been allocated a total of £1.392m for winter 2018/19, a reduction of 30% compared to 2017/18. EHSCP submitted 11 bids totalling £379,698. 8 of these bids were successfully funded to a total of £286,043.

Implications for Directions

74. There are no implications for directions arising from the detail contained within this report.

Equalities implications

75. An integrated impact assessment was undertaken in December 2017 to consider both positive and negative outcomes for people with protected characteristics and other groups. The general findings were very positive. Areas for improvement were unpaid carers and hard to reach groups. It was noted that there has been an impact on staffing due to the Council and NHS staff having different contracts and the ability to pay enhanced rates to incentivise staff to work weekends or public holidays based on different terms and conditions.

Sustainability implications

76. The tests of change over Winter have demonstrated a longer term need for many of the projects, extension of H@H, CRT + and the development of seven day

working across the Hubs are essential for providing effectively and timely interventions within the community and therefore prevented unnecessary hospital admissions.

77. There is a sustainability issue for NE Locality to continue to provide all of the capacity required to support winter planning.

Involving people

78. Winter plans were developed in close consultation with key stakeholders through the EHSCP Winter Planning Group and the planners and operational managers who generated the proposals. It is recognised that earlier engagement with the third sector is appropriate and has not been robust in 2018/19 due to the short lead time for submissions and capacity issues. This has been flagged with NHS Lothian Unscheduled Care Programme Team.

79. A communication plan was 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.

80. 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, people with long-term health conditions, and unpaid carers.

Impact on plans of other parties

81. Winter plans have been developed in very close consultation with relevant parties through the EHSCP Winter Planning Group. This group has membership from acute sites and includes leads for flu, resilience and communications. For 2018/19 this will extend to include third sector.

Background reading/references

82. Scottish Government DL(2017)19 guidance

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Appendices

Appendix 1	Supplementary Checklist of Winter Preparedness: Self-Assessment
Appendix 2	6 Essential Actions
Appendix 3	Ministerial Steering Group Indicators
Appendix 4	EHSCP Winter Weather Resilience Arrangements

Appendix 1

Preparing for Winter 2018/19:
Supplementary Checklist of Winter Preparedness: Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Seasonal Flu**
6. **Respiratory Pathway**
7. **Key Partners / Services**

This checklist supports the strategic priorities for improvement identified by local systems from their review of last winter and includes other areas of relevance.

This list is not exhaustive and local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

NHS Special Boards should support local health and social care systems to develop their winter plans as appropriate.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups can use these checklists to self-assess the quality of overall winter preparations and to identify where further action may be required. This should link to the guidance available for continual provision of service avaible on the associated web links highlighted on the accompanying paper

- There is no requirement for these checklists to be submitted to the Scottish Government.

- The following RAG status definitions are offered as a guide to help you evaluate the status of your overall winter preparedness.

RAG Status	Definition	Action Required
Green	Systems / Processes fully in place & tested where appropriate.	Routine Monitoring
Amber	Systems / Processes are in development and will be fully in place by the end of October.	Active Monitoring & Review
Red	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	Resilience Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details.The NHSScotland Standards for Organisational Resilience (2018) sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☐ ☐		
2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios. Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner. The partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	☐ ☐ ☐		
3	The NHS Board and HSCPs have appropriate policies in place that cover: • what staff should do in the event of severe weather hindering access to work, and • how the appropriate travel advice will be communicated to staff and patients • how to access local resources (including voluntary groups) that can support the transport of staff to and from their places of work during periods of severe weather.Policies should be communicated to all staff on a regular basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*	☐		

4	The NHS Board's and HSCPs websites will be used to advise on travel to appointments during severe weather and prospective cancellation of clinics.	☐		
5	The NHS Board, HSCPs and local authority have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☐		
6	The effectiveness of winter plans will be tested with all stakeholders by 30 October The final version of the winter plan has been approved by NHS Board and HSCPs	☐		

2	**Unscheduled / Elective Care Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity. *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		
1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked.	☐		
1.3	A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.* *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*	☐		

1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☐		
2	**Undertake detailed analysis and planning to effectively manage schedule elective and unscheduled activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*	☐		
2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring.* *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.*	☐		

3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge.**			
3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events (e.g.). Hogmanay Street parties on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☐		
3.2	Extra capacity should be scheduled for the 'return to work' days after the festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services. The Monday following the festive weekend breaks should not be routinely used as a day off thereby creating a 5 day weekend.	☐		
3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*	☐		
3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*	☐		

4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge to shift the discharge curve to the left and ensure same rates of discharge over the weekend and public holiday as weekday.**			
4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross)* *Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☐		
4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Pharmacy services should also be avaible to issue timely prescriptions to support discharge. Criteria Led Discharge should be used wherever appropriate. *Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.*	☐		
4.3	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*	☐		

4.4	Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre Christmas discharge *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*	☐		
5	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			
5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.* *Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☐		
5.2	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible. *Paertnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.* *All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible*	☐		
5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*	☐		

5.4	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.*	☐		
6.0	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
6.1	Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		
6.2	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *NHS 24 are leading on the 2018/19 'Be Healthwise This Winter' media campaign, and SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around repeat prescriptions', respiratory hygiene, and norovirus are effectively communicated to the public.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*	☐		

3	Out of Hours Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	The OOH plan covers the full winter period and pays particular attention to the festive period. *This should include an agreed escalation process.* *Have you considered / discussed local processes with NHS 24 on providing pre-prioritised calls during the OOH period?*	☐		
2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☐		
3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☐		
4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*	☐		
5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☐		
6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa	☐		
7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☐		
8	In conjunction with HSCPs, ensure that there is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☐		
9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation*	☐		

	to a particular profession, this should be highlighted.			
10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☐		
11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☐		
12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☐		
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☐		
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☐		
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic plan including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*	☐		

4	Prepare for & Implement Norovirus Outbreak Control Measures *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☐		
2	IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which nursing and care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*	☐		
3	HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.	☐		
4	NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☐		
5	Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☐		
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.	☐		
7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.	☐		

8	NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.*	☐		
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☐		
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *This could include the notification of 'tweets', where appropriate, to help spread key message information. HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.*	☐		
11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message. *This could include HPT supporting schools to have awareness raising prior to norovirus season and the notification of 'tweets', where appropriate, to help spread key message information.*	☐		

5	Seasonal Flu, Staff Protection & Outbreak Resourcing *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	Staff working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients, as recommended in the CMOs seasonal flu vaccination letter due to be published in Aug 2018. *This will be evidenced through end of season vaccine uptake submitted to HPS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.*	☐		
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2018) clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.*	☐		
3	The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required and an agreed protocol is in place with NHS Boards on the use of the contingency stock. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)*	☐		
4	HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Health Protection Scotland and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. HPS produce a weekly influenza bulletin and a*	☐		

	distillate of this is included in the HPS Winter Pressures Bulletin.			
5	Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☐		

6	Respiratory Pathway *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☐		
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☐		
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*	☐		
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☐		
2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).*	☐		
2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or	☐		

	intermediate care team.			
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* https://www.bo.scot.nhs.uk/. *This release estimates an individual's risk of emergency admission.* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☐		
4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			
4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☐ ☐ ☐ ☐		
5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic*	☐		

	notifications such as eKIS, or by patient help cards, message in a bottle etc.			

7	Key Roles / Services		RAG	Further Action/Comments
	Heads of Service	☐		
	Nursing / Medical Consultants	☐		
	Consultants in Dental Public Health	☐		
	AHP Leads	☐		
	Infection Control Managers	☐		
	Managers Responsible for Capacity & Flow	☐		
	Pharmacy Leads	☐		
	Mental Health Leads	☐		
	Business Continuity / Emergency Planning Managers	☐		
	OOH Service Managers	☐		
	GP's	☐		
	NHS 24	☐		
	SAS	☐		
	Territorial NHS Boards	☐		
	Independent Sector	☐		
	Local Authorities	☐		
	Integration Joint Boards	☐		
	Strategic Co-ordination Group	☐		
	Third Sector	☐		
	SG Health & Social Care Directorate	☐		

Appendix 2

Winter Planning Prioritisation Scoring
5. Significant level of delivery against criteria 4. Substantial level of delivery against criteria 3. Moderate level of delivery against criteria 2. Minimal level of delivery against criteria 1. Insignificant level of delivery against criteria

EA1	Max points 5	EA2	Max points 5	EA3	Max points 5	EA4	Max points 5	EA5	Max points 5	EA6	Max points 5
General Definition		**General Definition**		**General Definition**		**General Definition**		**General Definition**		**General Definition**	
Clinically Focused and Empowered Management		**Hospital Capacity and Patient Flow Realignment**		**Patient Rather than Bed Management**		**Medical and Surgical Processes Arranged to Pull Patients from ED**		**7 Day Services**		**Ensuring Patients are Cared for in their own Home**	
Aims		**Aims**		**Aims**		**Aims**		**Aims**		**Aims**	
Quadrumvirate Management		Basic Building Blocks Analysis		Patient Tracking through System		Triage to Appropriate Assessment		Smooth Variation in Services		Redirections/Know who to Turn to.	
Clinical Leadership		Bed Planning Toolkit		Admission/Discharge Prediction		Flow through to ED		Surgical Emergency and Elective Services		Shift Emergency to Urgent	
Escalation		Workforce Capacity Toolkit		Balance Capacity and Demand		Access to Senior Decision Maker		Access to Diagnostics/Intervention		Short Stay Assessment/Avoid Admission	
Safety, Flow Huddles		Performance Toolkit		Daily Dynamic Discharge		Access to Assessment/Diagnostics		GP/OOH Support		Discharge When Fit and Ready	

MSG 1	Max points 5	MSG 2	Max points 5	MSG 3	Max points 5	MSG 4	Max points 5	MSG 5	Max points 5	MSG 6	Max points 5
Accident and Emergency		**Unscheduled Admissions**		**Occupied Bed Days**		**Delayed Discharges**		**The balance of spend across in community or institutional setting**		**End of Life Care**	

Appendix 3 – Ministerial Steering Group Indicators

Objectives and Action Plan Table

MSG Improvement Objectives – summary of objectives for Adults and Children

Source of all baseline data: SOURCE (November 2017 update – see footnote for location)

<insert Partnership name>	Unplanned admissions	Unplanned bed days[1]	A&E attendances	Delayed discharge bed days	Last 6 months of life (% in a large hospital)	Balance of Care (% in a large hospital)
Baseline for EH&SCP	All ages via SOURCE data (Q1 2015-16 onwards), Edinburgh ranks consistently among the lowest (i.e. best performing) 3 Partnerships Scotland	Median for 2016-17 a) Acute: 28,890 per month b) MH: 35, 987per quarter c) GLS: 5,609 per quarter	Median for 2016-17: 11,663 per month	Median for 2017/18 – 5,985 per month (based on data from April – December 2017)	13.5%	**2015-16** 2% large hospital
Objective	**For 2018-19** The objective is to maintain current levels (as performance is	**For 2018-19** a) Acute: 1% reduction (equates to 289 ~10 beds)	**For 2018-19** Reduce attendance level by 1% (116 per month) to support	**For 2018-19** Reduced reportable delayed discharge bed days by 5%.	**For 2018-19** Reduce the percentage of time in the last 6 months of life in a	**For 2018-19** Progress towards Scottish median level: 1.6% for 2015-16

[1] G:\HSC\HSC-HQ\H&SC File Plan\Strategic Policy & Perf\R&I - Team\Information & Reporting\Joint Performance Reporting\Integration Local Improvement Plans 2017-18\Phase 2 Jan 2018 on\MSG Targets LIST Jan 18

	comparatively good).	b) MH: 1% reduction (equates to 360/quarter ~ 4 beds c) GLS: 1% reduction (equates to 112 bed days/quarter ~ 1 bed	pressure on staff and improve performance against 4 hour target	This equates to 261 bed days per month, which would free up 8.7 beds.	large hospital from 13.5% to 12.5% This is the equivalent to a reduction of circa 7,500 (7,484) Bed Days Saved	
How will it be achieved	Due to population increase, a number of actions will be taken to ensure the unscheduled admission rate remains at current levels: a) Locality Hubs will identify people at risk of admission to hospital and provide short-term intensive support at home b) The Partnership will continue to	a) Community respiratory team (winter initiative) b) Development of intermediate care facilities and provision in Edinburgh City c) Increase in grade 4 and 5 provision by 2020 (Mental Health draft outline strategic commissioning plan, Jan 2018)	a) Extend Pan-Lothian Admission Avoidance Network which is being tested in two GP clusters in North Edinburgh b) Continue to support a range of multi disciplinary preventative services and initiatives – explored in Locality Improvement plans	a) Increase the capacity of care home places in the city by flexibly using resources as they are available. This additional capacity could be used to provide respite or emergency placements as an alternative to hospital admission, or as interim care home placements. b) Review of the	a) Working with City of Edinburgh Council and NHS Lothian, EH&SCP will produce a local palliative care strategy in response to the National Framework and Commitments. b) EH&SCP will also liaise with Mid, East and West Lothian Partnerships primarily through the Lothian	a) Support the development and implementation of the Older People's Strategic Commissioning Plan b) Support the development and implementation of the Mental Health Strategic Commissioning Plan c) Prevention of illness, addressing

	support the Integrated Older People's Service (Hospital at Home) to prevent emergency admissions c) Winter range of initiatives including: - enhanced community respiratory team - enhanced Hub activity via weekend support; Extending hospital at home to NE; care home liaison d) GP initiatives such as anticipatory care planning and workforce modelling	d) Alignment of care home capacity with demand, which will include a supply and demand analysis e) The range of actions to support the reduction of delayed discharges will contribute f) Mental Health – support the development and implementation of the Mental Health Strategic Commissioning Plan g) Older people – support the development and	c) Continue to support preventative initiatives outlined in the Edinburgh Health and Social Care Improvement Plan. Including the expansion of the Telecare programme. d) Exploration of opportunities to work with SAS and GPs by looking at admission rate of those who have arrived by ambulance e) Continuation of the development of the falls service f) Support the development and	Care at Home contract for older people to ensure it is able to meet demand c) Continued embedding of the Service Matching Unit in localities to work flexibly with providers to meet demand d) Ensure that conversations take place on wards that means that patients and families are aware of the choices they are making that they are realistic, risk appropriate, consider Self Directed Support options and	Palliative Care MCN in support of this work c) We are also working with ISD/ LIST colleagues to get a better appreciation of the data (and data collection processes) in order to better understand where the most impact may lie and the extend to how any improvement can be best captured. This should support more robust actions and plans going forward.	inequalities despite increase in population, ageing population and increasing co morbidity

	e) The partnership will support hospital based initiatives to support more planned admissions such as rapid access respiratory clinics	implementation of the Older People's Strategic Commissioning Plan	implementation of the Older People's Strategic Commissioning Plan	include moving on policy conversations. e) Support the development and implementation of the Older People's Strategic Commissioning Plan		

Appendix 4

Briefing Note

Winter Weather Resilience Arrangements

IJB Winter Weather Report Inclusion

27 August 2018

Executive Summary

1. This report includes an update on the Edinburgh Health and Social Care Partnership's (the Partnership) overarching resilience arrangements.
2. Following early March 2018 'Beast from the East' winter weather incident, the Partnership's resilience arrangements have significantly changed to better support its services.
3. In May 2018, the Edinburgh Integration Joint Board (IJB) approved the Partnership's Overarching Resilience Arrangements. Its strategic approach provides a framework for the organisation to continue the delivery of services during any incident (including winter) that could potentially have an impact on the loss of premises, ICT, staff or key suppliers, it is designed to be flexible. This will improve the Partnership's resilience against an incident disruption and improve its ability to recover from any such disruption while protecting the welfare and safety of both service users and staff.
4. Operational teams are currently finalising their own resilience plan for Executive Management Team sign off by the end of October 2018.

Background

5. The short but eventful winter episode 'Beast from the East' of severe snow and icy conditions of 28 February to 4 March 2018 created a unique opportunity to introspectively look at incident readiness and response through a live case analysis.
6. Resulting debriefs were very well attended with an unprecedented high level of engagement from various service managers and staff across the Partnership. As a result, the Partnership's Overarching Resilience Arrangements benefited from the direct input of staff feedback based on the principles of 'what had gone well' and 'what needed improvement'
7. Table 1 was shared with NHS Lothian and the Council's Resilience Teams. It summarises the extreme winter weather briefing session's lessons learned which in turn has helped the Partnership understand its frontline/operational points of view, recognise good practice and improve its response to similar incidents.

Table 1:

What were the main impacts of the extreme weather from 28 February to 4 March on your service area?
1. Transport – Dangerous conditions and the decision to close down public transport affected the ability for essential staff (eg. Home Care, Care Home and District Nursing, Social Care Direct staff, etc.) to get to and from work safely.
2. Service Users Welfare – Large Scale effort to prioritise and ensure that vulnerable service users were adequately taken care of.
3. Staff Welfare – Large scale effort to secure taxis or 4x4s for operational staff. Resilience and Senior Mgmt Teams had to find alternative modes of transports which included Council 4x4s, Charitable Organisations, Police Scotland and contract taxis.
4. Communications – with managers unable to physically attend a central control room, most top level/central coordination effort were made virtually.
Considering our responses:
What went well?
1. Staff good will, essential services were run and delivered with no adverse impact to service users.
2. Coordination effort with Council and other business partners – Resilience team, Roads, Parks, Police Scotland and Lothian 4x4. They provided much needed chauffeured 4x4 assistance for harder to reach areas where taxis were unable to attend.
3. Teleconference capability – created a for virtual control room for senior managers to discuss and escalate issues, secure transport assistance and plan for the next day.
What did not go well? Or could be done differently?
1. Clear Partnership Incident Management Structure in place. Once amber warning was announced, and incident management group should have met to discuss contingency arrangements, available resources/alternative ways of service delivery, etc. Need to finalise Plan, Business Impact Assessments, control room, etc.
2. Essential Services – Clarity needed on which services, tasks and roles are essential for the Partnership. Corporate message was too generic and caused confusion.
5. Communications –The use of teleconferencing, emails and mobile working worked well for the most part, not all teams felt included or connected to the wider Partnership strategy. They were receiving separate corporate message from the Council and NHS Lothian. Better overarching Partnership comms plan needs to be developed.

3. Scottish Government – Although the Council had secured a memorandum of understanding with Lothian 4x4 and other charitable organisations for the use of chauffeured 4x4, the Scottish Government had taken over control of this asset. When arrangements had been booked for staff to be collected on Friday morning by Lothian 4x4, SG had pulled away the vehicles at short notice (7am) leaving staff stranded and giving resilience/Senior Management Teams less than 30minutes to secure taxis or alternative transport arrangements.
Which issues need to be explored more fully?
1. Partnership Incident Management Structure and Operational Plans with clearly defined roles (with deputies) – these are currently in development.
2. Essential services mapping – What services take priority, how will they be supported, alternative ways of working, etc.
3. Transport: Mapping of 4x4 assets (Partnership, Council, NHS Lothian, Police Vans, etc.) and Drivers available. Snow tyres for Partnership fleet. Better contract arrangements with taxis – priority allocation given to Partnership requests during an incident
4. Comms plan – Centrally controlled messages from the Partnership.

Main report

8. The IJB approved the Partnership's Tactical Resilience Plan on 18 May 2018. The plan's framework is designed to be flexible so that it can address risks and safety issues while promoting cooperation across multi-organisations, which is vital but a difficult management challenge – especially during extreme weather events.
9. Overall staff awareness was increased by this year's severe winter weather and managers have since gained a stronger understanding of where risks lie and where business continuity management is integral.
10. The Partnership is now clear on the formation of its Incident Management Team – roles, decision making and giving of directions. Formal arrangements for secure 'virtual' control rooms (teleconference) are also now in place. On amber/red alert (winter weather) announcement – the Partnership's Resilience Lead and/or Chief Officer will likely request an immediate Partnership Incident Management Team meeting to discuss winter weather resilience arrangements.
11. Localities are currently finalising their Business Impact Assessments to identify their essential services (and corresponding service business continuity plans).This will aid the Partnership's Incident Management Team's decision-making process on where to allocate resources (such as staff and transport) in the event of a winter weather incident.

Next Steps

12. Throughout Autumn, a series of staff workshop and communications announcements will also occur to raise staff awareness of winter planning.
13. Localities and Operational Teams' Resilience Plans are currently being finalised. It is anticipated that the Partnership's Executive Management Team will sign off the plans by the end of October 2018.

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