Item 6.1

Report

Evaluation of 2018/19 Winter Plan

Edinburgh Integration Joint Board

21 June 2019

Executive Summary

1. Scottish Government DL (2017)19 guidance on Preparing for Winter 2017/18 is the most recent government circular outlining the requirement for Health and Social Care Partnerships to produce an action plan to ensure health and social care services are well prepared for winter. Further to this Jeane Freeman, the Cabinet Secretary for Health & Sport, wrote to the Chairs of Health & Social Care Partnerships on 31 August 2018 regarding preparing for Winter 2018/19.

2. The winter plan 2018/19 was outlined at the IJB meeting on 28 September 2018.

3. This report and its appendices provide an overview of the suite of winter planning actions and services, and an evaluation of the impact of each. In addition, this year, the plan sets this in the context of the Partnership's performance for key performance indicators, compared to last winter.

4. Winter Planning for 2019/20 has commenced. The Partnership has a deferred surplus of £122,600 to enable earlier implementation of priority services that align with our strategic intent.

Recommendations

5. The Edinburgh Integration Joint Board is asked to:

    - Note the Local Review of Winter 2018/19 Report, the full version of which is included in Appendix 1

    - Support the strategic intention to expand, on a phased basis, the successful Discharge to Assess model across the City. Initially, to the whole of the North of the City, to align with Home First and the Edinburgh offer

    - Note that work is underway with regards to defining our key local priorities for Winter 2019/20. Our top priority will be to support a non-bed based

model to ensure that Ward 15 (Western General Hospital) or an equivalent is not required

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. This year, prioritisation of proposals was geared towards those that could demonstrate the greatest impact on the Scottish Government 6 Essential Actions and the Ministerial Steering Group indicators.

8. The Cabinet Secretary's letter of 31 August 2018 confirmed the amount that NHS Lothian was allocated for 2018/19 and instructed Health Boards and IJBs to use this allocation to specifically target the delivery of 3 priorities:

    - Demanding local improvement trajectories for weekend discharge rates to be agreed by the end of November 2018
    - 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; including clinical staff, pharmacists, AHPs, auxiliary and domestic staff

9. The letter requested that Winter Plans were submitted by the end of October 2018. A supplementary checklist of winter preparedness: self assessment was included for completion. A copy of this is available on request.

10. Scottish Government then wrote to HSCPs a second time, on 16 October 2018, requesting that all winter plans meet the following criteria:

    - Include an Executive Summary setting out key actions that are being taken to help prepare for this winter
    - Include a table setting out what additional capacity/resource will be purchased as a result of your total winter allocation
    - Clearly set out planned actions which will avoid unnecessary admissions;
    - Include a commitment to establish clear improvement trajectories for weekend and earlier in the diary discharges as set out in the Cabinet Secretary's letter of 31 August

- Include a commitment to maximising elective theatre capacity over the winter/festive period including day cases to ensure that elective performance is not adversely impacted during the winter period

11. A copy of the EHSCP Winter Plan for 2018/19 is attached at Appendix 2, along with the EHSCP response to the Government's letter of 16 October at Appendix 3.

12. The EHSCP Winter Planning Group, which includes multi-agency and multi-disciplinary representation, led on the planning and evaluation of the Winter Plans. Monthly meetings were held in the lead up to and throughout Winter 2018/19.

Main report

13. A total of 9 bids were funded for EHSCP. These were:

- Festive Services
  - Festive Public Holiday Enhanced Primary Care Service Model for City, operational on 30 December, 1 January and 2 January, providing a service to 119 patients
  - Festive Public Holiday Cover by Allied Health Professionals in Astley Ainslie and Liberton Hospitals, ensuring that Occupational Therapists and Physiotherapists maintained rehabilitation programmes to support flow
  - Psychotherapeutic support for carers (VOCAL): provided targeted support for 7 very vulnerable people who might otherwise have requested or sought support from statutory services
- Other Services
  - Liberton Hospital Clinical Support Workers provided a transdisciplinary role and enhanced the multidisciplinary team by supporting the delivery of prescribed rehabilitation programmes and liaising with family members over weekends
  - Enhancement of Community Respiratory Team (CRT+) provided a specialist community based service for 47 people with acute respiratory infection who might otherwise have been admitted to hospital; 90% of admissions prevented
  - Enhanced Hub Services working with Weekend Home Care Coordinators provided additional social work capacity for rapid assessment and turnaround, a consistent service for urgent

prevention of admissions and facilitated 37 discharges over the weekends in winter including 12 Sunday discharges

- Discharge to Assess: supported 36 people to go home 3 days earlier than would otherwise have been possible, to be assessed at home and continue their rehabilitation with OT and PT input outwith a hospital environment

- Rapid Telecare Provision: by extending hours of operation and aligning to winter teams was able to provide 19 clients with a service either preventing or facilitating a discharge

14. The Scottish Government Winter Debrief template was released on 11 April 2019 for boards to complete. The Partnership provided comprehensive details of actions taken, and commentary on what went well and what could have gone better, under each of the following headings:

    - Clear alignment between hospital, primary and social care
    - Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods
    - Local systems to have detailed demand and capacity projections to inform their planning assumptions
    - Maximise elective activity over winter – including protecting same day surgery capacity
    - Escalation plans tested with partners
    - Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings
    - Delivering seasonal flu vaccination to public and staff
    - Top Five Local Priorities for Winter Planning 2019/20

15. In addition, the Partnership included:

    - Third Sector Services
    - Data comparing 2017/18 to 2018/19
    - Winter funding breakdown

16. The full report is detailed in Appendix 1; highlights of the service outputs have been detailed in 13. Other key performance metrics of note are:

- Delayed discharges reduced from an average of 212 to 152.
- The numbers of people awaiting commencement of and completion of hospital social work assessments reduced from 44 to 23
- A&E attendances and unscheduled admissions significantly reduced in December
- Occupied bed day rates remained very similar to 2017/18 and would have significantly improved were it not for AWI bed days increasing
- The number of people delayed in hospital due to waiting for a package of care has reduced and continues on a downward trend. There is no comparative data from last year
- The number of weekend discharges increased from 32 to 44, a 28% improvement

Flu Vaccinations

17. Staff flu vaccination clinics were well advertised on both CEC/NHS Intranet systems, and staff were invited to attend any clinic on a number of sites and locations across Edinburgh and the Lothians to be vaccinated.

18. Support for care homes was provided from the vaccination team and district nursing teams offered vaccinations to carers when appropriate.

19. NHS Staff Uptake rates: This year 17,270 vaccines were issued. Of the total 11,916 completed consent forms returned by mid-March, 1395 were for non NHS staff (mainly council staff and some volunteers). It is therefore estimated 17,270 – 1395 = **15875** vaccines were used for NHS staff. With a head count of 26,485 this gives an uptake of **60%** among NHS staff. For Local council social care staff, 585 consent forms were returned for Edinburgh. This shows an increase of **8.9%,** from **51.1**% last year. Edinburgh is now rated as 3rd top mainland Board.

20. As a result of a concern raised at the September 2018 IJB meeting by one of its members, guidance was included on NHS Inform for the first time around eligibility criteria for flu vaccinations for young and unpaid carers.

Festive Staffing Cover

21. A spreadsheet was developed mapping the annual leave arrangements during the 2 week festive period for all managers and team leads in the 4 EHSCP localities, hospital and hosted services, and the Executive Management Team. This provided a quick reference tool for cover arrangements and points of contact in each service. Managers and Team Leads were also asked to provide assurance about the level of staffing in place throughout this period, particularly on the weekends and public holidays.

Winter Weather Resilience Arrangements

22. A Severe Weather Planning Group was created to coordinate severe weather response between the Council, NHS Lothian and the Partnership by pulling together resources (where possible) and by sharing information in order to effectively manage resilience operations. Key principles were agreed involving escalation protocols, key contacts and transport sharing arrangements via a 'Transport Hub', and 4x4s were made available in localities.

Communications for Winter 2018/19

23. The Partnership focused on:

    - Communicating with staff to provide advice to support service users
    - Supporting the NHS Lothian flu vaccine campaign for frontline staff, particularly on social media and through the various newsletters
    - Communicating with key audiences, particularly vulnerable groups, with specific information

24. The main learning from the 2017/18 communications was that we needed to start communicating earlier and better target key audiences with discreet messages. Winter 2018/19 communications therefore started from 8 October 2018, with a series of targeted communications for:

    - High risk/frontline staff about getting the flu vaccine
    - Care home staff and GP Practices
    - Homecare staff on keeping themselves and clients safe and healthy over winter
    - Those with long term conditions
    - Those most at risk of falling
    - Unpaid carers

Key risks

25. There is a risk that without any additional winter bed base our community infrastructure may not meet demand if there is a particularly challenging winter in 2019/20.

26. Ability to recruit the best candidates for Discharge to Assess if posts are fixed term.

Financial implications

27. The Partnership received a total allocation of £385,660, £263,060 was committed and £122,600 has been deferred. A full breakdown is attached at Appendix 4.

28. It is intended to utilise the deferred amount to enable pre-winter implementation of the North East/North West Discharge to Assess model as detailed in recommendation 3 (ii).

Implications for Directions

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

Equalities implications

30. An integrated impact assessment was undertaken in December 2017 to consider both the 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. Winter 2018 has seen an improvement in support for unpaid carers.

Sustainability implications

31. The Discharge to Assess test of change over winter has demonstrated a clear need for sustainability and spread of this model of delivery to align with the Home First plan.

32. Recent Day of Care audits have further evidenced the opportunity that exists for earlier discharge for home based rehabilitation.

Involving people

33. Winter plans were developed in close consultation with key stakeholders through the NHS Lothian Unscheduled Care Committee, the EHSCP Winter Planning Group and the planners and operational managers who generated the proposals.

34. 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 were aware of the services available over the festive period and how to access these.

35. The key target groups were 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

36. Winter plans have been developed in very close consultation with relevant parties through the NHS Lothian Unscheduled Care Committee and the EHSCP Winter Planning Group. This group has membership from acute sites, Social Care Direct, and includes leads for flu, carers, resilience, ATEC 24 and communications.

Background reading/references

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Appendices

Appendix 1	Local Review of Winter 2018/19
Appendix 2	EHSCP Winter Plan for 2018/19
Appendix 3	EHSCP Response to Scottish Government
Appendix 4	Financial Breakdown

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

NHS Board, HSCPs:	Edinburgh Health and Social Care Partnership	Winter Planning Executive Lead:	Angela Lindsay (NE Locality Manager)

Introduction

As in previous years, to continue to improve winter planning across Health & Social Care we are asking local systems to lodge a draft of their winter review for 2018/19 with the Scottish Government to support winter planning preparations for 2019/20.

Local reviews should have senior joint sign-off reflecting local governance arrangements.

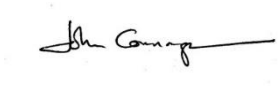
We expect that your Chairs and Chief Executives are fully engaged in the review.

We expect this year's local review to include:

- the named executive leading on winter across the local system who will produce the local plan for 2019/20
- key learning points and planned actions
- top 5 local priorities that you intend to address in the 2019/20 winter planning process

Thank you for your continuing support.

JOHN CONNAGHAN CBE



Chief Performance Officer, NHSScotland
and Director of Delivery and Resilience

1 Clear alignment between hospital, primary and social care

- The Discharge to Assess (D2A) pilot was established this winter as it is recognised, for older people in particular, that longer stays in an acute hospital environment can lead to worse health outcomes and increase their long term care needs. One of NHS Lothian's strategic aims is to put in place robust services to support the delivery of integrated care and support patients who have had an unscheduled care episode to be optimally cared for, or discharged to their own home. Similarly, the Edinburgh HSCP has a commitment to people being home first and assessed in their own environment. D2A is one model that can support health and social care systems to achieve this. The model aims to support safe patient discharge to people's own homes, wherever possible, for assessment. The service is a good local example of a successful move to shift care out of hospitals, reduce or shorten admission rates and support effective patient centred care.
- The community respiratory team plus (CRT+) is an enhanced service re-introduced over the December 2018 – March 2019 winter period. The second year of the service was aimed at providing community specialist respiratory physiotherapy assessment and treatment for patients with acute respiratory infections. As there continues to be an increased demand on existing community services, similar to the test-of-change model, the main objectives of CRT+ were to provide support to primary care services and prevent admissions or where applicable readmission to secondary care.
- The Partnership's Telecare Service (ATEC 24) delivered a rapid Telecare service, on an extended 7-day enhanced basis between the hours of 09:00 – 19:00, aligning with other frontline direct care and support services as part of the Winter Planning programme. The service focused on the rapid set-up of Telecare services for individuals, prioritising avoidance of acute admission and facilitating timely hospital discharge. Individuals were then supported at home with the wrap-around provision of the Telecare monitoring and response service.

1.1 What went well?

- Outcomes of the Discharge to Assess project highlighted that of the 43 patients who were referred to the project, 36 were accepted. 78% of those discharged were seen within the defined timescales. Of those not seen, 8% were not seen within timescales at the patient [or their family's] request and 14% due to capacity within the team. The pilot improved patient outcomes by supporting patients medically fit for discharge to cope independently in their own home. The speed of discharge was only possible due to the additional capacity which anecdotally also supported system flow within the hub. The principles support rehabilitation continuing outside the hospital environment with an average of **3 bed day** savings per patient. Potential cost savings were captured with the potential for longer term costs savings through reduction of provision of care needs.
- The CRT+ service ran from 17/12/18 – 31/03/19 and offered community patients respiratory assessment, treatment and management from specialist physiotherapists embedded in CRT. Sources of referrals were primarily GPs but also Secondary Care. During the service period, **53 referrals** were received and 47 were appropriate; 35 of these were deemed at risk of hospital admission (74.5%). The service successfully supported a prevention of admission of 91.43% at 48 hours and 90.63% at 7 days.

- Telecare installation of equipment - In total, **19 clients** were provided with a rapid service preventing or facilitating hospital discharge. 11 Clients were able to be discharged sooner and 8 clients had a hospital admission prevented.

1.2 What could have gone better?

- Discharge to Assess pilot could only allow for 6 new people per week and where demand exceeded that level then service level agreements were impacted on. It was always recognised that any annual leave and unplanned absence within the D2A team, without the capacity to backfill, would impact on the ability to meet agreed timescales. In addition, staff employed in the pilot had other non-clinical responsibilities such as attendance at city wide meetings and supervision of other staff which also had an impact on available capacity.
- Some challenges which the CRT+ team experienced consisted of initial minor computing issues (TRAKCare access to caseload), which proved problematic especially in the first week of joining the service, for example there was quite some time spent contacting e-Health (85050) and subsequently waiting on response to resolve the issue. After an assessment and treatment plan was provided for patients, we found some returning to their GP (telephone call or face to face) for further assessment and treatment of their condition. This was despite patient education and provision of CRT+ contact number. When discussing optimal management of patients who were supported in their hospital discharge there was an assumption and expectation that CRT+ service would have access to specialist respiratory equipment such as suction machines, cough assists devices and lung volume recruitment bags. After looking at other community services which could be appropriate there was a gap in available support for multiple sclerosis patients; Lanfine service, home ventilation team and MS nurse specialist do not support these patients with respiratory complications.
- As the telecare project began later due to extra available funding, the pilot operated for 7 weeks instead of 12. Further significant impacts could have been captured with a longer proposal. The project also struggled to market and promote the service in time for full engagement.

1.3 Key lessons / Actions planned

- For enhanced hub services, use of TEC has been limited despite input from the ATEC 24 team. Further training and input from these teams to encourage referral and use. This will be fed back to the Hub TEC Champions to address.
- For Telecare services, prior to go live date, awareness sessions should be held with a guarantee of staff availability as well as the need for in depth training for staff use of equipment.
- Whilst the limitations of the team size for the Discharge to Assess pilot are accepted, going forward it would worth considering a different/integrated operating model whereby teams are cross skilled to flexibly support across the hub services. This model would allow for variation in demand from the hospital for the D2A service and staff would have the capacity to assist with other hub tasks. This would also provide staff development and potential opportunities. Workforce development requirements would have to be considered should the operational model be adapted. Future considerations will also include incorporation of care at home to the model. This Test of Change used pathway 0 (rehab only).

- Along with having electronic communications sent out prior to beginning the service, there is scope to improve communications with primary and secondary care services to highlight and enhance awareness of the CRT+ service. There also continues to be a need for an Advanced Physiotherapy Practitioner to provide expert respiratory skills/knowledge and support prescribing requirements, this could be explored more fully. The name of the service was occasionally confusing for referrers who are already familiar with the main community respiratory team (CRT). Following the communications email re-sent at the end of January 2019 we received a few referrals meant for CRT in February 2019. Through liaison with other relevant community services we found that the home ventilation team would be able to support patients with neurodegenerative conditions who had ongoing chronic respiratory complications. It could be beneficial to spend some time with this team to build upon professional relationship and familiarity with each service role.

2 Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods

- The Enhanced Hub Services/Home Care Coordinators package provided a consistent service for urgent prevention of admission work and to support discharge. Working to ensure SDS options were fully understood and used where appropriate to widen choice and availability of appropriate care, especially over weekends and during holiday periods.
- The Liberton project recruited Clinical Support Workers to enhance the multi-disciplinary team by providing a trans-disciplinary role working across traditional OT, physio and nursing roles. The post holders were ward based and supported the delivery of the prescribed rehabilitation programmes and acted as a liaison between team members, the patient and their families / carers by ensuring there is a consistent approach to the rehabilitation programme and the key goals and milestones agreed by the MDT are shared.

2.1 What went well?

- Enhanced Hub projects facilitated 37 discharges over the weekends of winter months, including 12 Sunday discharges. Working with a team of Home Care Coordinators has been positive and the support of Enhanced Hub Care (EHC) staff has been very helpful ensuring safe practice. Positive qualitative feedback from discharged patients with care allocated has also been well received, with patients expressing relief to be at home and not having to wait for a Monday discharge. Social work resource has been very valuable in each area in managing workload overall. This was particularly noticeable over the Christmas period into the New Year avoiding a spike or upward trend.
- The Liberton project collected high quality qualitative data provided from staff, patients and relatives and built positive relationships, proving the rehabilitation ethos to be extremely important to all. This project has allowed a focused piece of rehabilitation work to take place, work that needed to be tried and tested and allowed a platform and resources to do so. The work has also enabled continued best practice of communication e.g. introducing and continued use of communication boards and will influence workforce plans going forward within Liberton Hospital.
- Physio @ Home who operate a general weekend service, supported work that CRT+ would have picked up if there had been a 7 day service. Their reply – 'We touched base with CRT+ on Fridays and were able to support with a total of 7 respiratory patients (Jan x2, Feb x3, Mar x2)'.
- In total, winter projects resulted in **44 additional weekend discharges**, compared to 32 during winter months 2017/2018. This represents an increase of **28%** in weekend discharges during 2018/2019.

2.2 What could have gone better?

- For enhanced hub services, a number of discharges were planned and then subsequently cancelled by the hospital. Reasons for this included pharmacy problems, family requests, transport issues, as well as people becoming progressively unwell.
- The Liberton project had originally aimed to recruit to Assistant Practitioners but, following a series of focus groups, it was felt that an additional Band 2 on the ward would be the best utilisation of winter resource to deliver enhanced rehab and better care

2.3 Key lessons / Actions planned

- For Enhanced Hub and Social Work Services, further input to both WGH and RIE sites is needed to ensure that wards are aware that weekend discharges are possible at weekends and holiday periods. Home Care Coordinators who's usual days of work are Mon – Fri expressed a relief at knowing the work that was required for safe discharge and personal planning was done allowing them to plan other discharges and care packages for the following week. There also needs to be a launch or continued work to build trust and change attitudes towards using weekend services. This work should include weekend planning on acute sites for those who are also ready to discharge and work with family to expect discharge. Pharmacy needs to available. Currently discharges are delayed by lack of transport and pharmacy cover.
- Increased capacity of the Discharge to Assess and CRT+ projects to enable effective discharge through weekend and festive periods.
- The Liberton project highlighted the need to use short contracts to employ staff. Although some bank staff were consistent within the wards, a more reliable staffing system would benefit future practice.

3 Local systems to have detailed demand and capacity projections to inform their planning assumptions

- Planning for additional urgent primary care based on lessons learned and demand from last year's Festive Practice
- A spreadsheet was developed mapping the annual leave arrangements during the 2 week festive period for all managers and team leads in the 4 localities, hospital and hosted services, and the Executive Management Team. This provided a quick reference tool for cover arrangements and points of contact in each service. Managers and Team Leads were also asked to provide assurance about the level of staffing in place throughout this period, particularly on the weekends and public holidays.
- Staffing for Liberton and AAH based on flow in previous 2 years.

3.1 What went well?

- Senior and middle grade leaders available throughout the festive period.
- Local arrangements for managed annual leave plans, ensuring bank/agency staff were not being used to provide cover.
- Festive Practice service opened between 9 am and 5pm on 30th December, 1st January and 2nd January were GPs saw a total of 109 patients. A practice nurse worked on 1st and 2nd and saw 5 patients each of these days. The referrals for the Practice Nurse came from Practices that would have required District Nurses to attend to patients requiring a visit. Providing this service saved 10 DN visits over the two days.
- The AHP Public Holiday Cover proposal allowed extra staffing of Occupational Therapy and Physiotherapy in Astley Ainslie and Liberton Hospitals for staff to work on the festive public holidays to ensure rehabilitation therapy programmes are maintained on both sites to support patient flow.
- EHSCP reduced the number of Delayed Discharges from an average of 212 to **152**; reduced the numbers of people awaiting commencement of and completion of hospital social work assessments from 44 to **23**; demonstrated very similar occupied bed day rates to 2017/18 and would have significantly improved were it not for AWI bed days increasing; significantly reduced rates of A&E attendances and unscheduled admission in December and improved Care at Home capacity. (See graphs attached as appendices)

3.2 What could have gone better?

- The festive roster is circulated well in advance of the festive period to enable wide circulation and reach across the partnership.
- Threshold to admission could be reviewed and changed, patients admitted rather than discharged (partly due to overcrowding). EHSCP staff could be present to do assessments of those known to locality rather than admission into the main arc. Focus this on the first few days post Public Holidays.

- It is our view that creating additional capacity in ward 15 created additional delays and reduced the admission threshold.
- A focus on increase of resource to the Partnership rather than focusing on a hospital bed based approach through increasing social work, home care and AHP capacity within winter in EHSCP. This really needs to start in the summer.
- Communication around flow was sometimes unhelpful and lost credibility when daily crisis texts came out re delayed discharge.
- Improved conversations re expectations of what could be delivered in the hospital setting.
- Getting winter guidance from Scottish Government so late in the day, after plans had been formulated.
- Recruitment for backfill for D2A and recruitment for discharge coordinator.

3.3 Key lessons / Actions planned

- If successful next year, the festive practice team would like to build on the Practice Nursing element of the service and increase support to Nursing homes over the PH period.
- Do not open additional capacity in an acute setting as the beds will be filled.
- Increase the resource to Partnerships to set the direction as they have the knowledge to enable the direction, decision and risk around discharge.
- Need to increase homecare capacity to support prevention of admission team/ responsive team, and greater accessibility to GPs.
- Need to increase AHP capacity in the community to support winter planning to enable early pull and the management of risk – including weekends
- AWI plans were rejected at planning stage which led to a significant increase in occupied bed days for this client group. Normal staffing (2 WTE MHO) has now been reinstated by the Partnership.
- Several winter funded plans did not get off the ground due to HR delays (job description) and recruitment for such a short period. This is not new.

4 Maximise elective activity over winter – including protecting same day surgery capacity

4.1 What went well?

N/A

4.2 What could have gone better?

N/A

4.3 Key lessons / Actions planned

N/A

5 Escalation plans tested with partners

5.1 What went well?

- Severe Weather Planning Group was created. The purpose of this Group to coordinate severe weather response between the Council, NHS Lothian and the Partnership by pulling together resources (where possible) and by sharing information in order to effectively manage resilience operations.
- Key principles have been agreed involving escalation protocols, key contacts and transport sharing arrangements via a 'Transport Hub'.
- 4x4s were available in each locality

5.2 What could have gone better?

- The Group is relatively new and did not benefit from a live trial this year due to this year's mild winter.

5.3 Key lessons / Actions planned

- Development and approval of the Group's Terms of Reference
- Test of resources: table top exercise of 'Transport Hub' is to be planned for the Summer.

6 Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings

6.1 What went well?

- No visible increase in rates of norovirus across the partnership.
- Information on closures and outbreaks provided by Public Health.

6.3 Key lessons / Actions planned

- Continued focus and link with escalation plans.

7 Delivering seasonal flu vaccination to public and staff

7.1 What went well?

- Staff clinics were available at many sites and locations across the partnership
- Flu Vaccinations were advertised well on both CEC/NHS Intranet systems
- Support was provided from the vaccination team for care homes
- District nursing teams offered vaccinations to carers when appropriate
- Engagement from political leaders – Getting the message out
- NHS Staff Uptake rates: This year 17,270 vaccines were issued. Of the total 11,916 completed consent forms returned by mid-March (some are still coming back to be counted), 1395 were for non NHS staff (mainly council staff and some volunteers). It is therefore estimated 17,270 – 1395 = 15875 vaccines were used for NHS staff. With a head count of 26,485 this gives an uptake of **60%** among NHS staff. For Local council social care staff, 585 consent forms were returned for Edinburgh. This shows an increase of **8.9%,** from **51.1**% last year. Edinburgh is now rated as 3rd top mainland Board.
- Clear guidance was included on NHS Inform around eligibility criteria for flu vaccinations for young and unpaid carers. This resulted from a concern raised by one of the IJB members at its September meeting about a lack of clarity around eligibility for this group.

7.2 What could have gone better?

- Limited available accurate data to allow a targeted response in areas of low uptake.

7.3 Key lessons / Actions planned

- Accurate available data to support ongoing targeted flu vaccination programme.

8 Third Sector Services

VOCAL – Emotional Support for Carers

VOCAL received funding for a psychotherapeutic support pilot where during November and December Carers Support Staff and the Counselling Team identified carers (from caseloads and waiting lists) for whom the festive season would be particularly challenging and worked with them to develop coping strategies drawing on personal assets and also any services that would be open. Those carers who were not confident of their ability to manage or who faced very specific emotional challenges were offered a phone call from a qualified counsellor during the festive period.

8.1 What went well?

- The Carers Support Team identified 7 carers who would benefit from therapeutic support. These carers were in a wide variety of caring roles and included one carer who had been recently bereaved, one who had experienced a significant change in caring role, and one who has consistently reported feeling isolated and using alcohol as a coping mechanism.
- All carers identified participated in a phone call of between 25 and 60minutes. The majority were for the full 60minutes. These calls were gave the carer a safe space to explore their thoughts and feelings around their caring situation. Phone calls tended to focus on the impact of caring on relationships, feelings of loss, stress and low mood.
- In two incidences the carer identified some information/practical needs which the Counsellor gained permission to pass on to the Carer Support Staff on duty who followed up on these.
- The counsellor also spoke to two of the 14 carers on the telephone who called into the Carers' Hub (following the promotion of our opening hours) both spoke to Carer Support Workers who addressed the carer's information needs and provided a listening ear but identified there was a need for a more intensive input and offered a follow up call by the counsellor.
- The counsellor also spoke to a carer who attended the drop in who was struggling emotionally and had engaged with the crisis centre earlier that morning as she was having suicidal thoughts.

8.2 What could have gone better?/ Key Lessons/ Actions Planned

- A key lesson from the festive support for carers was that this kind of support is very much needed. Those carers who participated in the support highlighted the impact that the support made most notably in terms of addressing emotional and psychotherapic needs, reducing isolation, feeling valued and heard alongside addressing information needs.
- A second key lesson was the need to offer support both in person and over the phone to ensure that the service was accessible to all. The flexibility of the support offered was key to our success reaching vulnerable people at a difficult time.

With a larger amount of funding VOCAL could have had a bigger impact and supported a larger section of the caring population as we were limited by the volume of Therapist time we were able to purchase.

- With larger funding VOCAL would have felt more confident to advertise the support more widely without the risk of over subscription.
- Planning with other third sector colleagues needs to start earlier in the year.

9 Top Five Local Priorities for Winter Planning 2019/20*

1. An early, proactive dialogue with acute partners with regards to what community capacity is required to prevent ward 15 opening in 2019/20.
2. An analysis of AWI bed days and ensuring dedicated senior social workers are in place, as well as learning from the East Lothian model of Guardianship.
3. Roll out of D2A model across the partnership.
4. Care Home Falls initiative
5. Enhanced 'front door'/Hub Services including appropriate weekend cover.

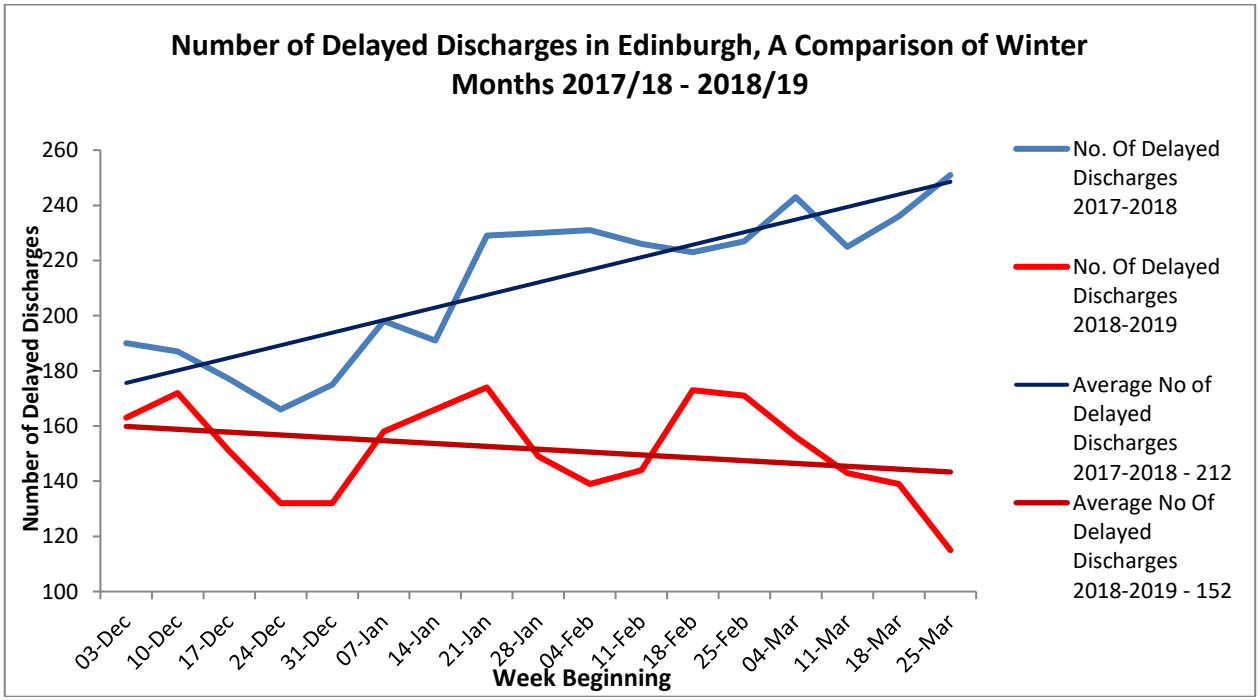
*Top 5 Local priorities are a working discussion, subject to further consultation with Winter Planning Group, Leadership Team and EMT.

10 Data Comparisons from 2017/18 to 2018/19

Figures from winter months (Dec-March) have been analysed for comparisons between 2017/18 to 2018/19 to highlight any significant changes in winter period outputs.

Delayed Discharges –

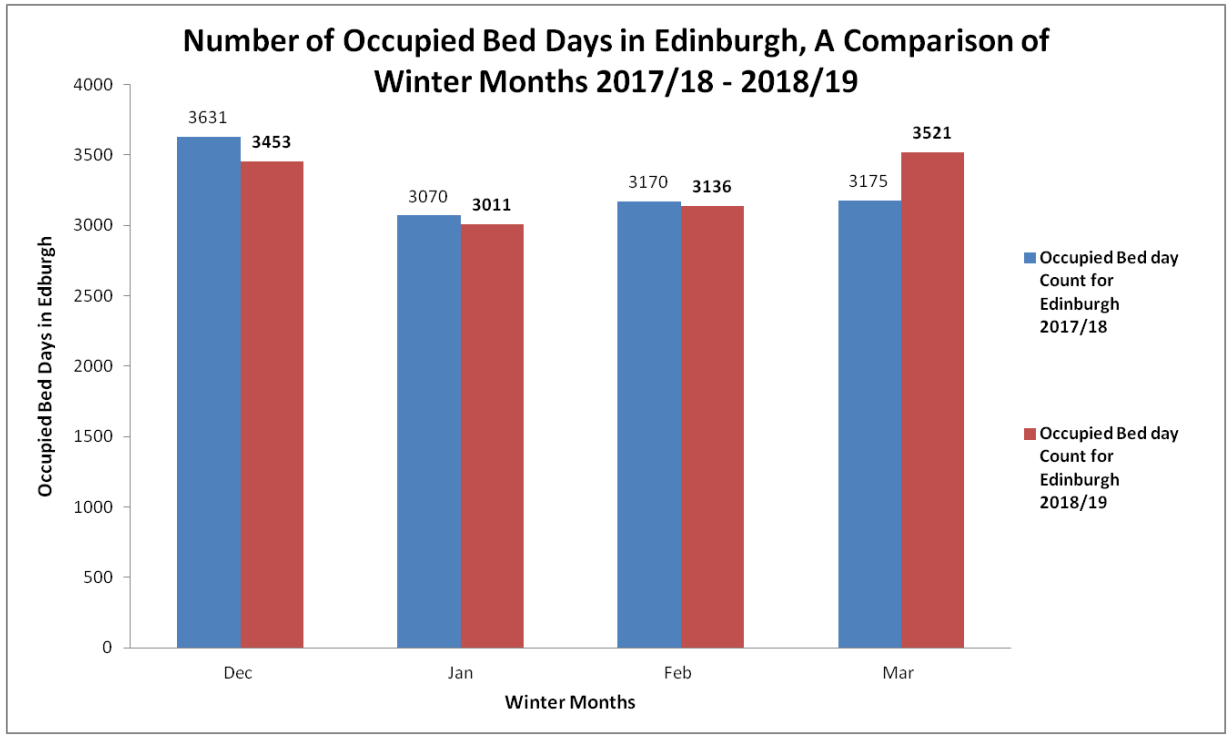
Delayed Discharge figures have been extracted from Hospital Flow Dashboard for Edinburgh correct as of 11/04/2019.



Delayed Discharge figures have been extracted from Hospital Flow Dashboard for Edinburgh correct as of 11/04/2019. As displayed in the graph above, average numbers of Delayed Discharges in Edinburgh have decreased from an average in winter months for 2017/18 of **212** to an average of **152** in 2018/19.

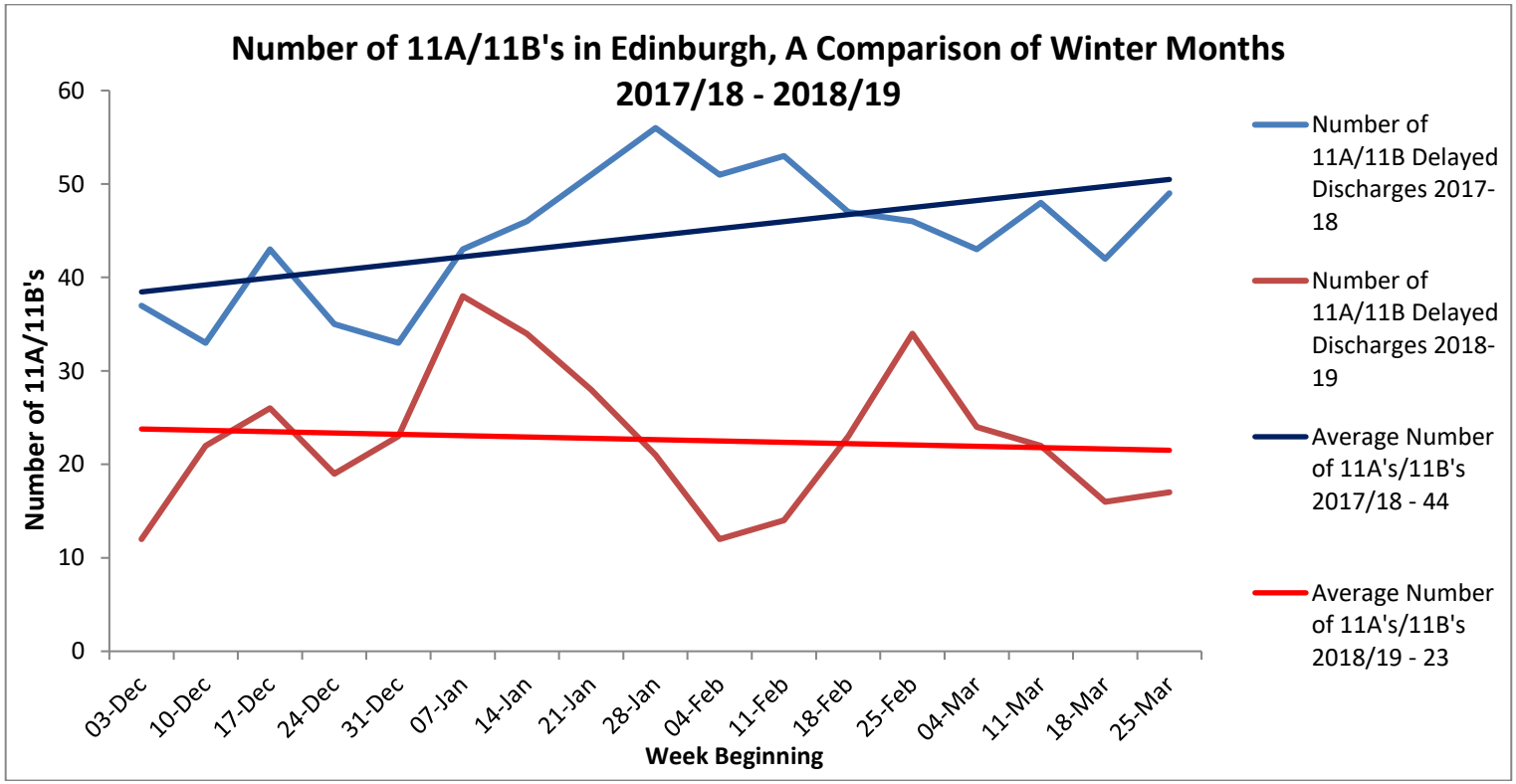
Occupied Bed Days

Occupied Bed Days Figures have been extracted from Hospital Flow Dashboard correct as of 11/04/2019.



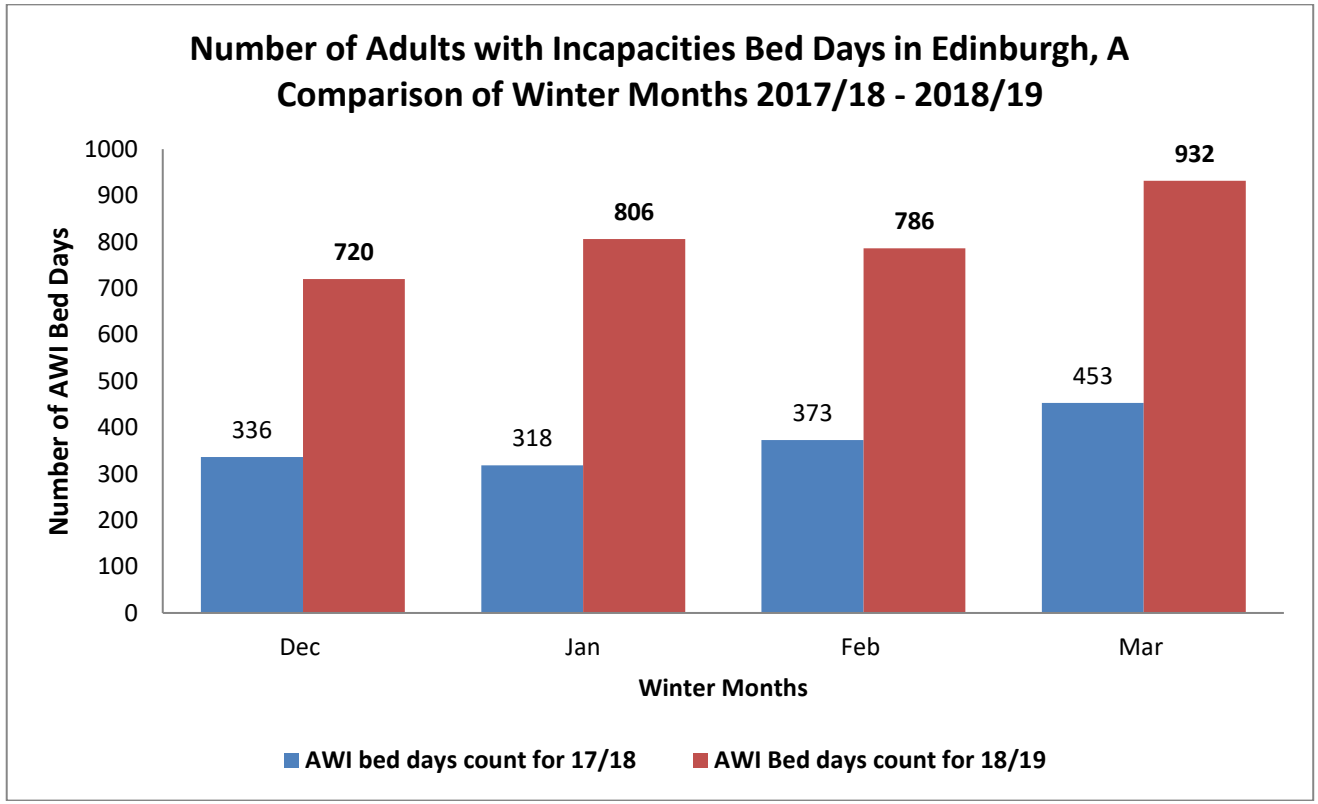
Occupied Bed Days Figures have been extracted from Hospital Flow Dashboard correct as of 11/04/2019. As presented above, similar figures can be seen for winter months 2017/18-2018/19, therefore reflecting the need for more heavily influenced bed day reduction intervention to take place during winter months.

11A's & 11B's –



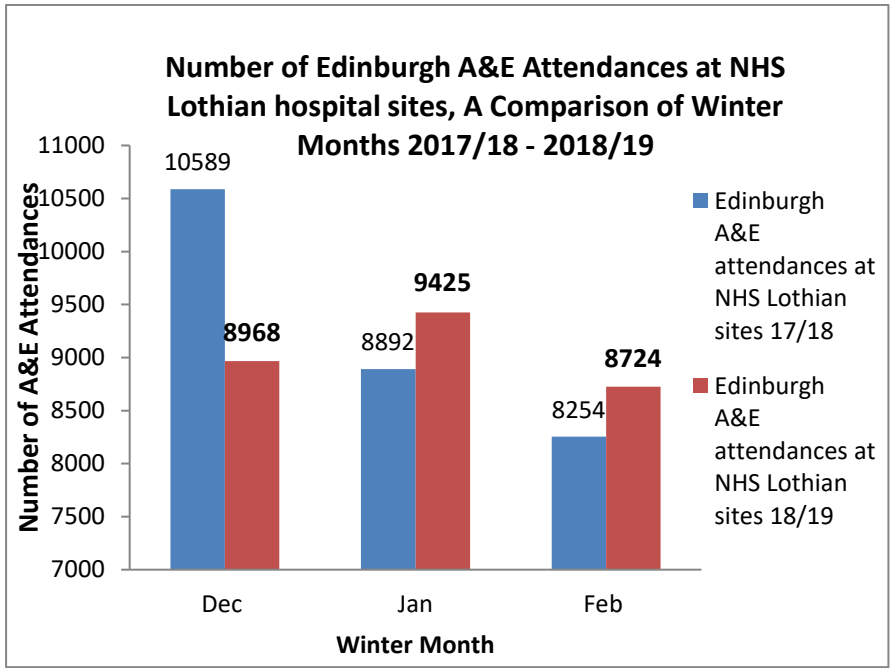
(11A- Number of Patients in Edinburgh awaiting commencement and completion of post – hospital social care assessments (including transfer to another area team), Social Care includes home care and social work occupational therapy). The average number of 11A's/11B's has almost halved from an average figure for winter months in 2017/18 of **44** to an average of **23** in 2018/19. These figures highlight the effectiveness of Social Work enhancement projects during 2018/19, which have delivered the target of reducing unallocated work and the time to allocation.

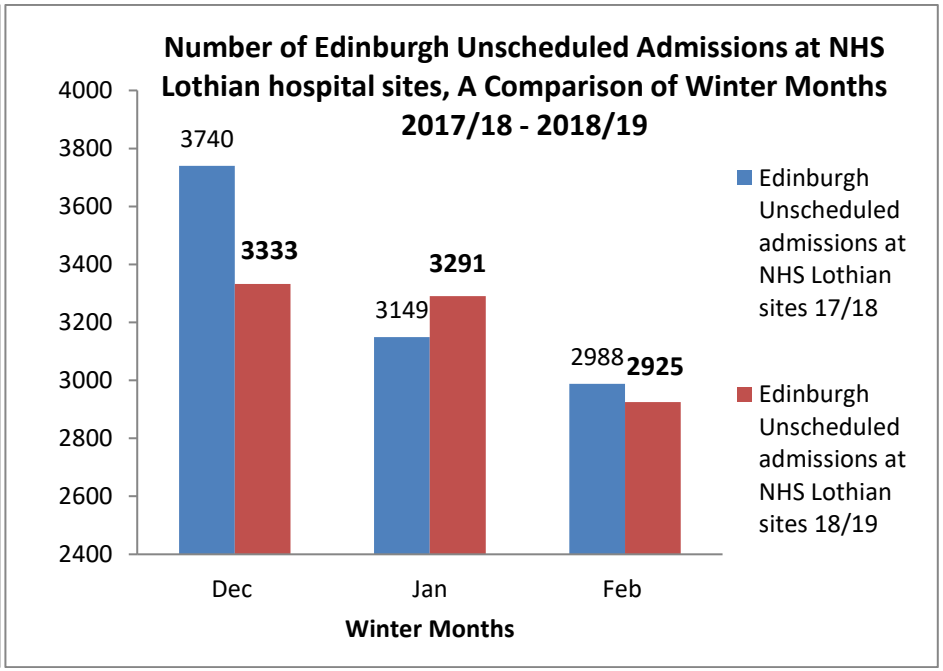
Adults with Incapacities –



The high increase in amount of Adult with Incapacity bed days for winter 2018/19 is due to the lack of two dedicated senior social workers whose job is solely to focus on guardianship for these individuals. Funding for this particular aspect of care was not granted in 2018/19.

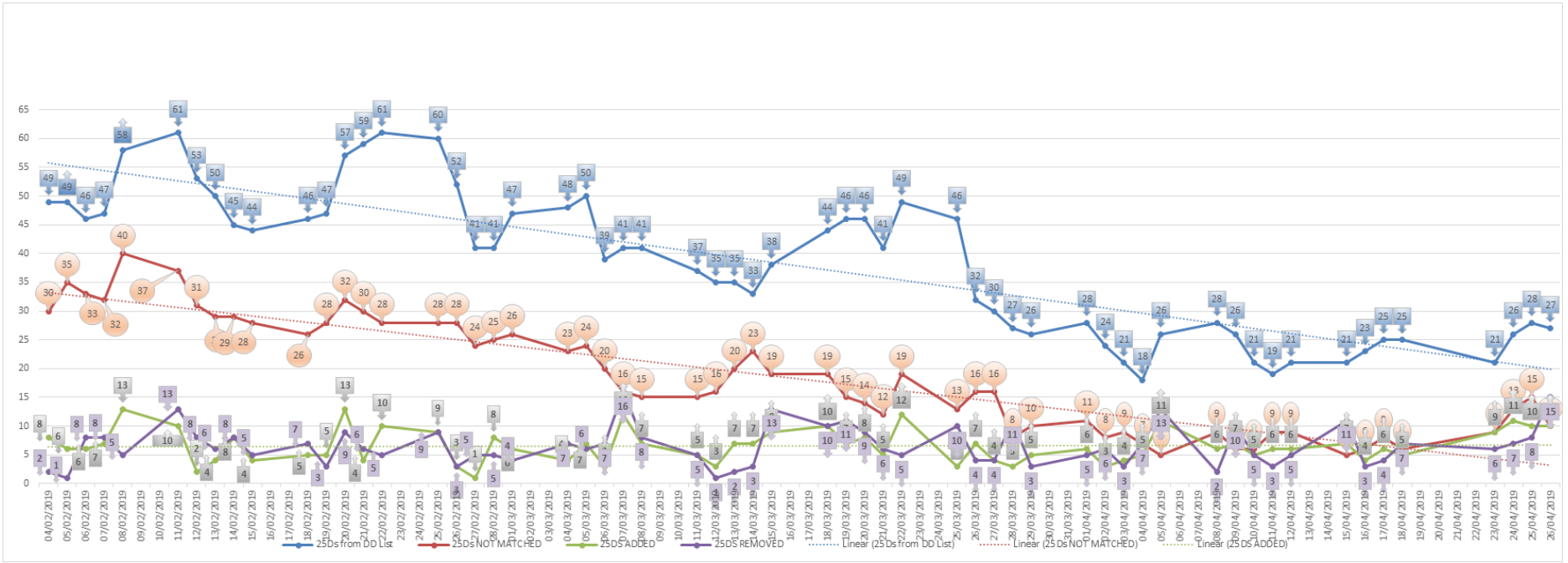
A&E Attendances & Unscheduled Admissions –





Rates of A&E attendances and Unscheduled Admissions for Edinburgh have been produced by NHS Lothian ISD. During December a significant drop can be noted for both A&E attendances and unscheduled admissions. However further analysis highlights some variance but no significant difference in months between 2017/18 and 2018/19.

Care at Home - 25Ds



Comparisons with winter 2018/19 are not available. Data capture commenced in February 2019.

11 Winter Funding 2018/19

	Amount Allocated		Added to Deferals @ Year End		18/19 Spend
Festive Public Holiday Enhanced Primary Care Service Model for the City	36,834		12000		24,834
Liberton Hospital: Assistant Practitioners	34,616		0		34,616
Festive Public Holiday Cover by AHPs in Astley Ainslie and Liberton Hospitals	2,284		0		2,284
CRT+	31,605		12000		19,605
Hubs: Hospital Social Work Assessments	56,951		0		56,951
Hubs: Enhanced Therapy Teams	36,117		23000		13,117
Hubs: Enhanced Discharge Facilitation	14,507		5000		9,507
Hubs: Assistant Practitioners	24,200		15000		9,200
Discharge to Assess	38,672		12000		26,672
Home Care Coordinator	7,344		7300		44
Discharge to Assess OT/PT	19,336		8000		11,336
Hubs: Social Work Enhancement	74,926		20050		54,876
Home Care Manager	8,267		8250		17
TOTAL	**385,660**		**122,600**		**263,060**

Edinburgh Health & Social Care Partnership

Winter Plan 2018/19

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	Pat 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 Business Continuity & Resilience Group with regular meetings to develop joint NHSL/CEC procedures to allow fully integrated responses. • Resilience is on the agendas for Locality Meetings. • Business Continuity Operational Plans on shared drive for all essential services available to Senior Management and Clinical Managers. • Close connection and contact with NHS Lothian and CEC Resilience Leads. NHSL policy and FAQ's on Intranet under HR Online.	Ongoing
Severe weather plans reviewed each year and updates implemented when they occur	Pat Wynne and Cathy Wilson	• CEC Severe Weather Plan was further developed following the 'Beast from the East' and communicated, outlining plans for capacity & recruitment, prevention and responding to emergencies. • An EHSCP Incident Management Team has been identified • Formal arrangements for secure 'virtual' control rooms (teleconference) are also now in place. On amber/red alert (winter weather) announcement – the	Ongoing

		Partnership's Resilience Lead and/or Chief Officer will likely request an immediate Partnership Incident Management Team meeting to discuss winter weather resilience arrangements. • CEC Severe Weather Plan 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 and standard cars with snow tyres. • Agreement reached with Police Scotland to utilise their mini buses to pick up and drop off staff. Police Scotland will provide drivers.	
Norovirus outbreak plans in place	Sheena Muir for hospital sites Cluster Managers for care homes Pat Wynne (Gylemuir & QAIG)	• 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.	Ongoing

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 & 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	H&SCP management team	• Liberton Hospital will have internal escalation procedures with clear trigger points and actions. • For the Intermediate Care / Interim Care beds at Liberton Hospital there are much improved systems/processes in place for MDT discussions and GP rapid rundowns to ensure that decision making is as timely as possible with regards to discharge planning, so patients are identified as 'ready for discharge' as soon as possible. The challenge is that for many patients who require ongoing care in the community their discharge is delayed until a POC is available for them. A waiting list is maintained for the beds so when discharge dates are known, admissions are planned from the waiting list so the beds are occupied again on the same day. The AAH Discharge Hub monitors the waiting list daily, attends twice daily teleconferences with acute services so they are aware of any areas of particular pressure so patients can be taken 'out of turn' from the waiting list if it is more helpful to the whole system (3 –way moves for example can be more beneficial than 2-way moves). Sheena Muir is in regular contact with the AAH	In place and ongoing monitoring

		Discharge Hub throughout the day especially over winter and has knowledge /early sight of any specific issues which could impact on flow and assist the team in finding solutions. There are no plans to increase the capacity in Liberton over winter. Any escalations will be via Tom Cowan to the EMT / Chief Officer. • 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.	
3. Safe & 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%.	
a. Prevention of hospital admissions where appropriate b. Facilitate early discharges & reduce occupied bed days c. Staffing and resources appropriate to meet demand	**Fiona Wilson** **Tom Cowan**	**Hub and Cluster Capacity and Flow Realignment** • The Partnership has seconded a delayed discharge lead to work with the Hub Managers and Discharge Coordinators to ensure timeous flow across the whole system • A Hub Redesign Team are meeting weekly and have	**Ongoing (as part of Essential Action 2)**

		a proactive plan to deliver a range of improvements across the Hubs in a consistent manner that will enhance access to our POA services and facilitate earlier and more discharges. • We have established performance management and trend data to ensure that the correct resources are applied at the right time, right place and in the right format. • Daily Multi Agency Triage Team (MATT) Huddles; • Daily UCC Debrief on day before performance (as required); • Whole System Capacity Link via Teleconference (as required); • End of Day Rapid Run Downs; • Weekly Delayed Discharge meetings • Links to Hospital Emergency Access & Winter Planning Meeting; • We are conducting demand and capacity analysis (DCAQ) within Hubs to establish capacity gap • Use DCAQ analysis to inform options analysis on options for increasing capacity at locality level. • 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 & Telecare Service for uninjured fall patient. Developing improved onward referral pathways for winter 2018 with localities. This will be part of the Hub response for winter. • GP Anticipatory Care Plans for nursing home residents/identified patients at risk well developed and active in x care homes. • Closer working with Care Homes to avoid unplanned admissions to acute settings. • Edinburgh has just implemented a sustainable community support programme which should deliver a 10% increase in care at home capacity over the winter	

		period. • Implementation of the Carnall Farrar recommendations (1st quarter), which covers the winter period, will result in Hub redesign – one Hub in four locations – creating a single point of access and an improved interface between acute social work/community, as well as stretch targets for localities. By February 2019, the trajectory for Delayed Discharge will be 111 (currently 244). • Hospital at Home will be rolled out to the North West of the City • Work is ongoing to determine how we can build on last year's winter successes where 32 additional hospital discharges were facilitated by the enhanced Hub Services.	

4. Strategies for additional surge capacity across Health and Social Care Services

Outcome:	**Indicators:**
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.	• Additional staff in place to support: a. chronic conditions & people at risk; b. management of hospital LOS & 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)	Hub Managers	• 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	Ongoing

d. Supporting GP Capacity		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** :- • **Festive Practice** – provision for the second year of a city centre walk in clinic for 3 public holidays over the festive period (the service will not run on Christmas Day) Will avoid presentations at A&E, LUCS and IHTT • **CRT+** - The referral criteria of the Community Respiratory Team will be widened to include acute respiratory infections in frail elderly (by GP referral) without a diagnosis of chronic respiratory condition. • **Enhanced Locality Hubs** – The Hubs will be enhanced in the following ways: Assistant Practitioners will be employed to reduce falls presentations and reduce the risk of a further admission after a first fall; the number of staff undertaking enhanced discharge facilitation will be increased. These staff will be hospital based and will directly track patients from specific localities to provide more consistent support to flow by supporting early discharge for more people; additional physiotherapy capacity will be provided to assess and treat people at risk of admission to support early discharge with the aim of providing rehabilitation in the home as an alternative to continued hospital stay and; hospital based social work will be increased in order to improve responsiveness and reduce length of stay and delay • **Assistant Practitioners at Liberton Hospital -** will be employed to enhance multi-disciplinary teams by providing a trans-disciplinary role working across traditional occupational therapy, physiotherapy and nursing roles. The post holders would be ward based	

		and support the delivery of the prescribed rehabilitation programmes and act as a liaison between team members, the patient and their families / carers by ensuring there is a consistent approach to the rehabilitation programme and the key goals and milestones agreed by the MDT are shared • There will be **occupational therapy and physiotherapy cover at both Liberton and Astley Ainslie Hospitals** on the festive public holidays, to ensure rehabilitation therapy programmes are maintained on both sites to support patient flow. • A **Discharge to Assess** test of change will be implemented, targeting patients in hospital requiring rehabilitation and facilitating their pull to community. This joint bid will facilitate movement between the North West Hub and WGH high volume older people flow, providing equity of rehabilitation across the site and targeting patients currently prioritised out of treatment due to lack of capacity particularly in MOE and ORS and other areas across WGH. This will also improve patient function and resilience with the aim to reduce package of care requirements or requirements for continuing care, focus on realising capacity for pathway zero in Discharge to Assess, and reduce length of stay **Winter bids that remain unfunded but may be considered in the event of any slippage are:-** a. **PLAAN Phase 2** b. **ACPs & CMHTs** c. **AWI/Guardianship**	
5. Whole system activity plans for winter: post-festive surge/respiratory pathway			

Outcome:	**Indicators:**
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.	• 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

Action	**Owner**	**Status**	**Complete**
Flow activity to be managed through the partnerships range of services and supports	H&SCP Management team Locality Managers Angela	• 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 (as required) • 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 and that appropriate level of care is being delivered particularly over the festive period. • CRT+ Team will be working with Acute Respiratory	Plan in place to be regularly reviewed and updated

	Lindsay Katie McWilliam	Services to mirror their January model of delivery. • Up scaling telecare deployment to over 65's and to meet 4-hour provision for Discharge to Assess • Chalmers – provision of a city centre walk in clinic for three of the public holidays over the festive period. 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 & 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	H&SCP Management team	• Tableau Dashboard was further developed in 2017 • Specific output and measures associated with funding proposals • Philip Brown can support data and analysis	Systems in place and on-going monitoring and analysis

7. Workforce capacity plans & 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	**Indicators:** By locality: a. Workforce capacity plans & 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

periods		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	
Festive period and public holidays	H&SCP management team Pat Wynne Eileen McGuire	• Rostering appropriate staffing and resources to maintain services through the 2-week 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 HR. • On call rota for duty managers and clinical service leads are in place. • DN service runs 365 days a year with system to cover all weekends and PH 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 public holiday discharges. • Pan city review of care home agency utilisation. • Festive Practice – provision of a city centre walk in clinic for three of the public holidays over the festive period. Will avoid presentations at A&E, LUCS and IHTT.	Protocol in place

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 on public holidays.	Hub Managers	• 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 for the Test of Change in North West as a minimum. The aim is for this to be City wide dependent on staffing levels. • Plans are in development for Hub staff doing Discharge to Assess to in reach to acute sites (RIE and WGH) at weekends and on public holidays. • Hub weekend services are under development • CRT will be working 7 days and public holidays	Ongoing
9. The risk of patients being delayed on their pathway is minimised			
Outcome: SYSTEM BAROMETER FOR FLOW: • Crowding in the Emergency Dept 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.	Sheena Muir and DD Lead Hub Managers	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 (as required) • Teleconferencing across sites re beds twice a day Monday – Friday (as required) • Single point of contact between Localities/Hubs and RIE Discharge Hub. Hospital in-reach to liaise on a	In place and ongoing monitoring

		daily basis with the Discharge Hub; WEEKLY • 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 & voluntary sector. • Work underway to implement referral pathway from Social Care Direct to Locality Hubs and inter referrals between flow centre and the Hubs. • Carer Discharge Support Workers within each locality hub and each hospital site. • 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. • Long Term Conditions Team working with Scottish Ambulance Service to develop service COPD patients • Establishing training to be delivered by falls team within identified 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	
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	Ann Duff	▪ Briefing & 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 first draft of this year's Communication Plan has been developed. Priorities to be agreed and then these have to fit with the NHSL overarching Communications Strategy which will take the lead on the wider winter communications ▪ A series of targeted communications began on 22 October vaccination 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 -	Ongoing
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**	
Robust Norovirus outbreak management Introduction and monitoring of the HPS Norovirus Outbreak Guidance (2016/2017)	Sheena Muir + Cluster Managers	• 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 re this issue. • Ensure compliance with all infection control procedures.	Ongoing
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 & locality and variance from planned levels in line with CMO	.
Action	**Owner**	**Status**	
Seasonal Flu	Pat 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). • A Housebound Flu Vaccination team is in place • Flu Champion identified for each locality, hosted	Ongoing

		services, HBCCC and Rehab. • Clinic dates are published on Council Orb and NHSL Intranet.	

Edinburgh Health & Social Care Partnership - Winter Plan 2018/19

Summary of Key Actions

Actions taken to help prepare for this winter by business units

- The Locality Hub teams will be enhanced in the following ways:
  - Assistant Practitioners will be employed to reduce falls presentations and reduce the risk of a further admission after a first fall
  - The number of staff undertaking enhanced discharge facilitation will be increased. These staff will be hospital based and will directly track patients from specific localities to provide more consistent support to flow by supporting early discharge for more people
  - Additional physiotherapy capacity will be provided to assess and treat people at risk of admission to support early discharge with the aim of providing rehabilitation in the home as an alternative to continued hospital stay
  - Hospital based social work will be increased in order to improve responsiveness and reduce length of stay and delay
- The referral criteria of the Community Respiratory Team will be widened to include acute respiratory infections in frail elderly (by GP referral) without a diagnosis of chronic respiratory condition.
- A Discharge to Assess test of change will be implemented, targeting patients in hospital requiring rehabilitation and facilitating their pull to community. This joint bid will facilitate movement between the North West Hub and WGH high volume older people flow, providing equity of rehabilitation across the site and targeting patients currently prioritised out of treatment due to lack of capacity particularly in MOE and ORS and other areas across WGH. This will also improve patient function and resilience with the aim to reduce package of care requirements or requirements for continuing care, focus on realising capacity for pathway zero in Discharge to Assess, and reduce length of stay.
- Assistant Practitioners at Liberton Hospital will be employed to enhance multi-disciplinary teams by providing a trans-disciplinary role working across traditional occupational therapy, physiotherapy and nursing roles. The post holders would be ward based and support the delivery of the prescribed rehabilitation programmes and act as a liaison between team members, the patient and their families / carers by ensuring there is a consistent approach to the rehabilitation programme and the key goals and milestones agreed by the MDT are shared

- The Festive Practice will be in operation for the second year at Chalmers Sexual Health Centre, providing additional urgent primary care, treatment of minor injuries, and wider social care support at periods of peak demand. This model will draw activity from pressurised services such as Emergency Departments, LUCS and mental health services. This is a refined version of last year's model, making better use of nursing available by taking referrals from Practices and direct from A&E over the festive period for patients able to travel who require dressing or other treatment to free up District Nursing time. The Practice will also liaise with LUCS to cover Nursing home visits.
- There will be occupational therapy and physiotherapy cover at both Liberton and Astley Ainslie Hospitals on the festive public holidays, to ensure rehabilitation therapy programmes are maintained on both sites to support patient flow.
- EHSCP flu campaign commenced on 1 October 2018 focussing on highlighting the serious nature of flu and urging those eligible for the vaccine to act early to ensure they are ready for flu ahead of winter. Information about eligibility for the vaccine has been widely circulated, as has information about staff flu clinics, on both the Council's orb and NHS intranet.
- EHSCP has developed a Communications Plan for winter 2018/19. A series of targeted communications will begin on 22 October 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
- Winter weather resilience plans are in place and an Incident Management Team has been identified. 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.

Additional Capacity / Resource

Purchased as a result of winter allocation

Ref	Project Title	Values Sum of Proposed Winter Plan	Sum of Proposed Budget
EHSCP	Discharge to Assess	42,332	38,672
	CRT+	34,597	31,605
	Festive Public Holiday Cover by AHPs	2,500	2,284
	Festive Practice	40,320	36,834
	Locality Hub: Hospital Social Work Assessment	62,341	56,951
	Locality Hub: Additional Physiotherapy	39,535	36,117
	Locality Hub: Assistant Practitioner (Falls)	26,491	24,200
	Locality Hub: Enhanced Discharge Facilitation	15,942	14348
	Liberton Assistant Practitioners	38,040	34,236

Funded as of 19 September 2018 by NHS Lothian Unscheduled Care Committee

Unnecessary Admissions

Highlight which schemes, which have currently been committed funds, will avoid unnecessary admissions.

The following schemes, which have been detailed above, will avoid unnecessary admissions:

- CRT+
- Festive Practice
- Assistant Practitioners for Falls in the Hubs
- Additional Physiotherapy provision in the Hubs

Improvement Trajectories

Highlight which schemes, which have currently been committed funds, will support delayed discharges

The following schemes, which have been detailed above, will support weekend and delayed discharges:

- CRT+
- Discharge to Assess
- Festive Public Holiday Cover by AHPs
- Hub Hospital Social Work Assessment
- Additional Physiotherapy provision in the Hubs
- Hub Enhanced Discharge Facilitation

Response to Health Workforce, Leadership and Service Transformation Directorate letter dated 16th October 2018

The Partnership aims to build on successes from winter 2017/18, where 32 additional hospital discharges were facilitated by the enhanced Hub Services.

Edinburgh has just implemented a sustainable community support programme which should deliver a 10% increase in care at home capacity over the winter period.

Implementation of the Carnall Farrar recommendations (1st quarter), which covers the winter period, will result in Hub redesign – one Hub in four locations – creating a single point of access and an improved interface between acute social work/community, as well as stretch targets for localities. By February 2019, the trajectory for Delayed Discharge will be 111 (currently 244).

Winter 2018/19 - EHSCP

	Amount Allocated		Added to Deferals @ Year End		18/19 Spend
Festive Public Holiday Enhanced Primary Care Service Model for the City	36,834		12000		24,834
Liberton Hospital: Assistant Practitioners	34,616		0		34,616
Festive Public Holiday Cover by AHPs in Astley Ainslie and Liberton Hospitals	2,284		0		2,284
CRT+	31,605		12000		19,605
Hubs: Hospital Social Work Assessments	56,951		0		56,951
Hubs: Enhanced Therapy Teams	36,117		23000		13,117
Hubs: Enhanced Discharge Facilitation	14,507		5000		9,507
Hubs: Assistant Practitioners	24,200		15000		9,200
Discharge to Assess	38,672		12000		26,672
Home Care Coordinator	7,344		7300		44
Discharge to Assess OT/PT	19,336		8000		11,336
Hubs: Social Work Enhancement	74,926		20050		54,876
Home Care Manager	8,267		8250		17
TOTAL	**385,660**		**122,600**		**263,060**