Edinburgh Integration Joint Board

# REPORT

## Evaluation of 2019/20 Winter Plan

Edinburgh Integration Joint Board

24 August 2020

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| **Executive Summary** | The purpose of this report is to present the following:<br>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 Malcolm Wright, Chief Executive NHS Scotland and Director General Health & Social Care, wrote to the Chief Officers of Health & Social Care Partnerships and the Chief Executive of NHS Lothian on 04 September 2019 regarding preparing for Winter 2019/20<br>2. The winter plan 2019/20 was outlined at the IJB meeting on 28 November 2019.<br>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 Edinburgh Health and Social Care Partnership's (EHSCP) performance for key performance indicators, compared to last winter.<br>4. Winter Planning for 2020/21 has commenced, with priorities based on the lessons learned from COVID-19 thus far. |

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| **Recommendations** | It is recommended that the Edinburgh Integration Joint Board (EIJB):<br>1. Note the Local Review of Winter 2019/20 Report, the full version of which is included in Appendix 1. One of the successful outcomes of Winter 2019/20 is that the additional Social Work and Mental Health Officer posts have been funded on an ongoing basis<br>2. Note the Lessons Learned from the COVID-19 |

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| | pandemic attached at Appendix 2, which will inform future planning<br>3. Note that planning is underway with regards to our key priorities for Winter 2020/21. |

## Directions

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| Direction to City of Edinburgh Council, NHS Lothian or both organisations | | ✓ |
| | No direction required | ✓ |
| | Issue a direction to City of Edinburgh Council | |
| | Issue a direction to NHS Lothian | |
| | Issue a direction to City of Edinburgh Council and NHS Lothian | |

## Report Circulation

1. The report will be circulated to the Edinburgh Integration Joint Board for the meeting on 24 August 2020.

## Background

2. 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.

3. Malcolm Wright, Chief Executive NHS Scotland and Director General Health & Social Care, wrote to the Chief Officers of Health & Social Care Partnerships and the Chief Executive of NHS Lothian on 04 September 2019 confirming the amount that NHS Lothian was allocated for 2019/20 and instructing Health Boards and IJBs to use this allocation to specifically target the delivery of 5 priorities:
   - Reducing attendances wherever possible by managing care closer to home, preferably at home, with services focussed on assessment and care closer to home
   - Managing/avoiding admission wherever possible, with services developed to provide care at home across 7 days

- Reducing length of stay
- Focus on flow through acute care
- Workforce

4. The letter requested that Winter Plans were submitted by the end of October 2019. A supplementary checklist of winter preparedness: self-assessment was included for completion. A copy of this is available on request.

5. A subsequent Scottish Government communication on 30 October 2019 requested that all winter plans meet the following criteria:
   - Include an Opening Summary contextualising the plan, expanding on what worked last year, what learning has gone into developing it and what existing policies or plans underpin the winter plan
   - Provide a full breakdown of the specific additional activity/capacity that will be put in place with additional investment to support performance over winter alongside the measurable outcomes this will achieve
   - Outline the actions planned to sustainably reduce attendances and how this will be measured
   - Detail the planned level of provision over the festive period
   - Provide reassurance of the resilience arrangements in place over the festive period and indeed throughout the whole of winter
   - Demonstrate how sustainable reductions will be made on delayed discharges
   - Clarify how NHS Lothian plans to monitor predicted unscheduled care demand to avoid cancellations and plans in place to protect electives throughout winter
   - Describe the actions planned to achieve the national target of 60% uptake of the seasonal flu vaccination for health and social care staff

6. A copy of the EHSCP Winter Plan for 2019/20 is attached at Appendix 3.

7. 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 2019/20.

## Main Report

8. The provision of unscheduled care for the people of the Lothians is the responsibility of five organisations: the 4 Lothian IJBs and NHS Lothian; working with partner national organisations Scottish Ambulance Service and NHS24. The Unscheduled Care Committee was originally established to add rigour and governance to the process of developing robust and resilient winter plans that align with local priorities. The Committee recently widened this remit in order to support the newly established Unscheduled Care Programme Board to ensure a whole system approach is taken to delivering a sustainable model of unscheduled care. The aim is to provide timely access to care in the right place at the right time, avoiding delays anywhere in the whole system. A copy of the Committee's Terms of Reference is available on request.

9. A total of 7 bids were funded by the Lothian Unscheduled Care Committee for EHSCP, and 2 bids were funded by EHSCP. These were:

| Bids | Achievements and Impact on Budget Pressure |
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| **Funded by Lothian Unscheduled Care Committee** | |
| Festive Public Holiday Enhanced Primary Care Service Model for City | The Festive Practice was operational on 1 and 2 January, providing a service to a total of **46** patients: **32** patients were seen by a GP, **8** patients were seen in CPN appointments and **6** patients were seen by a Practice Nurse - **6** district nurse visits saved |
| Enhancement of Community Respiratory Team (CRT+) | CRT+ provided a specialist community based service for **65** people with acute respiratory infection, **40** of whom might otherwise have been admitted to hospital; **64**% of admissions prevented. The service successfully supported a prevention of admission of **94%** at 48 hours and **89%** at 7 days. Weekend statistics for the CRT team also noted Physio@Home assessed **3** patients over weekends and retained **2** of them on their active caseloads |
| Winter Support Team | The Winter Support Team received **71** referrals in 16 weeks, of which **58** were appropriate. The majority came from the Flow Centre (**22**) and the Hub Prevention of Admission (POA) Teams (**31**). **55** people out of the 58 referrals were prevented from going into hospital, totalling a reduction **658** bed days |

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| Social Work to Support Home First Model | **5** WTE Social Workers were recruited over the winter period to work across the city. The aim of the additional capacity was to ensure that people were allocated within the 24 hour target and then assessed appropriately within the aim of completion of 72 hours, however, due to very high levels of staff sickness and social work vacancies throughout the period, the overall capacity still fell short of that required |
| Care at Home | Call In Homecare started **49** packages from Reablement totalling **390.5** hours, and Reablement started **86** hospital discharge packages totalling **1034.5** hours. This was an increase of **33** packages and **396** hours from a similar period in the weeks immediately prior to the incentive commencing, when Reablement started 53 hospital discharge packages totalling **638.5** hours. |
| Adults with Incapacity (AWI): | One additional Mental Health Officer was employed increasing the availability for case conferences to be held which reduced the length of time waiting for such decision-making forums. This enabled the least restrictive option to be explored promptly leading to some people moving on from hospital without the need for guardianship applications being made. It also enabled work to commence without further delay. Between December 2019 and March 2020, there were a total of **250** delayed discharges for AWI, a reduction of **34**% from the same period the previous year |
| Open House | EVOCs Open House proposals had significant engagement from all providers. Support Minds Scotland supported **110** people over 11 sessions, and the Caring in Craigmillar Phonelink service supported **12** people. Data is still outstanding from Health All Round and Artlink Edinburgh, however, we have been unable to collect the data due to the impact of the COVID-19 pandemic on these organisations |
| **Funded by EHSCP** | |
| Walking Aid Safety Assessments in Care Homes | **164** walking aids were assessed across 7 Edinburgh care homes (which were chosen due to the high falls rates within these homes) with **18** (11%) needing repairs and **25** (15%) needing replacements, either due to age or being irreparable. Therefore **38** of **164** (23%) needed repaired or replaced and the remaining 77% were considered safe for appropriate use. A&E attendances and falls related admissions data collected via Tableau to evaluate the impact of this work will not be available until 6 months post project delivery |
| Psychotherapeutic support for carers (VOCAL): | VOCAL provided targeted support for **216** very vulnerable people who might otherwise have requested or sought support from statutory services. 30 carers on VOCAL's waiting list were called and offered therapeutic support, with **7** referrals made for counselling as a result. **3** carers were highlighted with the Carer Support Team to check any immediate support requirements were met. VOCAL also hosted 'Open days' for carers to drop in on 30 and 31/01/2020, when **9** carers 'dropped in' for support and an additional **5** were spoken to on the telephone either to take referrals or give support. **6** carers benefited from complementary therapy sessions. |

10. In 2019, Scottish Government released a Winter Debrief template for completion, however, this was not requested in 2020 as a result of the COVID-19 pandemic. Lothian Unscheduled Care Committee did, however, request

that a similar template be completed to evaluate winter planning in 2019/20. 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
- Third Sector Services
- Adults with Incapacities
- Top Five Local Priorities for Winter Planning 2020/21

11. The full report is detailed in Appendix 1.

**Flu Vaccinations**

12. 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.

13. Staff Uptake rates: This year **19,186** vaccines were issued across Lothian. Of the total **13,228** completed consent forms returned by mid-March (some are still coming back to be counted), **1,975** were for non NHS staff (mainly council staff and some volunteers). It is therefore estimated **16,175** vaccines were used for

NHS staff. With a head count of 26,679 this gives an uptake of **64%** among NHS staff.

14. EHSCP Staff Uptake rates: **837** consent forms were received for EHSCP CEC staff (585 in 2018/19), an increase of **30%** from last year. **781** consent forms were received for EHSCP NHS staff, bringing the total number of staff vaccinated in EHSCP to **1,618**.

15. Support was provided from the vaccination team for care homes and for housebound individuals (who are not currently on the district nurse caseload)

16. A total of 6,816 individuals across Lothian who were housebound or resident in care homes received their flu vaccinations from the vaccination team, potentially reducing pressure on admission to acute and community services. 4,692 (4,596 in 2018/19) patients were vaccinated at home and 2,124 (1952 in 2018/19) residents vaccinated in care homes

**Festive Staffing Cover**

17. For the second year, 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**

18. The EHSCP Severe Weather Resilience Plan was updated and released on 07/11/2019. Key principles were agreed involving escalation protocols, key contacts and transport sharing arrangements via a ‘Transport Hub’.

19. EHSCP coordinated the provision of 4x4 vehicles across the localities which could be accessed in the event of an episode of severe weather, to allow staff to visit the homes of service users where poor weather might have otherwise prevented travel to these homes.

**Communications for Winter 2019/20**

20. 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

21. Winter 2019/20 communications started from 19/12/2019, 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

## Implications for Edinburgh Integration Joint Board

**Financial**

22. The Partnership received a total allocation of £535,661, of which £364,642 was committed. A full breakdown is attached at Appendix 4

23. It should be noted that some proposals did not utilise the full amount of funding allocated. The Festive Practice only opened on 2 days but was funded for 3 days. Hub Managers were unable to recruit to all of the available Social Work hours. The Winter Support Team funding was not used in its entirety as, due to

timescales, external recruitment was unfeasible, therefore staff were redeployed from each of the locality teams. A similar proposal has been submitted this year, however, a detailed plan is in place to recruit to the posts within timescales.

**Legal / risk implications**

24. Ability to recruit to short term posts that are only required for surge capacity and do not require permanency

25. Ongoing contractual limitations to facilitate weekend working beyond that which is voluntary

**Equality and integrated impact assessment**

26. 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. Improvements have been made in subsequent years for both these groups in collaboration with our third sector partners. 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. This remains the case. A new integrated impact assessment will be undertaken for 2020/21.

**Environment and sustainability impacts**

27. A positive outcome for future sustainability is the ongoing funding of the social work and Mental Health Officer posts

28. Going forward, the Unscheduled Care Programme Board, under the chairmanship of the Chief Officer of the West Lothian Health and Social Care Partnership, will consider any proposals relating to new and/or enhanced services all year round.

## Consultation

29. 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.

30. A communication plan was developed for the EHSCP 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.

31. 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.

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

## Report Author

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## Appendices

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| Appendix 1 | Local Review of Winter 2019/20 |
| Appendix 2 | COVID-19 Lessons Learned Debrief |
| Appendix 3 | EHSCP Winter Plan for 2019/20 |
| Appendix 4 | Financial Breakdown |

# Health & Social Care: Local Review of Winter 2019/20

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| **NHS Board H&SCP s:** | NHS Lothian<br>Edinburgh, West, East & Midlothian H&SCP | **Winter Planning Executive Lead:** | Angela Lindsay, Locality Manager – North East Edinburgh |

| 1 | **Clear alignment between hospital, primary and social care** |
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| | • The Community Respiratory Team Plus (CRT+) is an enhanced service reintroduced over the December 2019 – March 2020 winter period. The third year of the service was aimed at widening the referral criteria of CRT capacity over the winter period to include acute respiratory infections in frail elderly (referrals coming from GPs) without a diagnosis of chronic respiratory conditions, in addition to providing community specialist respiratory physiotherapy assessment and treatment for patients with acute respiratory infections; preventing admissions or, where applicable, readmission to secondary care.<br>• The Winter Support team was established this year to boost capacity through an additional 16 frontline staff and 2 Home Care Coordinators. The recruited staff were focused on providing care to prevent admission as part of the Reablement assessment processing. The proposal increased each Hub area by 2 teams of 2 staff working back to back over 7 days. Their focus was on pushing a Home First model through admission avoidance and supporting discharges, allowing real time discharge rather than waiting on a package of care. When a patient was ready for discharge the Winter Support Team would be utilised to bridge until the POC could start. The service prevented admissions to the front door by offering an alternative to admission and allowed the flow centre to have options as an alternative to admission.<br>• The walking aid assessment proposal was established this year to support a service to assess, identify, repair and replace unsafe walking aids in Edinburgh care homes. Initial assessments of all walking aids used by care home residents were followed by ordering repairs and replacements of unsafe aids through the equipment store (ATEC24), and constructive recommendations to support the care home towards setting up and acting upon weekly in-house walking aid checks. All 7 core criteria were met by this proposal: 1. It promoted collaborative working of healthcare professionals in a social work environment. 2. Services were delivered onsite so residents were not required to go elsewhere. 3. The aim of ensuring walking aids are safe is to directly reduce the rate of falls related A&E attendances and hospital admissions by reducing falls. 4. By setting up a system of weekly checks this project aimed to improve care homes ability to independently manage this process. 5. By introducing a system of early identification of unsafe walking aids and facilitating links with equipment and rehabilitation services as needed, care homes are empowered to make relevant referrals. 6. All services are delivered within the non-acute care home setting, and aim to reduce the rate of admissions. 7. Should a resident have an unplanned admission, already having safe walking aid equipment in place will help facilitate discharge. |

| 1.1 | **What went well?** |
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| | • The CRT+ service ran from Dec 19 –April 2020 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, **65** |

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| | **referrals** were received; **40** of these were deemed at risk of hospital admission (**64%**). The service successfully supported a prevention of admission of **94%** at 48 hours and **89%** at 7 days. Weekend statistics for the CRT team also noted Physio@Home assessed **3** patients over weekends and retained **2** of them on their active caseloads.<br>• Co-location of services - Allows sharing of resources between services when there is increased capacity in either CRT or CRT+<br>• Rapid Assess treat and discharge model of care is appropriate for referrals into this winter service<br>• Another respiratory referral option for GP's to avoid hospital admission in winter<br>• Has up skilled staff in respiratory and community working<br>• The Winter Support Team received 71 referrals in 16 weeks, of which **58** were appropriate. The majority came from the Flow Centre (**22**) and the Hub Prevention of Admission (POA) Teams (**31**). **55** people out of the 58 referrals were prevented from going into hospital, totalling a reduction **658** bed days. This reduction included patients either returning to their baseline or managing without a further package of care, or through the handover of the POC to another provider. The figure of £500 per night, per bed was used at the beginning of the Project. Therefore, 658 x £500 = savings of £329k in NHS bed days making this an extremely worthwhile and successful project.<br>• **164** walking aids were assessed across 7 Edinburgh care homes with **18** (11%) needing repairs and **25** (15%) needing replacements either due to age or being irreparable. Therefore **38** of **164** (23%) needed repaired or replaced and the remaining 77% were considered safe for appropriate use. Each care home cost on average £120 in terms of equipment supplied and replaced, a much lower cost than anticipated. Staff recruited to the project from the Physio@Home team reported benefits to understanding of care homes, care home understanding of Physio@Home, and improvement on existing working relationships with care home staff. The Walking Aids team stated excellent initial care home engagement with project as expected. The hope is to run this project in Edinburgh annually, and with the data available so far consider it both highly effective and highly affordable. |

| **1.2** | **What could have gone better?** |
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| | • There were issues recruiting staff for CRT+, given the late start to the recruitment process<br>• Due to the initial 'soft start', the Winter Support team referrals and contacts from GPs were slow. Second rounds of communications were sent to the GPs, including face to face presentations by team members, however referrals via the Flow Centre were expected to be higher. The Winter Support Team did not have any referrals at the weekends. Frontline staff were utilised 7 days a week however, working a 4 on 4 off shift pattern. The Navigator and Home Care Coordinators worked Monday to Friday. Weekend activity was discussed with referrers and they felt this would be welcomed and utilised going forward if people were made aware this was an option open to them.<br>• Recruiting staff from the staff bank created significant issues for the Walking Aids Project. Lengthy delays in recruitment impacted capacity for delivery stage. It was also difficult to coordinate team members who were often working in different teams and sites to ensure scheduling for care home visits. The project was also taken on and funded by the Long Term Conditions programme with an initial proposal of £22789 rejected. The LTC programme funded this project with £8711, resulting in reduced capacity and resources. Due to the COVID-19 epidemic, restrictions were put in place for all non essential visits in care homes, affecting some scheduled visits. A&E attendances and falls related admissions data collected via Tableau to evaluate the impact – data will not be available until 6 months post project delivery. There will be a delay in reporting on impact of project. |

| 1.3 | Key lessons / Actions planned |
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| | • CRT will explore the possibility of seconding staff from other services (including Physio@home/Pulmonary Rehab Teams etc.) earlier in the year to ensure the service is sufficiently staffed for winter months.<br>• More emphasis around communications e.g. weekly snapshots to GP's to raise awareness.<br>• Differentiate between CRT and CRT +, as there is some confusion between the two.<br>• Demonstrate the need for enhanced service throughout the year to manage a wider group of respiratory patients.<br>• The Winter Support Team noted for future practice, one contact number should be utilised for the Prevention Team, making it easier for everyone to refer and get straight through to the Team. GP feedback outlined they found it time consuming having to pass on information via the Flow Centre staff and then reiterate it to the WPT Navigator and Co-ordinator. The Winter Support team also noted, given the front-line staff were identified by their managers in their localities quickly at the beginning of the project, the team quickly discovered that some staff felt they hadn't been given a full understanding about what their new role entailed. Going forward it would be imperative that staff had the opportunity to apply for these positions and the full remit of the post explained prior to them doing so. This proposal has confirmed the need additional permanent, prevention team positions all year round.<br>• Lack of tableau dashboard updates of care home data is an issue for evaluation as this represents falls leading to A&E attendances or hospital admissions from each care home. The Walking Aid team hope to have this data in the upcoming months. Staff bank recruitment was not an easy or efficient process for this project. Other routes of recruitment are to be assessed for a similar project. |

| 2 | **Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods** |
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| | • The Social Work to Support Home First model has significantly contributed towards the reduction in number of people delayed in hospital. The current model of hospital flow waits for the person to be ready for discharge before a referral is made to social work, which then causes additional unnecessary delays. However, the recruited social work posts from this model aimed to support early intervention and a home first approach through actively linking with locality hubs to encourage assessments to take place earlier in the hospital patient pathway, with a focus of transition to follow up assessment to take place in the person's own home. Working closely with clinical colleagues at an early stage, the model enabled an earlier flow through community services from acute and ensured management of additional demand during winter.<br>• This year's Care at Home model was established to support additional care at home capacity. The proposal aimed to create increased flow and facilitate reablement teams across the city to meet the increased demands over winter. To do so, the project aimed to incorporate 500 additional care at home hours to unblock reablement teams. |

| 2.1 | What went well? |
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| | • The social workers recruited over the winter period equated to **5** WTE positions available to work across the city. With this capacity, it ensured people were allocated within the 24 hour target and then assessed appropriately within the aim of completion of 72 hours. The project has influenced a collaborative working across localities to ensure that work is not left uncovered across the city, with team members, including |

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| | Hub Managers, working together to support each other with challenges where possible. Working with a Home First ethos has allowed the teams to share a culture of planning for people to stay in their communities and own homes as long as possible.<br>• The Care at Home initiative commenced 25/11/19, with the last hospital discharge incentivised package of care starting with EHSCP Reablement team on the 20/12/19. Between 25/11/19 and 20/12/19 Call In Homecare started **49** packages from Reablement totalling **390.5hrs** (average package of care size 7.97hrs). Between 25/11/19 and 20/12/19 Reablement started **86** hospital discharge packages totalling **1034.50hrs** (average package of care size 12.03hrs). This was an increase of 33 packages and 396 hrs from a similar period in the weeks immediately prior to the incentive commencing, when Reablement started 53 hospital discharge packages totalling 638.50hrs (average package of care size 12.05hrs). This increase in Hospital Discharges reflected an equivalent return from Reablement on the hours transferred from Reablement to Call In homecare and funded through this initiative. |

| **2.2** | **What could have gone better?** |
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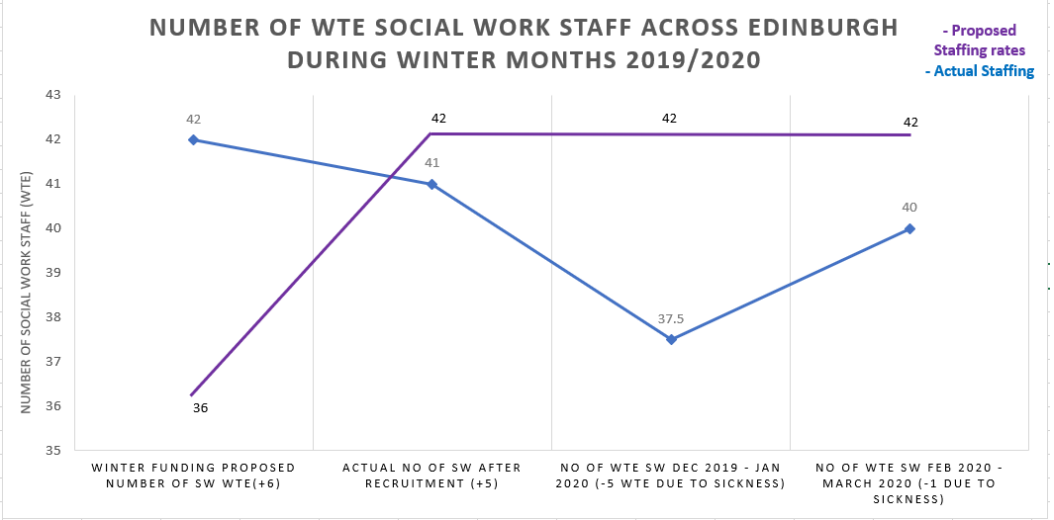
| | • The 4 Locality Hubs had an existing establishment of 34 WTE Social Workers, and funding was allocated for 6 WTE Social Worker posts, taking EHSCP to a proposed establishment of 42WTE. Due to recruitment issues, EHSCP was only able to employ an additional 5 WTE, taking the service to a total of 41 WTE. Due to sickness absence levels of staff and vacancies, there were only 37.5 WTE staff available to work in December and January, and 40 WTE in February and March, meaning that the service never reached the proposed total of 42WTE. This is detailed in the graph below:<br>  <br><br>• The number of people waiting for a care home bed fluctuated within the winter period, with a peak of 46 in the first week of February. Care at Home demand is still high but has shown some reduction with a peak of 96 mid-January. This data reflects the challenges faced by Hubs who have also been challenged by having to provide resources to cover in the community and prevent admissions.<br>• The Care at Home team noted that formalised data control documentation for regular submission during programme via nominated |

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| | individuals internally would have benefitted the project. Individuals responsible for this information should be based at an operational level instead of contractual level. The team recognised that there was a tendency to forget to record results locally when responsibility to produce report sat with another team who had no direct sight of operational activities. |

| **2.3** | **Key lessons / Actions planned** |
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| | • Due to high demand from acute sites, future work should advise services of other Home First routes including D2A and Prevention teams to relieve the pressure on social work teams and ensure the service is utilised in the full potential.<br>• Through our Transformation Programme we are currently evaluating how home based care services are re-designed and delivered going forward in Edinburgh. This will pave the way for new arrangements to be put in place, before the current care at home contracting arrangements end in September 2021. An important consideration will be how we support and maximise home based services at all times during the year and deliver the best outcomes and quality of care to residents in Edinburgh. Through this planning exercise and many of the other initiatives already implemented e.g. 3 Conversations and Home First and additional learning/opportunities highlighted through the COVID-19 responses, we would envisage a very different model of delivery for home based care will be the likely outcome of the collaborative engagement ongoing. Our aspiration is that there are suitable and appropriate home based support services available for individuals at their immediate point of need, regardless of where we are on the calendar. What these home based services will consist of, how they will be delivered and who will deliver them is very much open for discussion just now, so it would be difficult to suggest at this time that we will always need additional resource in the Winter. If nothing else COVID-19 has shown us that we need to be able to step up and step down capacity rapidly, safely and flexibly at any point during the year and capacity challenges are not just linked to Winter pressures alone.<br>It is important to add that all the aforementioned strategic planning is in development and unlikely to mitigate impact of next winter. Experience may be further amplified by further peaks of covid, and any associated pressures on care capacity within the system and as a result winter planning contingencies are still likely to be a sensible consideration for the coming year. |

| **3** | **Local systems to have detailed demand and capacity projections to inform their planning assumptions** |
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| | • For the third year running over winter, the enhanced Festive Practice service provided additional urgent primary care, minor injury care and treatments, and wider social care support at periods of peak demand during the festive period. Based at the Chalmers Centre, Lauriston and supported by a multidisciplinary team, the service provided a path from pressurised services such as Emergency Departments, LUCS and mental health services. Through coordinating clinician monitoring work flows and managing demand, patients were able to be redirected to alternative care services.<br>• For the second year, 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. |

| 3.1 | What went well? |
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| | • The Festive Practice service opened the 1st and 2nd January 2020. The location of Chalmers Sexual Health Centre was recognised as a favourable location due to the parking facilities and easy access for bus routes. Over both of the public holidays, 32 patients were seen by a GP, 8 patients were seen in CPN appointments and 6 patients were seen by a Practice Nurse – resulting in 6 district nurse visits saved.<br>• Senior and middle grade leaders available throughout the festive period.<br>• Local arrangements for managed annual leave plans, ensuring bank/agency staff were not being used to provide cover. |

| 3.2 | What could have gone better? |
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| | • The Festive Practice service intended to run clinics on 26th and 29th December 2019, but there were difficulties in recruiting GP cover. The service usually recruits GPs from members of LUCS after their staffing is established. However the LUCS service had significant difficulties in staff cover for these dates, therefore the decision was made not to run the Festive Practice service on these dates. |

| 3.3 | Key lessons / Actions planned |
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| | • For the continuation of the Festive Practice service over the winter months, it is essential to ensure sufficient staffing of GP's is available. |

| 4 | Maximise elective activity over Winter – including protecting same day surgery capacity |
|---|---|
| 4.1 | What went well? |
| | Non-applicable for Community Health & Social Care |
| 4.2 | What could have gone better? |
| | N/A |
| 4.3 | Key lessons / Actions planned |
| | N/A |

| 5 | Escalation plans tested with partners |
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| 5.1 | What went well? |
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| | • The EHSCP Severe Weather Resilience Plan was updated and released on 07/11/2019. Key principles were agreed involving escalation protocols, key contacts and transport sharing arrangements via a 'Transport Hub'.<br>• EHSCP coordinated the provision of 4x4 vehicles across the localities which could be accessed in the event of an episode of severe weather, to allow staff to visit the homes of service users where poor weather might have otherwise prevented travel to these homes. |

| 5.2 | What could have gone better? |
|---|---|
| | • The EHSCP Severe Weather Resilience Plan did not benefit from a live trial this year due to this year's mild winter. |
| **5.3** | **Key lessons / Actions planned** |
| | • Test of resources: table top exercise of 'Transport Hub' still to be held (this was scheduled for Summer 2020, but has been delayed by COVID-19 pandemic) |

| 6 | Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings |
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| 6.1 | What went well? |
|---|---|
| | • No visible increase in rates of norovirus across the partnership.<br>• Information on closures and outbreaks provided by Public Health. |

| 6.2 | What could have gone better? |
|---|---|
| | |
| **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<br>• Staff Flu Vaccinations were advertised well on both CEC/NHS Intranet systems<br>• Staff Uptake rates: This year 19,186 vaccines were issued across Lothian. Of the total 13,228 completed consent forms returned by mid-March (some are still coming back to be counted), 1,975 were for non NHS staff (mainly council staff and some volunteers). It is therefore estimated 16,175 vaccines were used for NHS staff. With a head count of 26,679 this gives an uptake of **64%** among NHS staff.<br>• EHSCP Staff Uptake rates: **837** consent forms were received for EHSCP CEC staff (585 in 2018/19), an increase of **30%** from last year. **781** consent forms were received for EHSCP NHS staff, bringing the total number of staff vaccinated in EHSCP to **1,618**.<br>• Support was provided from the vaccination team for care homes and for housebound individuals (who are not currently on the district nurse caseload)<br>• A total of 6,816 individuals across Lothian who were housebound or resident in care homes received their flu vaccinations from the |

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| | vaccination team, potentially reducing pressure on admission to acute and community services. 4,692 (4,596 in 2018/19) patients were vaccinated at home and 2,124 (1952 in 2018/19) residents vaccinated in care homes |

| 7.2 | **What could have gone better?** |
|---|---|
| | • Currently vaccinators are allocated to care homes by General Practice (patients in care homes can be registered to different practices) resulting in vaccinators requiring to attend the same care home on multiple occasions.<br>• Data collation and analysis of staff flu vaccinations remains an issue as consent forms are counted manually. A sub group from the Lothian Immunisation Coordinating Group (LICOG) was formed to consider electronic solutions available with a view to undertaking a pilot of an electronic consent form, however this was put on hold as could it could not meet information governance guidelines.<br>• The uptake figure continues to be calculated by the number of vaccines used. |

| 7.3 | **Key lessons / Actions planned** |
|---|---|
| | • Accurate available data to support ongoing targeted flu vaccination programme is needed<br>• Introduction of electronic consent form to allow better and more timely reporting of data<br>• The implications of the current Covd-19 pandemic will need to be considered at every stage of planning for both the Housebound and Staff Flu Vaccination Programmes.<br>• It is planned to move the Housebound Flu Vaccination Programme to the HSCPs for ownership through joint working with community nurses and there is acknowledgement that community nurse teams will require additional resource to vaccinate patients not on their caseload. Although the wider Vaccination Transformation Programme work is currently on hold and has been extended by 1 year, there is a need to establish if the housebound programme is to continue in its current format.<br>• Commence the Housebound Flu Vaccination Programme as soon as the vaccine is available in September.<br>• Care home residents should be prioritised in the first tranche of the vaccination plans.<br>• Vaccines should be allocated per care home.<br>• Increase the number of peer vaccinators, through a mandatory requirement, to enable as many staff as possible to get their flu vaccination within the immediate workplace. |

| 8 | **Third Sector Services** |
|---|---|
| | • VOCAL services have provided additional emotional and psychotherapeutic support between Christmas and New Year 2019 to individual carers (through counselling support) and groups of carers (through planned mainstream peer activities) to relieve isolation and depression over the festive period. Carers who find the festive period a particularly difficult time were supported on a one to basis over the telephone by trained councillors and able to engage with carer support staff through planned drop in events scheduled during this time period. As well as socialise with other carers on peer group planned activities.<br>• Edinburgh's third sector providers, (EVOC) Open House proposal added 5 projects to support winter. The proposals created capacity for additional ring-fenced befriending, telephone befriending and telephone medication prompt capacity to older people who are either |

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| | engaged with H@H, D2A or are being discharged from a hospital setting. |

| 8.1 | **What went well?** |
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| | • VOCAL's carers counselling service supported **216** carers in total. 30 carers on VOCAL's waiting list were called and offered therapeutic support. Most reported appreciating the check in call and **7** referrals were made for counselling as a result. Caring situations were often extremely challenging and resulted in safeguarding and signposting to crisis intervention services to some extent. **3** carers were highlighted with the Carer Support Team to check any immediate support requirements were met, which has now been done. VOCAL also hosted 'Open days' for carers to drop in between 10am-4pm on 30/31 January. **9** carers 'dropped in' for support and an additional **5** were spoken to on the telephone either to take referrals or give support. **6** carers benefited from complementary therapy sessions.<br>• EVOC's Open House proposals had significant engagement from all providers. Support Minds Scotland had over the 11 sessions involving **110** people. Of those who attended, people shared their love of hot food, peer support and volunteer opportunities. This proposal allowed front-door staff a clear referral route to avoid admission and ensured appropriate community support for people with mental health and substance misuse challenges.<br>• Additionally from Open House proposal, the Caring in Craigmillar Phonelink service offered light-touch telephone befriending and medication prompts throughout the day. The service received **12** appropriate referrals in total. One particular success story: '*A lady who was admitted to WGH with suspected delirium, Mrs W, was calling NHS 24, her GP and the Police most days. When calling NHS she stated she was unwell and confused and when calling Police, Mrs W was saying she had people in her house. When either service responded they found she was fit and well and no cause for concern. She was then admitted with a suspected UTI, displaying confused and with poor mobility. She was referred to Phonelink on day of discharge. The service made contact with Mrs W 2 x per day to offer reassurance and distraction by talking to her about other things. The team received confirmation that she is no longer calling the emergency services as she has twice daily contact from the team.'* **3** of the referrals were Medication Prompt clients to bridge the gap until their package of care was put in place; these clients have stayed on the service. All 12 clients are still receiving the Phonelink service, receiving calls twice a day, 7 days per week. |

| 8.2 | **What could have gone better?** |
|---|---|
| | • People prioritised for VOCAL's therapeutic support were from the carer support waiting list, rather than from Carer Support Workers existing client list. The team found this surprising that no existing carers were identified from existing caseloads and this will be investigated further with the team to ascertain why this might be the case.<br>• Projects within the EVOC's Open House proposal outlined the need to ensure all potential participants are aware of the services. It was noted that a few families had not been informed of the referral opportunity or a full explanation of what the service entails. |

| 8.3 | **Key lessons / Actions planned** |
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| | • VOCAL aims to increase engagement by ensuring carers are aware of the service available. The service was promoted widely by a variety of carer organisations, including but not exclusively, VOCAL, The Edinburgh Carer Support Team, the Edinburgh Carer Network to ensure as many carers as possible are aware of the support opportunities. The service aims to advertise more widely for future engagement. |

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| | • A key lesson from the Open House projects is to ensure future projects run during specific times of the day which suit people taking part. Often services had to change timing of when services ran to ensure optimum engagement<br>• 2 of the Open House projects have been unable to provide data at this time due to focussing on the response to the COVID-19 pandemic. This information is awaited and will be added to the evaluation on receipt |

| 9 | **AWI (Adults with Incapacities)** |
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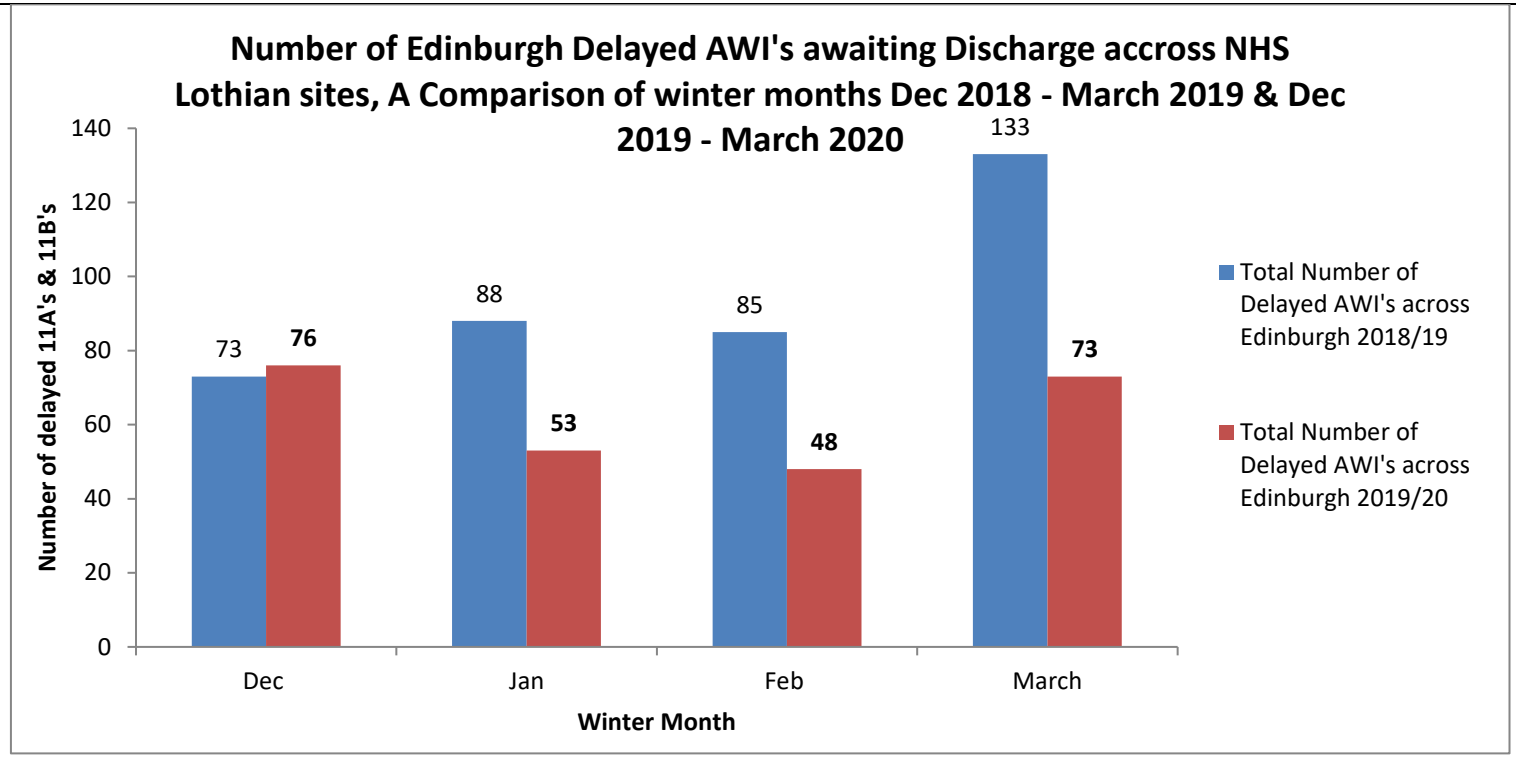
| | • The AWI proposal for winter 2019/2020 included the provision of 2 WTE Mental Health Officers to enhance current mental health provision to help identify and follow the appropriate path for people in respect of their incapacity. Current delays in hospital discharges include people awaiting legal intervention to allow selected individuals to make decisions on their behalf. Previous staffing of the AWI project team meant these people were not always fully supported. Discharge time can be significantly reduced if lawyers, family and other concerned parties are supported by this team. This is particularly critical over the winter period to enhance flow and ensure people are cared for in the right environment. |

| 9.1 | **What went well?** |
|---|---|
| | • The addition of one extra Mental Health Officer increased the availability for case conferences to be held which reduced the length of time waiting for such decision-making forums. This enabled the least restrictive option to be explored promptly leading to some people moving on from hospital without the need for guardianship applications being made. It also enabled work to commence without further delay.<br>• The overall outcomes are fewer people delayed in hospital than there were in the same period 2018/19 and a shorter on average length of stay. The additional staffing also enabled the permanent members of staff to identify training needs throughout the Partnership. The aim of identifying and addressing these needs are to increase staff knowledge around capacity issues for in-patients and relevant referrals carried out at the earliest opportunity with all discharges carried out lawfully without further delay. |




- The number of delayed AWI's awaiting discharge across Edinburgh has decreased dramatically. The introduction of 1 dedicated MHO has allowed AWI's to be more effectively supported and discharged from hospital more efficiently.

* Figures extracted from Hospital Flow Dashboard for Edinburgh correct as of 08/05/2020.

| 9.2 | **What could have gone better?** |
|---|---|
| | • Only one of the two funded posts was recruited to |

| 9.3 | **Key lessons / Actions planned** |
|---|---|
| | • The key lessons are that extra staffing reduces the number of delays and the length of delays.<br>• 1WTE MHO post has now been ringfenced permanently to support this and 1 additional MHO post has been funded on a permanent basis |

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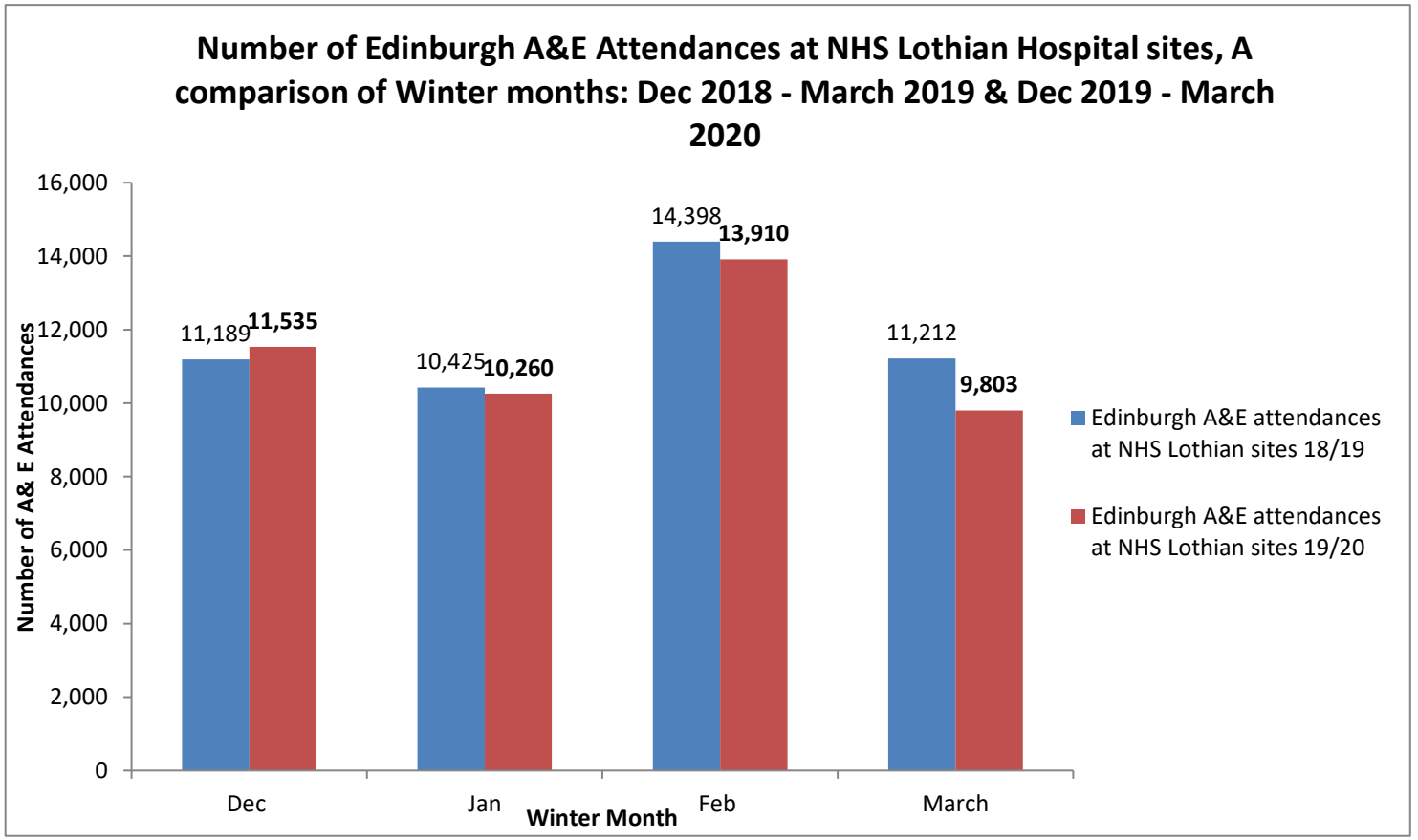
| **10** | **Data Comparisons from 2018/2019 to 2019/2020**<br>Figures from winter months (Dec-March) have been analysed for comparisons between 2018/19 to 2019/20 to highlight any significant changes in winter period outputs. **ALL FIGURES EXTRACTED FROM HOSPITAL FLOW DASHBOARD FOR EDINBURGH CORRECT AS OF 08/05/2020.** |
| **10.1** | **A&E ATTENDANCES ACROSS EDINBURGH** |




- Rates of A&E attendances for NHS Lothian sites across Edinburgh have been produced by NHS Lothian ISD. The data shows a slight decrease in attendance rates across winter months between 2018/19 and 2019/20. This drop could be a direct result of the successful winter projects which have focused on preventing admissions such as CRT+, Care at Home and Winter Support team who all had alternative patient care

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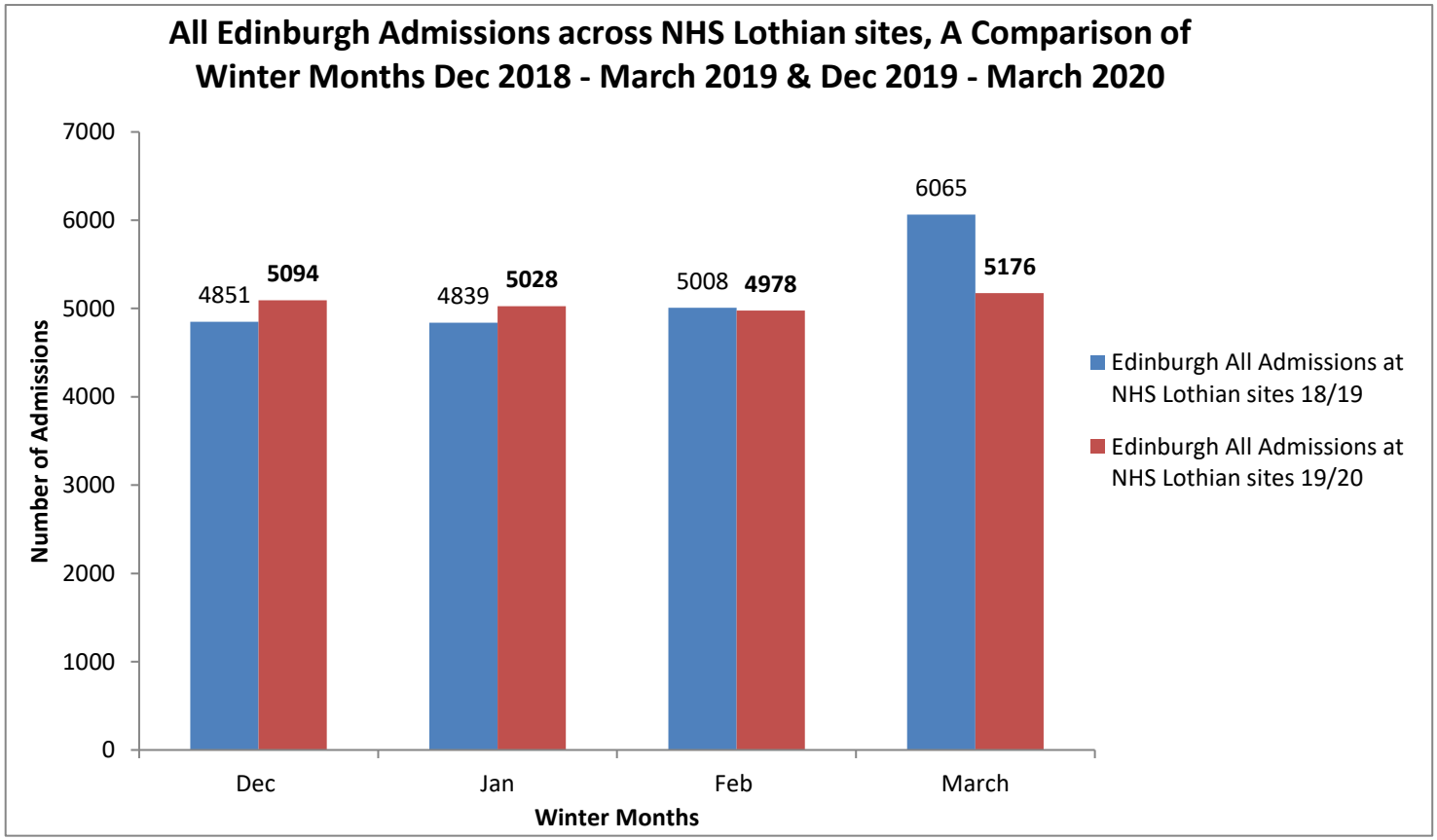
| | options than hospital admission. |
| **10.2** | **ADMISSION ACROSS EDINBURGH**<br>  <br><br>• Rates of Unscheduled Admissions for Edinburgh have been produced by NHS Lothian ISD. During March a significant drop can be noted for both A&E attendances and unscheduled admissions. However further analysis highlights some variance but no significant difference in months between 2018/19 and 2019/20. |

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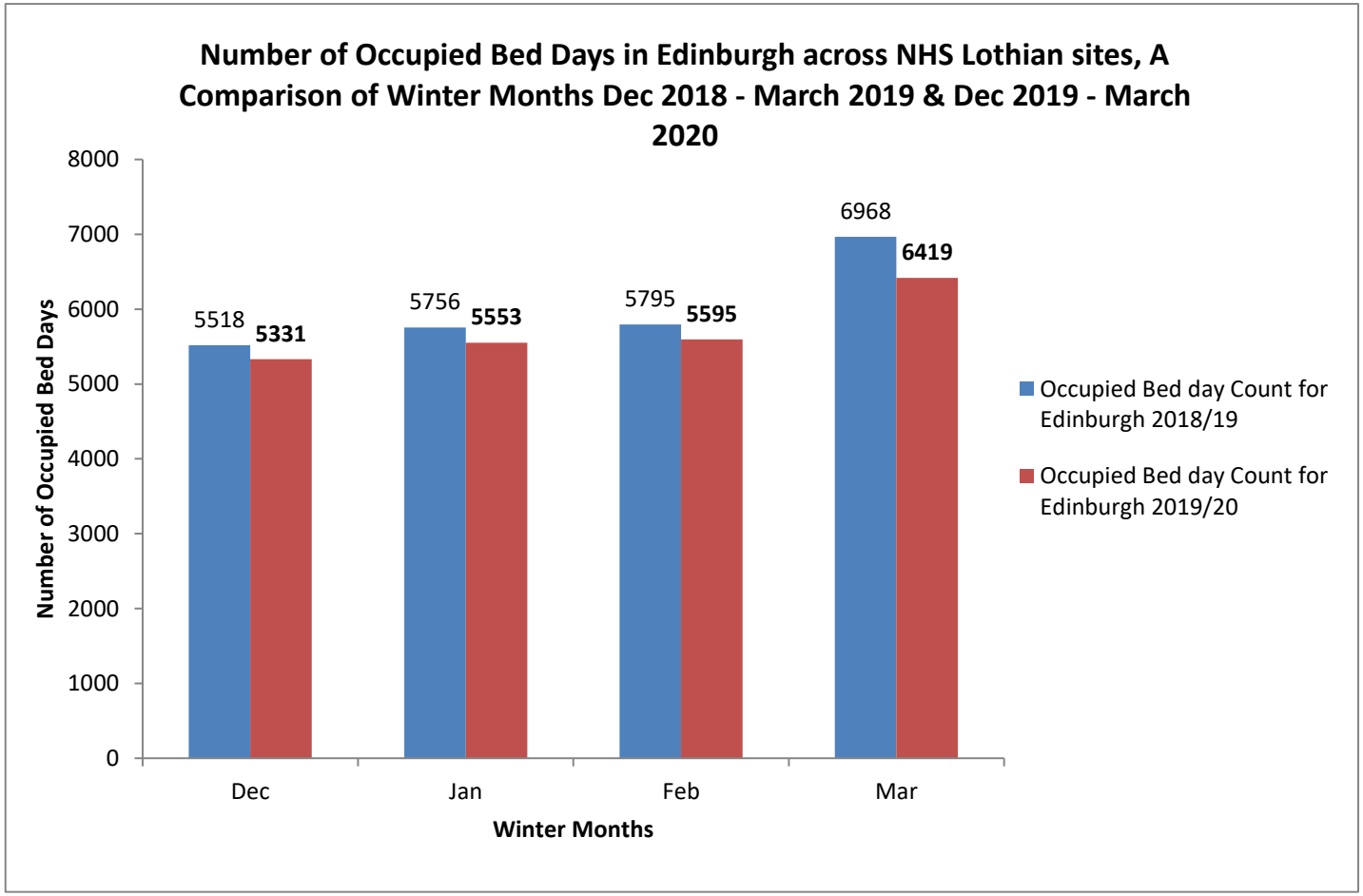
| **10.3** | **NUMBER OF OCCUPIED BED DAYS ACROSS EDINBURGH** |




- Occupied Bed Days Figures have been extracted from Hospital Flow Dashboard. As presented above, figures for 2019/20 have decreased steadily in comparison to 2018/19. This was a key priority of last years reflections to ensure occupied bed days to decrease. This success could be reflective of the winter projects which have focused heavily on reducing the number of people in hospital. Projects such as the AWI, Social Work to support home first model, Care at Home and Winter Support Team all actively contributed to reducing bed days across Edinburgh by creating alternative packages of care.

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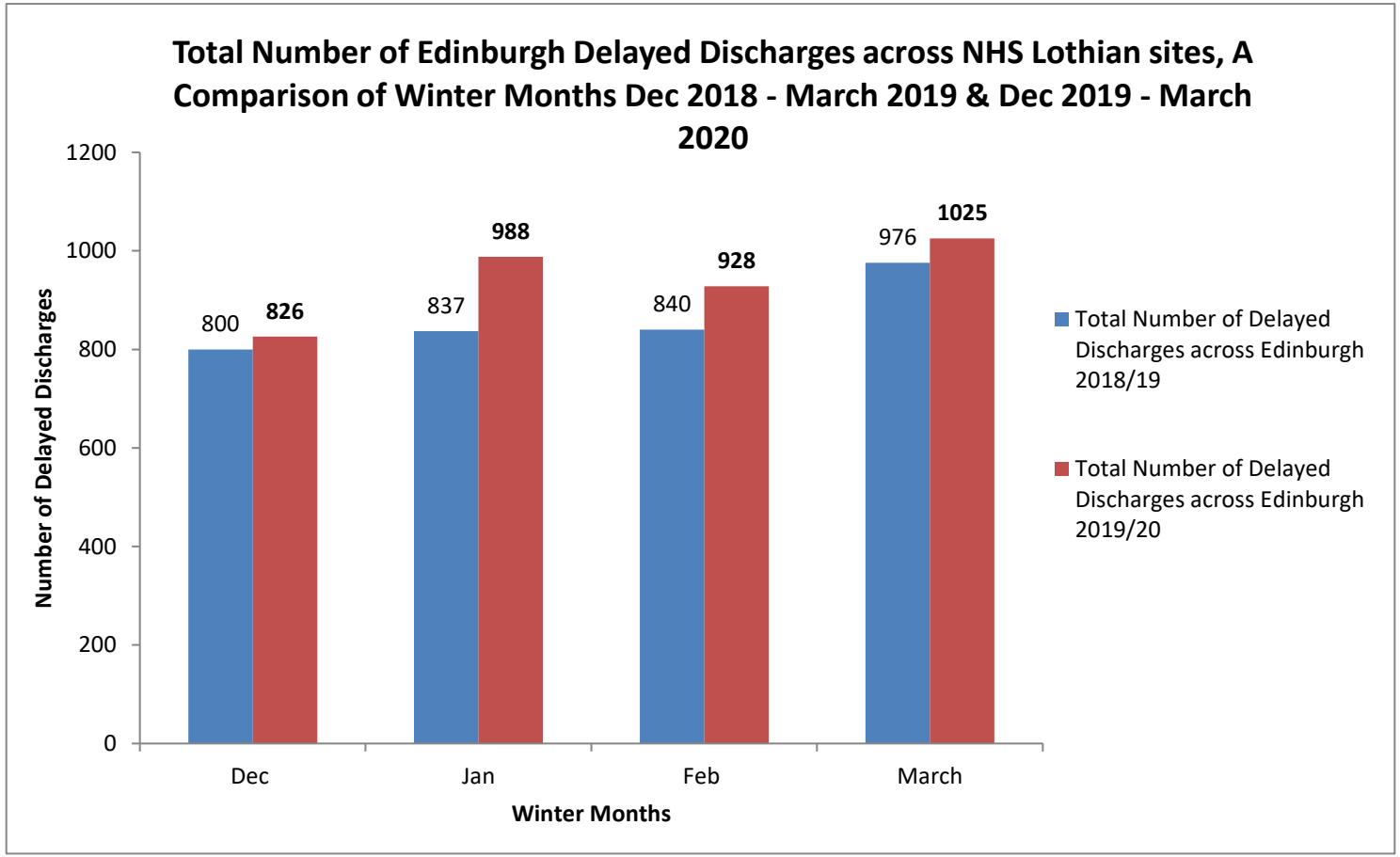
| 10.4 | **NUMBER OF DELAYED DISCHARGES ACROSS EDINBURGH** |




- Delayed Discharge figures have been extracted from Hospital Flow Dashboard. As displayed in the graph above, average numbers of Delayed Discharges in Edinburgh have increased from 2018/19. This will be a priority of next winter to ensure projects are successful in increasing discharge flow across the city. Learning from the response to COVID-19, and the resultant reduction in delayed discharges, will heavily influence this planning

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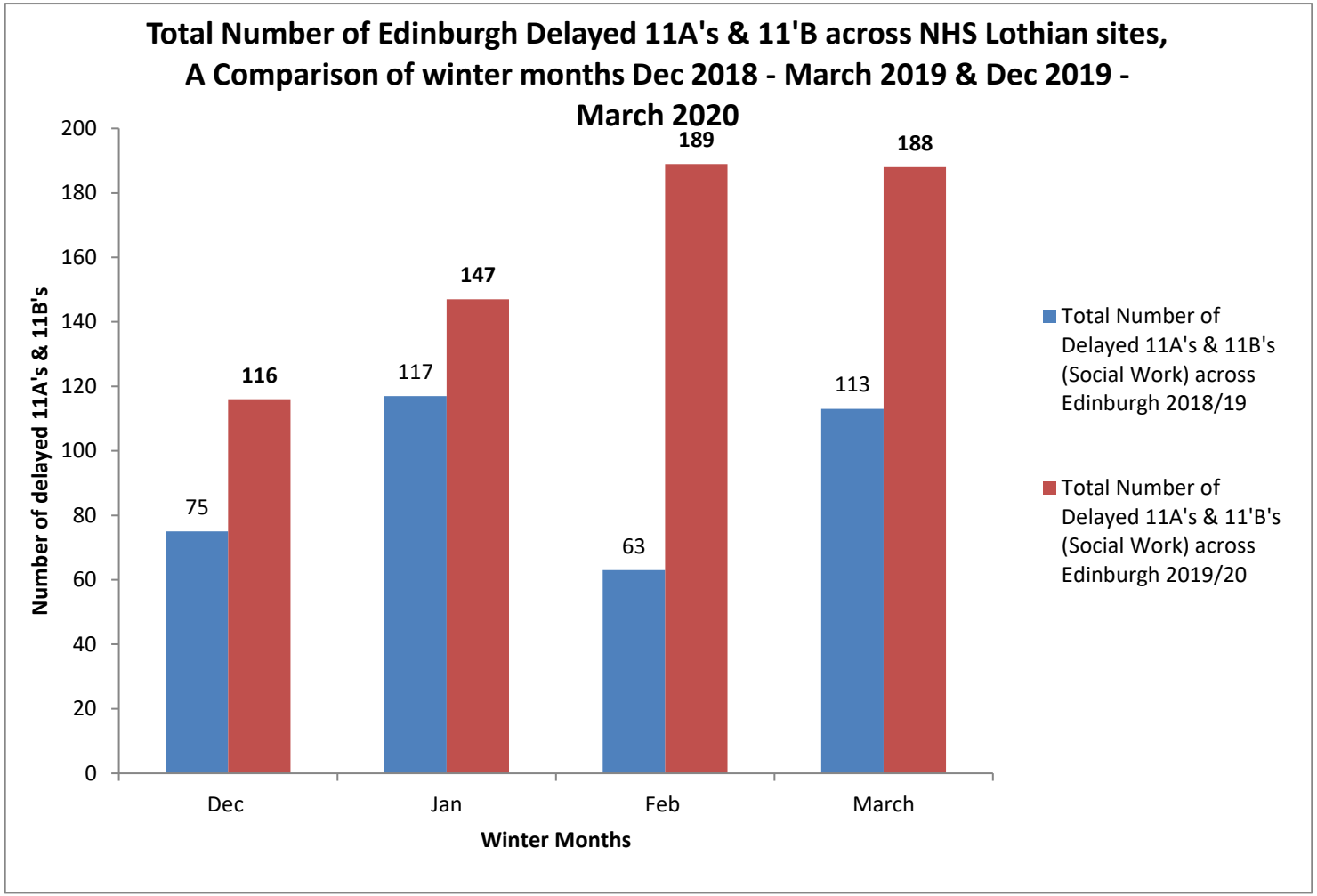
| 10.5 | **NUMBER OF DELAYED 11A'S/11B'S ACROSS EDINBURGH** |




- (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 unfortunately increased across Edinburgh during winter 2019/20. A priority for next year's projects is to ensure the effectiveness of Social Work enhancement projects which in turn will deliver the target of reducing unallocated work and the time to allocation.

| 11 | **Top Five Local Priorities for Winter Planning 2020/21** |
|---|---|
| | 1) It is expected that the answer to the priorities will lie in the lessons learned from COVID-19 thus far; this work is underway being led by the transformation team, so any priorities submitted will be subject to that caveat.<br>2) Renewed focus on Community Respiratory Team +, particularly in light of the COVID-19 pandemic, and the possible permanent expansion of this service, as well as continuation of the COVID-19 Advice Line<br>3) Care at Home winter planning contingencies are a sensible consideration for the coming year, based on experience from Winter 2019/20 and this may be further amplified by experience from COVID-19<br>4) Continued provision of the Festive Practice on 4 public holidays<br>5) Augmentation of Home First |

# Health & Social Care: Local Review of Covid 19 Pandemic

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|---|---|---|---|
| **NHS Board H&SCP s:** | NHS Lothian<br>Edinburgh, West, East & Midlothian H&SCP | **Unscheduled Care Committee Executive Lead:** | Alison MacDonald / Jacquie Campbell |

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| **1** | **There is a visible cohesion and alignment across Acute, HSCP, Primary Care and NHS Lothian Board** |

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| **1.1** | **What went well?** |
| | **Home First**<br>The Home First approach helped drive a reduction in delayed discharges with particular reference to those in acute.<br><br>○ 9th March- 169 delays with 114 on acute sites<br>○ 30th March- 144 delays with 82 on acute sites<br>○ 5th May- 60 delays with 21 on acute sites.<br><br>There was a clear focus on discharges through the home first team and access to beds and funding to support this. There was the ability Able to have realistic conversations at an early stage and cooperation from acute colleagues. Home First applied a community approach, with the whole system being engaged in this and the external market geared on a single objective. Usual cultural behaviours were effectively disrupted, with acute services recognising the need to handover to locality once the acute episode was dealt with.<br><br>**Primary Care**<br>In relation to Primary Care, all H&SCPs quickly ceded authority to the primary care tactical Group for GMS (and other contractor groups). This allowed a consistent approach from a group well used to working with each other , engagement from all H&SCPs and NHS Lothian and firm reporting links. More generally, the ability to make decisions quickly and report rather than request permission, was appreciated by all and made the decision-making process more focused. Decisions could be taken quickly – and then reversed when necessary, without the requirement of unhelpful formality.<br><br>**Carer Support**<br>The service has continued to function and receive referrals across all sectors. A helpline for carers was set up, with new systems such as Microsoft Teams and Near Me enabling staff to operate the helpline from home. Carers COVID-19 information |

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| | pack co-produced with the Edinburgh Carer Support Team (ECST) and partner organisations and sent out to all known carers in Edinburgh via carer organisations mailing lists. The pack includes details about appropriate use of Personal Protective Equipment (PPE) and supply options for carers - a policy that changed and developed quickly.<br><br>**Rehabilitation**<br>Acute hospital services were updated by EHSCP about community rehabilitation provision to support hospital discharge. This was done via email, and early in the COVID-19 response. Musculoskeletal Physiotherapists, Social Workers, Occupational Therapist and Community Care Assistants all underwent rapid additional training in manual handling, infection control and low-level medication prompting to allow them to be deployed into Care Homes and Home Care settings. There has been limited requirement to redeploy staff but it has happened in various settings.<br><br>**Mental Health & Substance Misuse Services**<br>Vulnerable groups of people were quickly identified and services adapted in order to support them at home, for example, monitoring of patients on high doses of medication. In one locality, the Substance Misuse Service was split into 2 teams to prevent infection outbreak across the team, and to enable good safe physical distance working for staff. Prompt response to enquiries submitted by the service to the Caldicott Guardian, which enabled staff to provide information to patients about wellbeing services and coping strategies; for example, the Caldicott team were able to turn around a request in 4-5 days, giving nursing and occupational therapists permission to share information with people by text and email about resources that can help people maintain good health and wellbeing. |

| **1.2** | **What could have gone better?** |
|---|---|
| | **Home First**<br>Care at Home capacity was a challenge initially which created the need for more Safehaven beds. Planning around the ongoing needs of people going into Safehaven was challenging – issues with people getting rehab when care homes were not giving access to therapy. Challenges with the prioritisation for OT - often the assessment came late in the pathway.<br>The Home First approach experienced some challenges with conflicting information coming from localities, emphasising the need to work in a city-wide home first structure.<br><br>**Primary Care**<br>The links between Primary Care and acute were less well developed at the outset and it took more time for the picture to emerge and for GMS to understand what was happening in acute services |

| 1.3 | Key lessons / Actions planned |
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| | There is an urgency for the Home First approach to be formalised with a staffing structure- currently it relies too heavily on negotiation with different parts of the system and this makes it difficult for acute teams to know who to contact. Home First is not being routinely being applied by acute teams- flow is seen as key rather than a whole system approach of getting the person to the correct place. There is too much emphasis on delayed discharge, rather than Home First being community facing and preventative.<br><br>**Carers**<br>Detailed mailing lists need to be kept up to date. This enables information to be provided quickly when requested. Identify categories for casework lists.<br><br>**Rehabilitation**<br>Action planned for having a Single Point of Access for all post COVID-19 referrals into EHSCP for post COVID-19 rehabilitation. |

| 2 | Arrangements in place to across the whole system to facilitate consistent discharge rates across weekends and public holidays periods |
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| 2.1 | What went well? |
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| | There was Home First cover over public holidays and discharges took place. The prevention team was in place to prevent admissions where there may be additional care required. |

| 2.2 | What could have gone better? |
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| | Seven day working in the partnership would have allowed for more effective responses. There was limited weekend cover. |

| 2.3 | Key lessons / Actions planned |
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| | |

| 3 | **There were clear actions between Acute Services (Unscheduled and Scheduled Care), Health and Social Care Partnership and Council, and Primary Care to provide safe, effective patient care** |
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| 3.1 | **What went well?** |
|---|---|
| | In general, there was very good engagement from staff across the systems to be flexible in their working approaches and environments, often taking on additional responsibilities and learning new skills. There was a high level of person-centred practice to support safe, effective care across the system.<br><br>There was recognition across the system of the importance of PPE to support **safe** care to protect the most vulnerable members of our society as well as protecting the staff.<br><br>**Long Term Conditions (LTC)**<br>Improved Anticipatory Care Planning (ACP) facilitating Key Information Summaries to be shared across the whole system. The Long Term Conditions Programme within EHSCP has taken a lead on these improvements. Guidance developed to support GP Practices, Care Homes and community health professionals to create COVID-19 relevant anticipatory care plans. This included development of recommended Key Information Summary (KIS) quality criteria to encourage people to think ahead and ensure information is meaningful and can be shared.<br><br>Through working with District Nurses, ACP questions were developed for people with severe frailty at home, enabling specific treatment options to be included in their Key Information Summaries (KIS). District nurses gave green key shaped 'KIS' fridge magnets to give to people who have a KIS in place. The fridge magnets helped prompt Out of Hours practitioners and Scottish Ambulance Service paramedics to check for a KIS.<br><br>Provided support to the Edinburgh Community Respiratory Team to have COVID-19 ACP conversations and input to shielding cohort ACP-KIS ECHO (Extension of Community Healthcare Outcomes) provides an education model for connecting communities of practice through teleconferencing and web-based technology. The Long-Term Conditions team virtually hosted two ECHO Network sessions to provide ACP implementation and peer support for all care homes in Edinburgh.<br><br>**Mental Health & Substance Misuse Service**<br>Made good use of daily MATT meeting to ensure people could be prevented from being admitted and support/ prevent delays in discharge. REH has had some capacity throughout the pandemic. This has been a testament to people's own resilience and not wanting to be in hospital, but also to the efforts adopted by EHSCP staff in maintaining a good level of contact with people to ensure they are keeping well and safe. |

| 3.2 | What could have gone better? |
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| | **Workforce**<br>There appeared to be a significant national movement to boost the workforce by bringing in those who had recently left without consideration of the availability of staff already within the system. EHSCP took considerable ownership of the work force issues and instigated a link with NHSL, until this point there was no clear connection (other than with nursing) between EHSCP and NHSL Covid-19 workforce planning teams until very late in the day. The pressures were anticipated to be in acute however in reality were spread across the system including care at home (including unpaid carers) and Care Homes.<br><br>**Primary Care**<br>Whilst primary care responded immediately to lock down with a different way to operate, some acute services attempted to carry on as normal, causing tensions and avoidable confusion where community service were operating from a quite different approach.<br><br>**Mental Health & Substance Misuse Service**<br>Some discharges were delayed as housing staff and social care providers were only offering telephone support. |

| 3.3 | Key lessons / Actions planned |
|---|---|
| | In relation to Primary care, we are working with SG to develop and implement the nursing workforce tools for community nursing – including care homes. For care homes, we are working to implement the new government guidelines. This will include building on existing good work and implementing systems to give assurance about the care of residents.<br><br>Requirement for very clear authority to be vested in one place for acute services, rather than individual depts. adopting operational arrangements which best suited their interests.<br><br>**Mental health and Substance Misuse**<br>It is anticipated that there will be a surge in mental health referrals for people that have been traumatised by events related to this pandemic. The service is, however, starting to think of ways to respond to this need and have trained up all mental health nursing, occupational therapy and social work staff in Decider Skills training in order to provide a collective response to this potential need. |

| 4 | Preparing effectively for infection control in Acute and Community settings |
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| 4.1 | What went well? |
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| | The newly established Care Home Support Team are now working 7 days per week. Following an initial self-assessment discussion, the team are visiting care homes to provide education and training on infection prevention and control and with PPE. Activity is prioritized through working closely with public health using the PAGs/ IMTs daily sit rep and through the Lothian care home daily operational group. We are reviewing the current structures to support care homes in line with the recently issued SG guidance.<br><br>Due to the personnel involved in the Command Centre and link with the PPE distribution Hub, EHSCP were able to respond rapidly to the numerous and ever-changing PPE guidance and processes. Quick responses from Procurement helped to reinforce the supply chain, with active and responsive supply.<br><br>Effective working relations with Infection Prevention and Control colleagues when patients in community hospitals were diagnosed with Covid-19; working together ensured there was clarity on 'red and green' areas, when admissions had to be restricted or managed carefully to limit the risk to other patients.<br><br>Additional uniforms were purchased for Home Care staff. The service was also able to procure uniforms for Community Psychiatric Nurses at relatively short notice – this built confidence in the workforce. Swift response to request to increase domestic services to help maintain cleanliness and reduce potential spread of infection in the building. |

| 4.2 | What could have gone better? |
|---|---|
| | More preparation time for care homes would have been helpful at the outset. Guidance at the outset was unclear and came from a variety of sources – it was not sufficiently clear which guidance care homes should listen to. Multiple changes to guidance in a short space of time. Care Home staff were not sufficiently well trained or confident using PPE. Staff encountered difficulties in dealing with negative press and needed better support in managing the impacts of this.<br><br>Earlier testing of non-NHS staff and people being discharged to care homes. Integrated PPE advice from outset. PPE supply should have been centralised at a very early stage, with a clearly articulated process for the ordering and delivery of equipment. At one point PPE was being ordered from three different sources. |

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| | If the care Home deaths had been reported on the COVID dashboard this issue would not have taken us 'by surprise'. Work was going on with the Health Protection team but not at the scale required and time was lost before the seriousness of the situation was recognised. Whilst it would most likely not have protected patients from infection the care homes would have been better supported during what continues to be a very challenging period.<br><br>There was a vast range of information and changes in process with regards to PPE which made it extremely difficult to keep on top of. The link with NSS was very challenging and created additional challenges across the system. Poor communication and direction within the EHSCP Command Centre and between NHSL resulted in additional challenges which required very rapid actions within the operational services. Improved communication between EHSCP personnel and, EHSCP and NHSL, with a recognition for expertise already in the system would have improved the tactical approach to PPE provision.<br><br>Sometimes difficult to keep up to date with changing guidance on red and green flows and how these were applied locally to ensure patients were admitted to the right area. Occasional different views from Infection Prevention and Control colleagues would cause confusion for local staff as to what actions they needed to take for safe patient management. Also a need to manage staff heightened anxieties about how long patient infectivity lasts especially for those who had a prolonged stay in ICU. This included the Scottish Government / NHS Scotland / HPS information and guidance vs what staff were reading in the media or hearing from other centres in the UK. |

| **4.3** | **Key lessons / Actions planned** |
|---|---|
| | Better training to be implemented for care home staff in relation to infection control. There have recruitment issues over the last 12 months and that has resulted in us going into this crisis with many vacancies which further exacerbated the situation.<br><br>The Care Home Tactical Group appears not to have the requisite authority to take decisions – e.g. the confusion and delay over the establishment of testing for care home patients. It became clear that an 'arms length' contractual relationship between the H&SCP and local care homes was not adequate under these circumstances. The disinvestment in 'linking' capacity was made by the H&SCP several years ago. GPs know their Care Homes well and are valuable sources of insight – this should be built into any future plans to respond to such circumstances.<br><br>Ensure that clearly articulated process pathways for pandemic response are developed as part of future resilience plans. |

| 5 | **Additional services/pathways were developed (for example, Community Covid-19 pathway) to manage increased demand for health and social care** |
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| 5.1 | **What went well?** |
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| | **Primary Care**<br>The speed at which the COVID clinics were established to take the symptomatic patients out of GMS. Speed at which individual GP practices moved to a completely different way of operating. After initial hesitancy the speed at which staff testing was scaled up and developed to provide both capacity and quick results was hugely influential in ensuring primary care practices were able to continue to function and not forced to merge as was originally presumed as inevitable.<br><br>**Home First**<br>Home First looked at all health delays which has dramatically reduced the number of people transferring to intermediate care beds when then may be able to go home. Safehaven- additional capacity as an interim move – resulted in reduced length of stay and moved people off site. Also supported when care home providers were not able to pick up.<br><br>**Hospital**<br>The AAH Discharge Hub have changed their processes to support the Home First approach in Edinburgh by directing patients for a Home First review first rather than automatically adding to a waiting list for bed based rehabilitation including intermediate care. Able to flex intermediate care beds in Liberton Hospital when additional capacity was required due to a loss of access to the intermediate care beds at Fillieside during a Covid-19 outbreak. In addition 'red and green' areas were able to be established quickly when patients in Liberton were diagnosed with Covid-19.<br><br>**Community Support**<br>The creation of a shielding phone number/email address and Vulnerable People phone number/email address linked to a range of support services including third sector responses (coordinated response across CEC/EHSCP/third sector). This clarity has been really important from user perspective – one number to refer to/contact. Pharmacy Deliveries to those in shielded and vulnerable groups using redeployed staff and volunteers – initial teething problems seemed to have been ironed out quite quickly<br><br>**Locality Responder Teams**<br>In one locality, the Hub and Clusters have split into 4 broad spectrum responder teams, comprising social workers, occupational therapists, physiotherapists and community care assistants, and will each take responsibility for being initial responders. A backup team is also in place that can be used should staffing levels fall below safe staffing levels, and to meet essential demand. The immediate allocation of work to a person who has ownership of that work until it is completed. Live |

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| | screening - actively responding to critical referrals, but all referrals have some form of contact/Conversation One. The service is no longer actively adding to waiting lists and are therefore able to respond to people w straight away.<br><br>**Carer support**<br>The Coronavirus Act temporarily relaxes the duty in the Carers (Scotland) Act 2016, which provides all carers with the right to an Adult Carer Support Plan (ACSP) or a Young Carer Statement. The ECST have, however, continued to offer ACSP via telephone consultation or Near Me video conferencing and are still able to access carer support payments where applicable. The team were able to access and be set up to use the Near Me video conferencing option.<br><br>**Rehabilitation**<br>New post-COVID-19 Advice Line set up to support people in their recovery and rehabilitation. New collaborative working with community neurological rehabilitations teams to create one team which allows for a sustainable and responsive rehabilitation team supporting neurological hospital discharges. Using technology to support rehabilitation/ assessments/ welfare. Community Respiratory Team has broadened its referral criteria beyond Chronic Obstructive Pulmonary Disease and now accepts referrals for all respiratory conditions, from both primary care and acute services.<br><br>Development of the COVID-19 self-referral line, which is staffed by Pulmonary Rehabilitation Physiotherapists. 50 calls were received in week 1. The COVID-19 Community Rehabilitation Single Point of Contact is very close to launch – giving Acute referral sources a dedicated referral point to refer those patients not requiring bed based rehabilitation and advice to seek multi-disciplinary team assistance and rehabilitation. Increased telephone consultations and extended use of Florence/ Attend Anywhere/ Skype/ NearMe offering telephone support and other telehealth.<br><br>**Long Term Conditions**<br>Creation of COVID-19 Digital Guide led by the Long Term Conditions Programme to support practitioners within EHSCP. The guide provides quick and accessible information on safe digital options to connect staff with peers and people in their homes, taking into account information governance across both the council and health systems. The use of Florence Telehealth was upscaled to support Home Health Monitoring for rehabilitation, welfare checks, anxiety management and to support people to stay active. Community health and social care services increased telephone consultations and implemented video consultations using Attend Anywhere/Near Me and Business Skype. The Scale Up BP (Digital) programme was expanded through the Long Term Conditions Programme – 12 GP practices opted to move to an enhanced national protocol to assist home monitoring of patient's blood pressure. Within the Long Term Conditions Programme, Falls Coordinators developed guidance for Care Homes to help support residents to stay active and reduce the risk of falls. A Falls Coordinator Near Me account was set up to provide advice using video consultations. All Edinburgh Care Homes were offered the opportunity to connect with the Falls Coordinators in this way. |

| 5.2 | What could have gone better? |
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| | Early assessment and determination of home first pathway by the acute teams. Home First should have been embraced at an earlier stage. Care Homes were reluctant to allow professionals in to carry out rehab. Risks of Covid meant that some people reluctant to go to a care home. Issue around internal care homes – reluctance to take safehaven due to high clinical needs they were balancing in the care home.<br><br>Speed at which the 111 telephone response was staffed up to capacity required – but extremely difficult to have foreseen the scale. Message to patients that their GPs continued to be 'open for business' should have started immediately. Perhaps did not happen as people were reeling from initial demand on practices and staff shortages. The poor communications around BOTH the supply and distribution networks for PPE.<br><br>**Community Support**<br>Better public communication from early on that GP practices and A&E departments remained open for non-COVID-19 symptoms too, and reassurance to public that measures had been put in place to allow for either a virtual consultation or safe(r) in-person assessment. This reassurance did come later, but services still not seeing normal levels attending, indicating at least some people are still staying away. Community organisations were reporting confusion on this issue until at least four weeks into lockdown. Reasonable to expect significant 'catch-up' demand for consultations once lock-down measures are reduced. |

| 5.3 | Key lessons / Actions planned |
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| | **Home First**<br>Ongoing learning and development both for acute and partnership staff. The Home First message is not yet fully understood. Constant review of the pathways,- are we getting the correct pathway for the people of Edinburgh? Direction of staff under acute - would the Home First/ Community message be easier if teams were embedded into the Partnership but still have the gains of flow?<br><br>**Locality Responder Teams**<br>Any perceived barriers between Hub and Clusters are now gone. Staff time is being better utilised – no passing work around the locality or between teams. There is a need to ensure that all staff who need it have access to TRAK. The team needs to monitor how overdue reviews, current reviews and guardianship are managed and what this means for future. Continue to use responder team model to manage Discharge to Assess referrals. This will need to be reviewed.<br>**Home Care & Reablement** |

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| | Improve communications at point of discharge and appoint a lead person. Haven beds for immediate discharge from hospital while awaiting POC. Reduction of Home Care services agreed with person/ family members/carers to critical cover only, creating capacity for discharge to reablement.<br><br>**Rehabilitation**<br>Balance of face to face initial assessments versus telephone assessments. This is person specific (depending on whether it is for a service user or carer) and dependant on circumstances/ confidence. Rehabilitation and keeping well – what is our role? Evidence base – physiotherapy and occupational therapy team leads to start thinking about how some of the non-critical occupational therapy work is managed in this model as lockdown is eased. Dedicated team/ rota to manage call volumes/ call backs. |

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| **6** | **Modifications were made across sites and services to manage staff absence, well-being and recruitment of supplementary staff** |

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| **6.1** | **What went well?** |
| | **Workforce Planning**<br>EHSCP Covid-19 workforce planning group set up at an early stage to have an oversight of key workforce issues and routes to obtain additional staff/volunteers and reassign existing staff to meet demand. The group established prompt contingency plans and processes to manage the potential and anticipated workforce challenges. In reality, the demands on the work force were lower than expected as service managers worked internally and with others to reassign individuals and teams to meet demands.<br><br>In general, staff have willingly volunteered to take on new roles and responsibilities to assist in meeting new and existing demands which allowed a significant amount of reassignment of staff across the system. Essential training was set up and accessible very promptly to allow the reassignment and recruitment of staff across the system. There were considerable resources available to support staff wellbeing across CEC and NHSL. Good access to confidential support services for staff within care homes, many of whom are traumatised and sad.<br><br>Despite the crisis and the need to adapt their processes, the recruitment teams in CEC and NHSL have mobilised to allow for recruitment to continue throughout this challenging time. |

| | |
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| | Primary Care Teams re-organised almost overnight to provide a different shape of service and facilitate home working for those who could. The NHS Lothian Primary Care IT team seemed to be able to operate with a pace and effectiveness which was hugely reassuring.<br><br>A process is now in place which provides care homes with NHS mutual aid once all local resilience plans have been exhausted. A small pool of bank staff can be accessed by care homes through a single point of contact to EHSCP.<br><br>**Mental Health & Substance Misuse Service**<br>The team acted early in the pandemic to implement public health guidance around social /physical distancing of staff, and this provided reassurance to staff that their health and wellbeing was of fundamental importance. This in turn reduced levels of anxiety.<br><br>**Locality/ Responder Teams**<br>Daily Microsoft Teams meeting with all responder groups to ensure staff stay connected, ensuring wellbeing support is directed as required. Daily Microsoft Teams meeting with Senior group at 10am to plan the work for the day and to discuss any barriers, create solutions and identify staff anxieties/provide support, ensuring work is planned and ownership taken. This has worked really well.<br><br>The creation of a fully up to date staff database, with key information about current role (band/grade, whole time equivalent), about personal circumstances which may impact upon their ability to attend work (for example, whether an individual has dependents, a caring role, or if they rely solely on public transport), and also information about additional skill set over and above their current substantive position, to aid in the appropriate redeployment of staff where required. The principle that staff work from home where possible. Wellbeing measures introduced such as a rota for a daily buddy call between members of the team. Daily check-in via WhatsApp. The use of Microsoft Teams for team meetings and keeping in touch where people could 'see' each other. File sharing on Microsoft Teams has been useful when mailboxes are full, which has been a regular occurrence during the pandemic. Daily team Skype handover to discuss service user issues. Supervision is still in place.<br><br>**Homecare and Reablement**<br>Despite staff sickness levels being higher than usual, together with staff shielding , POCs were reduced to critical care only to ensure appropriate staffing levels were maintained to care for people safely. |

| 6.2 | What could have gone better? |
|---|---|
| | **Workforce Planning**<br>There was a reticence amongst some managers to fully engage with the Covid Workforce Group which appeared to question the value and role of this group as a support mechanism. As a result, the data submitted to the group was variable and often incomplete which meant it did not provide an accurate oversight of the workforce issues. This appeared primarily to be as locality managers were working to mobilise staff internally however meant it wasn't clear where staff availability/demand was and what staff were available to draw on.<br><br>Additionally, the Nursing workforce was segregated from the remit of the group, this created a fragmented approach with a less than cohesive approach. An example being when CEC Care Homes had immediate demand it was nursing that was required to support that, without having oversight or access to data on their staff pool the group was hindered in its ability to fill the demand. Improved communication to/from the group, supported by the Command Centre and IEMT, with a more joined-up approach could have been much improved to encourage engagement in the value of the group across the system.<br><br>The workforce guidance from SG and NHS Scotland was complex and untimely which resulted in boards/partnerships making individual decisions when required. This created confusion and a lack of consistency across the organisations which inhibited the effectiveness of the group.<br><br>The NHS Lothian recruitment portal did not seem to be able to be responsive to what was a chronic shortage of capacity.eg a PC mental health nurse took 7 weeks to bring into post. |

| 6.3 | Key lessons / Actions planned |
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| 7 | Acute Services, Health and Social Care Partnerships settings were modified to ensure a safe environments for staff and patients |
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| 7.1 | What went well? |
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| | Staff who knew their buildings immediately made modifications. Helpful check list document was quickly made available to all GPs thru the Primary Care tactical group.<br><br><u>Social distancing</u><br>For staff who need to attend work because home working is not an option there has been flexible use of office and other |

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| | accommodation (such as meeting rooms) to ensure social distancing can be maintained. Most meetings are being held using technology but when a face to face meeting is required a suitable space is used to allow social distancing for the number of people attending.<br><br>In mental health and substance misuse services, gel is provided at front door, chairs in waiting room spaced out, working from home for non-essential staff. The service is only providing essential support (medication prompts, shopping support, personal care and so on) and all other support is via telephone. PPE is worn, and social distancing measures apply.<br><br><u>Home working</u><br>Staff who already have a work laptop were able to get set up for home working relatively quickly. MS Teams is able to be used for them to engage with online meetings or 1:1 discussions. New equipment provided for some staff to enable healthy working from home and prevent postural pain and discomfort.<br><br><u>PPE</u><br>In addition staff identified and took on the role quickly to be Face Fit Testers in hospital based services including working flexible hours to see to see staff who need tested (e.g. evening / night working)<br><br><u>IT</u><br>All staff having access to MS Teams in the NHS although introduced quickly at the start of the Covid-19 response so staff had little opportunity to learn how to use it properly. This has resulted in staff learning from each other and learning as they go along. |

| **7.2** | **What could have gone better?** |
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| | <u>Home working</u><br>Very difficult to get NHS staff set up for home working if they do not have a work laptop or a personal laptop of a suitable specification which allows them to get access via NTX Gateway. Laptops ordered from eHealth on 1st April have not yet arrived. Also some delays with getting set up at home in the first instance and then loss of connection is a common issue especially in the early days.<br><br><u>PPE</u><br>Staff anxieties were sometimes leading to the misuse of PPE, not helped by changing guidance. There has been a need to repeat face fit testing due to unavailability of some types of masks, so staff have to be fitted again. Confusion about ordering and supply processes although this has improved significantly recently. Mixed messages / understanding on what procedures |

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| | are classed as Aerosol Generating Procedures (AGPs) particularly in relation to nebulisers. Increased anxiety from frontline homecare and reablement staff in relation to appropriate PPE, when it was an ongoing issue. Staff asking for masks to use on a daily basis to protect them and clients. Staff going off sick due to self-isolating and stress from pressure they feel attending clients who may be positive.<br><br><u>IT</u><br>As noted above there have been occasions when staff working at home (when we have been able to get them set up with home access) have lost connectivity so are limited in what work they can undertake. This has been less problematic more recently but frustrating when it does happen as staff are then limited what work they can do at home and in some instances have come into their own base or another base to get access. There seems to be an issue for staff getting access to MS Teams if they are using a Wyse computer as this relies on a virtual desktop. Many staff have an old version of Outlook which makes it harder to set up MS Team meetings in diary invites (there is a work around, but this is not clear in the guidance and most people have learned from someone else).<br><br>Within the first two weeks of lockdown, guidance for video conferencing changed for EHSCP with the use of Zoom being withdrawn due to security issues. This was not communicated clearly across EHSCP, however, so many staff were unaware of the change. |

| **7.3** | **Key lessons / Actions planned** |
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| | <u>Home working / IT</u><br>Need to have better access to laptops / mobile phones to allow NHS staff to be quickly set up for home working.<br>Needs to be individual discussions with staff about whether they are able to work from home (if they have the equipment) as it is not possible for everybody depending on their personal / home circumstances. If the preference is to attend work then we have a responsibility to ensure they are safe such as social distancing. Some staff have felt quite anxious about working from home but have felt that they did not have an option even if it didn't suit their circumstances. |

| **8** | **Additional Costs Incurred (Please provide full details, staffing, grade, equipment associated with each intervention)** |
|---|---|
| | Moira Pringle is working on this information and will supply |
| **9** | **Additional Information** |
| | |

# NHS Lothian: Winter Plan 2019/20

Lothian NHS Board

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To: Chief Executive NHS Scotland and Director-General Health & Social Care, Unscheduled Care Director

Cc: Chief Performance Officer NHS Scotland and Director of Delivery and Resilience

Date 11 November 2019
Your Ref
Our Ref TPD/WINTER

Enquiries to Tim Davison
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Direct Line 0131 465 5807
Email chief.executive@nhslothian.scot.nhs.uk
EA elaine.watters@nhslothian.scot.nhs.uk

Dear Malcolm,

**PREPARING FOR WINTER 2019/20**

Following on from your letter of 4th September 2019, we attach the Lothian Health and Social Care System's Winter Plan.

The development of this plan has been overseen by the Lothian Unscheduled Care Committee which is chaired by Alison MacDonald, Chief Officer, East Lothian Integration Joint Board.

The Committee is tasked to plan, implement and produce a Winter plan that demonstrates safe, effective, patient centred care for patients with the best outcomes for relatives and staff. This Winter plan has utilised a scoring framework to prioritise Winter schemes which have been derived from the learning from previous years and as noted in the 2018/19 Debrief to Scottish Government.

A framework was developed through the Committee that encouraged prospective Winter objectives to be evaluated against:

- Supports Joint Working between Acute Services and Health and Social Care Partnerships (HSCPs)
- Supports a Home First Approach
- Admission avoidance
- Site and Community Resilience/Flow
- Supports a non Bed Based Model
- Facilitates 7 Day Working and Discharging

The allocation of Winter funding from Scottish Government has also been met with commitment from the NHS Lothian Board. NHS Lothian has therefore invested a further £2.0m into this plan.

Our focused investment from additional resources is intended to further support improvement priorities for Unscheduled Care. There are projects throughout Acute and Health and Social Care Partnerships that are already evidencing improving performance against the 4 hour Emergency Access Standard and Delayed Discharges. The improvement trajectories and Winter impact will be monitored through the Unscheduled Care Committee from December – March 2019/20.

Key Actions which the Board has taken and will progress through the Winter period are:

- Enhancement of senior medical and other clinical staffing at critical pressure periods across Acute, Community and Social care Services.
- Consistency of 7 day working principles for HSCP Teams
- Point of Care Testing (POCT) for Influenza for all Acute Sites
- Robust cross-system escalation, coordination and communication through senior Leadership at Chief Operating Officer/Chief Officer level.
- Increased capacity to support admissions, transfers and discharges through utilisation of additional vehicles through the Lothian Flow Centre.
- Contingency planning for additional bed capacity at WGH, Ward 15

As you are also aware, NHSL is adopting a programme approach to progress our unscheduled care performance, and this includes delayed discharges. We have discussed with you that we have complementary plans in place to deliver a trajectory of no more than 200 delays in the system by Christmas.

Yours sincerely

**Mr Tim Davison**
Chief Executive NHS Lothian

**Mr Brian Houston**
Chairman NHS Lothian

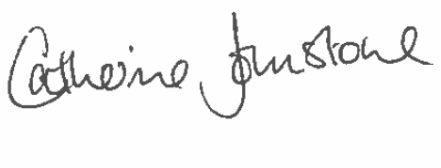
**Ms Alison MacDonald**
Chief Officer East Lothian
Integrated Joint Board

**Ms Fiona O'Donnell**
Chairman East Lothian
Integrated Joint Board

**Ms Judith Proctor**
Chief Officer Edinburgh
Integrated Joint Board

**Mr Angus McCann**
Chairman Edinburgh
Integrated Joint Board

**Ms Morag Barrow**
Chief Officer Midlothian
Integrated Joint Board



**Ms Catherine Johnstone**
Chairman Midlothian
Integrated Joint Board

**Mr Allister Short**
Chief Officer West Lothian
Integrated Joint Board

**Mr Harry Cartmill**
Chairman West Lothian
Integrated Joint Board

## 1. Winter Planning Process

1.1 NHS Lothian received notification from the Scottish Government that they would receive an allocation of £698,087 which should be specifically targeted to deliver winter performance with particular focus upon:

- Reducing Attendances
- Managing / Avoiding Admission
- Reducing Length of stay
- Focus on Flow in Acute Care
- Workforce

1.2 Through learning from previous years, it has been recognised that as a Board there is a degree of predictability in patterns of demand throughout the Winter period. This had led to a focus on robust flow throughout the system with seamless transition/intervention between hospital and community teams to support, wherever possible, rehabilitation nearest home.

1.3 The annual debrief to SG provided a platform to reflect and evaluate success from previous years and identify which schemes could be improved, replicated and which funded initiatives did not provide return on investment. Building from successful schemes from the Partnerships last year Festive Practice, additional Surge Capacity and POCT Flu Testing have been again prioritised in line with the process:

- Establishment of Festive Practice - This scheme has been successful over last 2 years at increasing capacity in GP out-of-hours services. This model will draw activity from pressurised services such as Emergency Departments, LUCS and mental health services.
- Additional Surge Capacity – Contingency planning for additional bed capacity at WGH, Ward 15 with capacity readied from January 2020.
- POCT – Flu Testing - Point of care testing for influenza in emergency medical patients (children and adults) attending Accident and Emergency and Medical Assessment areas the 4 hospital sites across Lothian. This was pre prioritised prior the scoring process and agreed to be of significant value across Lothian from the 18/19 Debrief.

1.4 Winter bids were solicited from across the whole system in Lothian and these were collated to a value of c.£6m. In order to rationalise these requests for funding a scoring framework was developed and referenced against each of the bids. This criteria was developed after a period of engagement with Acute and Partnership colleagues to ensure an inclusive / collaborative approach was undertaken to prioritising bids. This scoring framework was derived from the learning from previous years and as noted in the 2018/19 Debrief to Scottish Government.

1.5 This framework was developed through the Unscheduled Care Committee that encouraged prospective Winter bids to be evaluated and scored by 12 independent groups against the following criteria:

- Supports Joint Working between Acute/HSCP
- Supports a Home First Approach
- Admission Avoidance
- Site and Community Resilience/Flow
- Supports a non-Bed Based Model
- Facilitates 7 Day Working and Discharging

1.6 The schemes were subject to scrutiny and prioritisation by a Short Life Working Group workshop with Multidisciplinary input from all services.

1.7 The Winter Plan enclosed captures the response from NHS Lothian to deliver sustained performance and delivery of key operations over the Winter period to supplement year round plans. This plan demonstrates whole system engagement and collaboration between NHS Lothian, East Lothian, Edinburgh, Midlothian and West Lothian Health and Social Care Partnerships. The final plan is shown as Appendix 1.

1.8 The allocation of Winter funding from Scottish Government has been combined with reserve funding and slippage on the 6EA allocation to provide Winter funding of £3440k, the overall Winter plan is £3490k and it is assumed that there will be sufficient slippage in recruitment to cover this shortfall.

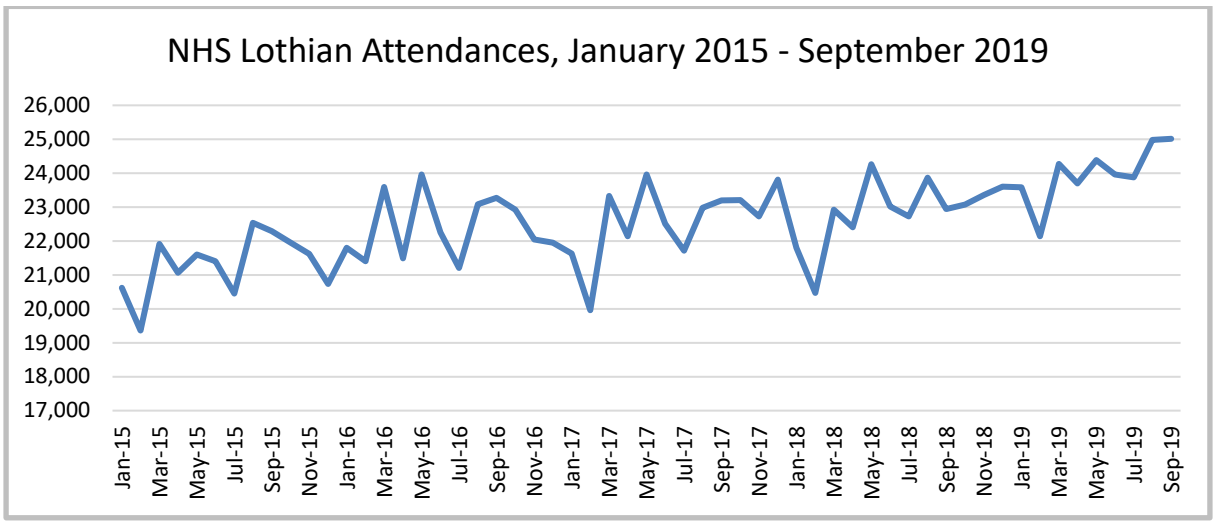
1.9 In 2018/19 NHS Lothian received a Scottish Government allocations to support Winter planning of £1392k, this has reduced by circa £700k in 2019/20.

1.10 In addition to the SG funding the plan is supported from the unscheduled care reserve. NHS Lothian holds recurrent reserves of £2.6m, against which there is £571k of commitment, leaving £2.0m reserve funding. This combined with an under commitment on 6EA funding and non-recurring slippage from 18/19 gives a total of £3440k to support the winter plan.

## 2. Projected Demand and Performance

2.1 Unscheduled Care activity has been increasing year and year since 2015. NHS Lothian experienced surge in demand during the summer of 2019 most notably during August 2019. The annual Edinburgh Fringe Festival brings higher number of tourists to Edinburgh and in doing so increases pressures on the adult Acute sites. This year the RIE had 11’579 attendances in the month of August. This represents an increase of 700 patients (c.6.5%) compared to the same dates for August 2018. Exhibit 1 below shows the gradual increase in attendances from January 2015 – September 2019 across NHS Lothian, all sites.

*Exhibit 1: Attendances from January 2015 – September 2019 across NHS Lothian, all sites.*




2.2 Performance against the 4 hour emergency access has fallen short of the national target throughout the 2019 calendar year although there have been signs of recovery during the mid- year period where 3/4 Acute sites maintained >90% for a period of 6 months. This performance must be contextualised against a backdrop of higher attendances, increased acuity and major capital works at one of the adult Acute sites (St John's Hospital).

2.3 Using data from January 2015 shows an annual increase in attendances from 69'896, 2015, to 69'993, 2019 which is c.13%. The uplift in attendances between the winter period 17/18 and 18/19 was 7.3%.

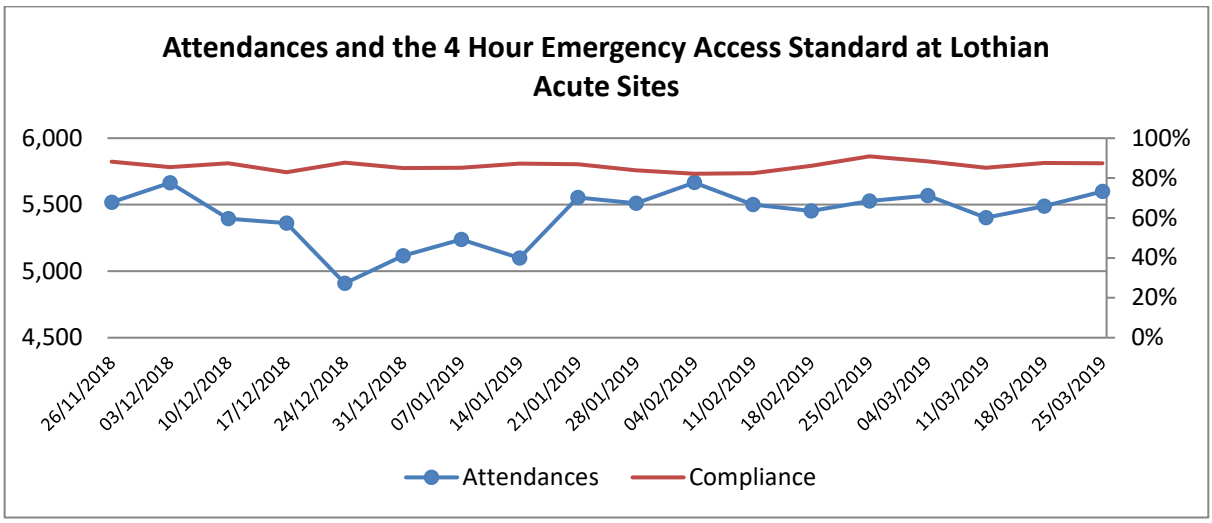
2.4 Extrapolating the performance to date across attendances gives the following predictions for January 2020 – March 2020:

*Exhibit 2: Predicted Uplift for NHS Lothian, Jan – March 2020*

| Month | NHS Lothian |
|---|---|
| Jan-19 | 23,582 |
| Feb-19 | 22,142 |
| Mar-19 | 24,269 |
| Predicted 6% Uplift | |
| Jan-20 | 24,997 |
| Feb-20 | 23,470 |
| Mar-20 | 25,725 |

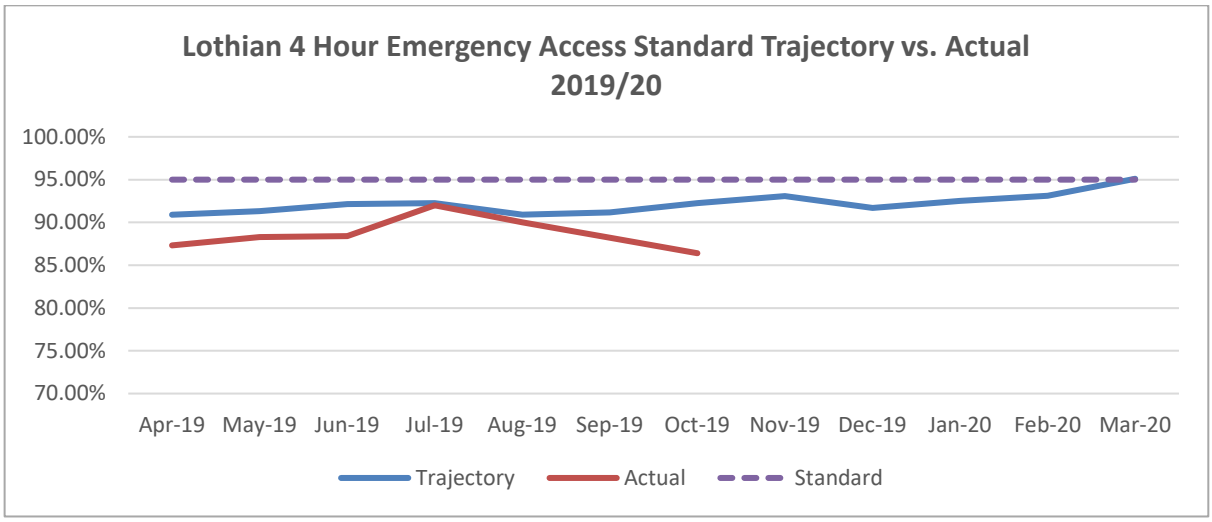
2.5 Weekly trends have been used to better understand the potential uplifts in admissions also, Exhibit 3 below show the 4 hour emergency access standard (4EAS) vs. Attendances for 2018/19. From this analysis we can predict that there will a drop in attendances end of December before these pick back up from January onwards.

*Exhibit 3: 4 hour emergency access standard (4EAS) vs. Attendances for 2018/19.*




2.6 Exhibit 4 below shows actual 4 hour Emergency Access Standard performance vs. the agreed Trajectory from April 2019 – March 2020. Note the axis is deliberately started at 70% in order to provide fuller representation of monthly variation and targeted improvement.

*Exhibit 4: 4 hour emergency access standard (4EAS) Trajectory vs. Actual 2019/20.*




2.7 Delayed discharges have been a significant challenge within Lothian and the resulting impact on patients, both those who are delayed in hospital and the corresponding impact on those waiting to access a hospital bed, is not an acceptable position. Whilst good progress is being made within Lothian to reduce the number of delays, it is recognised that Lothian still has a disproportionate number of delays compared to the rest of Scotland. The target for Lothian is to achieve **200 delays** by December.

2.8 Despite a scoring framework developed to avoid the reliance on bed based models during Winter there is a collective recognition from the unscheduled care committee that additional winter bed surge capacity will be required and this capacity will be functional from January 2020. The committee have acknowledged that while beds are likely to be opened further resilience will be

required to address demand across primary, community and Acute services. This has informed the key priority areas discussed in 1.4 above.

2.9 System Watch is recognised as a key tool to monitor demand and anticipate pressure points in admissions, bed days, GP consultations and Flu like presentations. At the time of writing the future prediction for admissions could only be reported to mid-December however this reporting will be used throughout Winter to ensure there is clarity and pro-active management of surge in demand.

## 3. Elective Capacity

3.1 A ring fencing policy has been developedand implemented to protect bed capacity for both elective surgical activity and emergency surgical activity. This is to ensure that all available surgical beds are not routinely used for medical borders but kept for surgical patients to ensure.

3.2 Sites will ensure patients are admitted on day of surgery unless clinically indicated otherwise and use day surgery wherever possible

3.3 There will be an earlier review of patients to ensure discharges are planned and managed robustly with an Estimated Date of Discharge (EDD).

## 4. Communications

4.1 A comprehensive and well targeted strategy is key to sign posting and educating the general population to the right service at the right time. Where possible the digital platform will be utilised using social media to drive prospective patients to NHS Lothian website and NHS Inform to get more details of all available options to them at home such as GP and pharmacy services. Last year, the Board a digital reach of 105,022 across social media, had 931 likes, shares, retweets and 46,722 impressions overall.

## 5. Staff Flu Activity across NHS Lothian and Lothian Health and Social Care Partnerships

5.1 Communications Teams, Public Health, and our clinical staff flu leads work together to promote the campaign. This season, we aim to increase uptake among our nursing and midwifery staff: our Executive Director for Nursing and Midwifery emailed staff directly to inspire participation. We are further encouraging staff to ‘Be Incredible’ through posters, the intranet, social media and payslip messages.

5.2 From Oct-Dec 2019, 260 staff flu clinics are planned across NHS Lothian. To date from October 7th to Nov 4th, 193 clinics have been completed. We estimate that between 8,000-10,000 staff have been vaccinated to date. The main clinics will run until December 20th followed by ‘mop up’ clinics in January.

5.3 Clinic locations range across acute hospital, community NHS and social care sites. All staff flu clinics are open to all Health and Social Care staff across Lothian. For social care, eligibility for these clinics includes staff who work with or have contact with people in the clinical at risk categories. Nursing home staff, including private nursing homes, are immunised on site or at staff flu clinics. To maximise staff access to vaccination, the ‘Flu email’ box will go live from mid-December to allow staff to request a suitable date and time to get their jab. The Flu email box will be live until March 2020.

5.4 In addition to scheduled clinics, roving teams of peer vaccinators attend clinical areas to vaccinate staff. Peer vaccinators immunise in acute and community NHS and social care sites. The Executive Director for Nursing and Midwifery wrote to all nursing staff to encourage them to become peer vaccinators; this led to more than 80 staff expressing an interest in supporting the campaign.

5.5 In 2018/19, a pilot was undertaken using a phone based app to record vaccinations. Results showed that whilst the app provided ‘live’ information, errors resulted from a lack of an electronic data entry process. The main recommendation from the pilot was the development of an electronic consent form. In preparation for the 19/20 season, a short life working group considered an electronic consent form but was not able to arrive at a solution within the timeframe. Real time data on uptake remains a longer term goal.

6. Key Actions taken by the Board

6.1 Key Actions taken under Enhanced staffing cover

| **Enhancement of senior medical and other clinical staffing at critical pressure periods across Acute, Community and Social care services** |
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| Acute Respiratory Nurse Specialist in-reach into ED and Medical Assessment Units |
| Cardiology Nurse Practitioner in-reach into ED |
| Increased Consultants on ward rounds |
| Increased staffing across all surge areas |
| Additional Consultants, Registrars and FY2 Cover during Winter months |

6.2 Key Action taken to delivery consistent working practices

| **Consistency of 7 day working principles for HSCP Teams** |
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| Seven day working for Discharge to Assess teams |
| Seven day working for Patient Flow Teams |
| Social work support of Home First Model |
| Use of Day of Surgery Admission to supplement capacity and will move to a 7 day service |
| Additional Adult and Paediatric physiotherapy services |

6.3 Key Actions taken under Flu

| **Point of Care Testing (POCT) for Influenza for all Acute Sites** |
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| Point of care testing for influenza in emergency medical patients (children and adults) attending Accident and Emergency and Medical Assessment areas the 4 hospital sites across Lothian. This was pre prioritised prior the scoring process and agreed to be of significant value across Lothian from the 18/19 Debrief. |
| Housebound Flu Immunisation Programme |
| Staff Flu Immunisation Programme – already underway |

6.4 Key Actions taken under Effective Escalation

| **Robust cross-system escalation, coordination and communication through senior Leadership at Chief Operating Officer/Chief Officer level.** |
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| All Acute sites and Partnerships have tested business continuity arrangements. The Acute sector has already reinstated 3 times daily conference calls for the discussion and action of flow decisions across the system. During Winter, and if required, these calls are escalated to Chief Officers who are invited to join the calls in order to facilitate whole system decision making. Senior Leadership is provided by the chairmanship of the calls which is shared amongst the Deputy Chief Executive, Chief Officer, Acute Services and/or Chief Officer IJB. |

6.5 The actions taken above provide a high level overview of priority areas as described in the Letter dated 14/10/2019 above. The full Winter submission from NHS Lothian can be found as Appendix 1 below. This details the Winter plan by priority action and the quantifiable impact of delivering these actions.

| **Reducing Attendances**<br>Wherever possible by managing care closer to home, preferably at home with services focussed on assessment and care closer to home. | | |
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| **Winter Initiative** | **Live Date** | **Context/Quantifiable Impact** |
| **Midlothian Health & Social Care Partnership** | | |
| ED Redirection/Support for < 65 | November 2019 | • On average, 6626 Midlothian residents attend ED each year.<br>• During June 2019 there were 1197 Royal Infirmary of Edinburgh ED attendances by Midlothian residents aged under 65. This is the highest monthly figure this year<br>• On average, about 29 people were frequent attenders each year (attending ED 10 or more times within that year).<br>• Top reasons for attendance included non-specific chest or abdominal pain, cellulitis, asthma, and lower respiratory tract infection. For the 18-44 age group, overdoses, wounds, and alcohol intoxication were unique top reasons. For ages 45-65, COPD, UTI, deep vein thrombosis, vasovagal syncope, and pulmonary embolism were unique top reasons.<br>• 76% self-referrers to ED took not advice prior to attendance. Funding will support a reduction to repeat attendance by signposting and redirecting. |
| **East Lothian Health & Social Care Partnership** | | |
| Enhanced Discharge to Assess | December 2019 | • The intensive rehabilitation model has been very successfully implemented within the central cluster of East Lothian; it has been one of the initiatives that has successfully enabled a reduction in bed utilisation. This has been very successfully applied to those patients within the stroke unit. East Lothian patients are being pulled out of hospital by the team utilising the agreed stroke pathway up to 10 days earlier than before. They now have active rehabilitation in the community within the confines of their own home.<br>• The COPD patients who would be admitted to Royal Infirmary of Edinburgh would be managed collectively with the advanced physiotherapy practitioner and hospital at home to team keep them within the community including administering IV antibiotics at home. |
| **Edinburgh Health & Social Care Partnership** | | |
| CRT+ | December 2019 | • Number of referrals.<br>• Source of referral.<br>• Average time to contact.<br>• Average home visits and telephone calls per patient.<br>• Number of patients at risk of admission.<br>• % of 'at risk' patients remaining at home at 48 hours and 1 week.<br>• Number of 'supported discharge patients'<br>• Number of supported discharge patients remaining at home at 48 hrs and 1 week |

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| | | • **This scheme will also support Admission Avoidance and Focus on Flow through Acute Care. Metrics include:**<br>o Number of 'supported discharge patients'<br>o Number of supported discharge patients remaining at home at 48hrs and 1 week |
| Festive Practice | 20th December 2019 | • Reduced number of attendances at A&E, LUCS, and Mental Health Services on public holidays<br>• Reduce need for DN home visits for dressings |
| Winter Support Team | December 2019 | • Reduction in attendances at acute hospitals<br>• **This scheme will also support Admission Avoidance and Reducing Length of Stay.**<br>• Metrics for Reduced Length of Stay include reduction in Delayed Discharges. |
| Open House (Stafford Centre) | December 2019 | • Providing an alternative to A&E for those in mental health crisis<br>o Numbers of people supported during a crisis<br>o Numbers of people reporting increased resilience<br>o Numbers of carers supported |
| **Lothian Unscheduled Care Service (LUCS) and Flow Centre** | | |
| Weekend cover for Care Homes | December 2019 | • For practices which are recognised as the lead practice for a care home or care homes to provide additional cover over winter weekends to improve continuity of care for patients, avoid hospital admissions, and reduce pressure on LUCS and A&E.<br>• Between 10 and 14 practices participated over the dates covered last year and 18 to 21 care homes received cover from their lead practice.<br>• 179 patients were visited at a total cost of £50,400 giving a cost per visit of £103 over the festive holidays and £142 on the other Saturdays<br>• There was a positive impact on LUCS demand for care home visits. If all Lothian practices had participated and had the same impact as the practices that did participate the LUCS visits to care homes could have reduced from 153 in 2017/18 to 55 in 2018/19. A home visit for LUCS is estimated to cost £200-£250/visit (based on volume of work and cost of supporting the service (GPs/drivers/equipment/drugs/other) over the course of a year) |
| Increase number of alternatives to admission including access to these in evenings and at weekends. | December 2019 | • % alternatives booked through Flow Centre<br>• Increase availability of alternative pathways |
| **Communications** | | |
| Winter Communications Plan | November 2019 | • Last year, the campaign reach was 105,022 across social media, and 931 likes, shares, retweets and 46,722 impressions overall.<br>• It is estimated that Bus advertising reached 89 per cent of adults visually and the aim is |

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| | | to replicate this again.<br>• Radio advertising on Radio Forth reaches an audience of 405,000 and the target will be aimed to improve this reach 19/20.<br>• The Plan will also support recruitment of flu champions and peer vaccinators via internal communications campaign using all channels: Intranet, staff magazine, social media and direct email cascade. Last year this tactic resulted in the recruitment of more flu champions and more peer vaccinators.<br>• Roll out seasonal flu campaign Be Incredible 2 – the sequel to last year's effective promotion. We ask staff to "Be Incredible" and fight flu by being vaccinated. |
| **Managing / Avoiding Admission**<br>Wherever possible with services developed to provide care at home across 7 days. | | |
| **Winter Initiative** | **Live Date** | **Context/Quantifiable Impact** |
| **Midlothian Health & Social Care Partnership** | | |
| Rapid Extended MDT Frailty Intervention | November 2019 | • People identified with severe frailty are 4 times more likely to be admitted into hospital within 12 months than the non-frail population.<br>• 716 frail people in Midlothian accounted for 20,000 unplanned OBD in 2018.<br>• 190 were from two practices that will be supported in this project.<br>• When someone with severe frailty presents to ED in 75% of presentations they will be admitted. For moderately frail patients the likelihood of admission is 60% (Midlothian analysis).<br>• Access and Relational continuity of care in general practice is associated with a significant number of benefits to individuals and wider health systems, including: better clinical outcomes for an array of conditions; reduced mortality; better uptake of preventative services; better adherence to medication; reduced avoidable hospital admissions (Nuffield trust 2018).<br>• A reduction of 20% hospital activity is achieved by this cohort, would equate to cost avoidance over £600K. This does not include the impact of the third practice. |
| **West Lothian Health & Social Care Partnership** | | |
| REACT Care Home | January 2019 | • Reduction in admissions from care homes at weekends |
| **Edinburgh Health & Social Care Partnership** | | |
| Open House (Phone link & Befriending) | December 2019 | • Providing an alternative to (for example) emergency Primary Care attendances for repeat medications<br>• Providing support to augment existing community-based care (e.g. D2A, H@H)<br>• Providing a link back to Locality Hub to intervene earlier in the event of a decline<br>o Numbers of crisis appointments reduced in (for example) PC |

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| | | o Numbers supported<br>o Numbers reporting increased resilience<br>o Number of carers supported |
| **St. John's Hospital** | | |
| Acute Respiratory Nurse Specialist (RNS) in reaching into ED and MAU | January 2020 | • Patients presenting with Respiratory illness increases over winter period. By providing a RNS into front door, will allow a treatment plan identified for those who can be discharged and supported in the community, rather than being admitted, therefore reducing admissions. This links also with the Flu campaign<br>• Monitoring impact will be through RNS activity :<br>o Number of patients reviewed<br>o Number of patients who were discharged<br>o Length of Stay<br>o Site admission profile<br>o Reduction in overcrowding in ED |
| Cardiology Nurse Practitioner (NP) in reaching into ED | January 2020 | • This would be a test of change for the site, where there would be a NP at front door. Troponin waits are the second largest reason accounting for clinical exception breaches. Buy having a NP at front door would allow them to assess patients and discharge all appropriate patients, with a view of moving into a planned clinic slot Monitoring impact will be evidenced through NP activity :<br>o Number of patients reviewed<br>o Number of patients who were discharged<br>o Length of Stay<br>o Site admission profile<br>o Reduction in overcrowding in ED |
| **Royal Infirmary of Edinburgh** | | |
| ED Hogmanay | December 2019 | • Enhanced staffing model to ensure we can deliver safe and effective patient care throughout the Hogmanay period. |
| ED Resilience | December 2019 | • The scheme will help reduce time to first assessment during the holiday period. |
| **Therapy Services** | | |
| Adult Physiotherapy – Respiratory (APP) Royal Infirmary of Edinburgh /Community | December 2019 | • Collecting data on the impact of APP working across acute and community managing acute respiratory patients.<br>• Reducing Length of Stay, aided by clinical decision making from experienced, well-established community respiratory physiotherapy colleagues and knowledge of community capacity to support discharge.<br>• Increased discharges on a Friday/later in week when confidence may previously be low |

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| | | for discharge over/towards the weekend, thereby a more consistent spread of discharges over the week.<br>• Increased weekend discharge as improved knowledge of CRT |
| Paediatric Physiotherapy | December 2019 | • Collecting data on the increased number of respiratory patients receiving physiotherapy in hospital and supporting hospital to home for immediate discharge from A&E and/or earlier supported discharge from wards will allow us to quantify the impact increased physiotherapy intervention has in contributing to decreased LOS and admission avoidance.<br>• Collecting data on the those patients receiving physiotherapy in the community with chronic complex respiratory conditions and the long term ventilated patients who are often in hospital for extended periods will allow us to quantify the impact increased physiotherapy intervention has in contributing to avoiding admissions. |
| **Lothian Unscheduled Care Service (LUCS) and Flow Centre** | | |
| LUCS winter (inc festive) provision | January 2020 | • Patient capacity / avoidance of redirection to EDs due to inability to provide timely OOH service / turnaround of festive patients (Christmas and NY) / increased home visiting and base capacity, supportive of admission avoidance to hospitals |
| Increase number of Alternatives to Admission including Hospital @ Home including evenings and weekends | December 2019 | • % H@H referrals booked through Flow Centre<br>• Increase availability of alternative pathways |
| **Reducing Length of Stay**<br>Through reduction in delayed discharges, discharge to assess, access to intermediate care services and provision of rehabilitation services at home or a community setting. | | |
| **Winter Initiative** | **Live Date** | **Context/Quantifiable Impact** |
| **Midlothian Health and Social care Partnership** | | |
| Seven day working for Discharge to Assess Team | December 2019 | • To date the service has delivered:<br>o 110 Patients supported home earlier from Royal Infirmary of Edinburgh<br>o Saving 542 bed days<br>o Financial savings of £135 000<br>o Provides ability for 7 days a week discharging |
| **East Lothian Health & Social Care Partnership** | | |
| 7 Day Working Patient Flow Team | December 2019 | • This initiative will allow weekend and extended week day hours within the Partnership to work with discharge teams in the two Edinburgh acute sites. This will allow the commencement of needs assessment quicker and allow the relevant information to support discharge across seven days rather than 5. |

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| | | • Weekday working till 8.00pm and Saturday and Sunday working.<br>• Enable discharge paper work and arrangements to be prepared and reduce length of time patients/clients are in the acute sector. |
| Increasing Hospital to Home Capacity | December 2019 | • The Hospital to Home team within East Lothian has been in existence for several years. The service has increased year upon year from one team to six including a double up team. Over the last year they have successfully supported a total of 448 patients to return home.<br>• The Emergency Care Service (ECS) is geared for rapid response to those in the community. It is currently a day time service and augmenting the service to run overnight will enhance their ability to maintain more people at home, avoiding a hospital admission.<br>• Increasing the capacity within the hospital to home team to provide packages of care within the community will ensure that patients can be allocated a package of care at the point of discharge.<br>• The further expansion of this service will reduce the number of patients waiting on packages within acute beds and will ensure that patient return to the community when medically fit.<br>• To increase capacity within the Emergency Care Service (ECS) to ensure that those requiring care within the community during a crisis are provided with this rather than being admitted to hospital beds or care home beds overnight, this service will be implemented from 10 pm to 8 am. |
| **West Lothian Health & Social Care Partnership** | | |
| 7 Day Equipment Delivery | January 2020 | • Reducing length of stay<br>• Facilitating weekend discharges<br>• Impact will be determined by demand<br>• Earlier discharges on Mondays with planning over the weekend |
| **Edinburgh Health & Social Care Partnership** | | |
| AWI (Adults with Incapacity) | December 2019 | • Reduced length of stay for patients in hospital whose discharge is being impacted by issues of capacity to make welfare and/or financial decisions<br>• Reduction in delayed discharges for this cohort of patients.<br>Impact will be evidenced through Tableau and local systems to monitor capacity such as delays coding. All delays due to issues of capacity are coded 51X and are reported weekly. |
| Social Work to Support the Home First Model | December 2019 | • Reduction in delayed discharges due to earlier intervention of social workers<br>• Reduction in number of people waiting for an assessment |
| **St. John's Hospital** | | |

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| Managing patient flow 4- additional nurse practitioner at weekends | January 2020 | • This will improve decision making at weekends, assisting in improving weekend discharges to meet demand on unscheduled care.<br><br>• Monitoring impact will be evidenced through:<br>o Discharges at weekends<br>o Time of discharge<br>o Length of Stay<br>o Boarding numbers<br>o Breaches associated with bed waits |
| Managing patient flow 6- Acute Consultant increase on Ward rounds | January 2020 | • This initiative was trialled last year and was evaluated well. Essentially job planned clinic activity in January is converted to ward rounds, to maximise the number of decision makers on ward rounds, to expedite patient treatment and decision to discharge. To offset the closed clinics in January, patients are booked into extra clinic slots generally within their TTG.<br><br>• Monitoring impact will be evidenced through:<br>o Length of Stay<br>o Time of Discharge<br>o Breaches associated with bed waits<br>o Out-patient TTG performance |
| REACH | January 2020 | • This will allow service to expand into back door and Sundays. Frail patients can be followed through their pathway, with early interventions and identification as to where they could be discharged to home or other facility, which would be more appropriate with their care requirements. Close working with the discharge hub will integral and having a Sunday service, will allow better planning for week ahead<br><br>• Monitoring impact will be evidenced through:<br>o Activity by REACH<br>o Reduced Length of Stay<br>o Reduction in delays<br>o Earlier in day discharge |
| **Royal Infirmary of Edinburgh** | | |
| Boarding Team: Acute & General Medicine | December 2019 | • Reduced length of stay<br>• Weekend senior medical cover to facilitate discharge decisions |
| Boarding Team: MOE & Stroke | December 2019 | • Earlier reviews for patients that are boarded out with their specialities. |
| Orthopaedic Supported Discharge | December 2019 | • Enhanced support with ambulatory care pathways<br>• Earlier access to services in the community |

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| | | • Earlier engagement with community teams<br>• Prevents delays as patients are able to have ongoing rehab in the community and reduce the amount of inpatient rehab that is required. |
| Orthogeriatric Pathways Coordinator | December 2019 | • Orthopaedic supported discharge has reduced 11,337 occupied bed days since commencing in feb 2017. This service supports on average 20-30 patients a day at home depending on their level of care/rehab dependency. Evidence supports that an additional 3 HCSWs would support a further 12 patients a day with OSD taking the service up to 32-42 a day. |
| **Western General Hospital** | | |
| Optimising length of stay in patients with diabetes | January 2019 | • Data analysis has demonstrated an increased length of stay for patients with diabetes. Evidence has also demonstrated that a focused **proactive** inpatient diabetes services (utilising e-health initiatives –which NHS Lothian are embedding) reduces length of stay.<br>• CHI linkage of information will allow length of stay analysis. Focused MAU pick up in the morning will reduce length of stay for appropriate patients and will facilitate early review rather than wait for post take ward round review and time to subsequent referral.<br>• QI work to data has focused 3 keys areas for intervention to improves length of stay / flow (based on tableau dashboard data) – inpatients on surgical wards, patients with type 1 diabetes and acute admissions which will be the targeted focused of this winter plan to facilitate timely discharge and improve flow. |
| **Pharmacy** | | |
| Royal Infirmary of Edinburgh Weekend Working (1)<br>Winter weekend clinical pharmacy service on the three anticipated busiest months<br><br>Royal Infirmary of Edinburgh Clinical (2)<br>Clinical pharmacy prioritising areas that did not have a pre-existing clinical pharmacy service | January 2020 | • Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives:<br>o Number of medicines reconciliation with error rate<br>o Volume of patients assessed/reviewed by clinical pharmacists<br>o No of IDLs & IPSs reviewed and error rate<br>o Number of Interventions<br>o Number of High Risk Patients<br>o Increase in capacity of over labelling service<br>o Time of receipt of requests to pharmacy<br>o Turnaround time of prescriptions from pharmacy performance |
| **Therapies** | | |
| Adult Physiotherapy - Royal Infirmary of Edinburgh /Western General Hospital MMOET | December 2019 | • Reduction in average length of stay for physiotherapy patients<br>• Patients being discharged faster from physiotherapy services<br>• A clinically meaningful improvement in patient function in more than 80% of caseload<br>• Patient flow was directed to a high degree of accuracy |

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| | | • Patients being discharged less frail and more independent |
| Physiotherapy - Activity Support Workers Royal Victoria Building/ Western General Hospital Royal Infirmary of Edinburgh | January 2020 | • Reduction in average length of stay for physiotherapy patients<br>• Patients being discharged faster from physiotherapy services<br>• A clinically meaningful improvement in patient function in more than 80% of caseload<br>• Patient flow was directed to a high degree of accuracy<br>• Patients being discharged less frail and more independent |
| Occupational Therapy - Roving - Western General | December 2019 | The target of increased Roving winter resource at Western General Hospital would be to decrease the length of stay of medical boarders and increase flow of patients to point of discharge. Medical boarding patients are predominantly: over 65yrs; fall under frailty groups; sit on medical wards outwith their specialities; and wait for assessment from under capacity teams. By improving links to OTs at the 'front door' and tracking patients from there who are boarded directly, roving team members can assist better handover and enable earlier intervention<br>Measurement is aimed at collecting data on:<br>1. Point of admission to hospital<br>2. Point of transfer to boarding ward from admissions and when referral received by roving.<br>3. Response time of OT roving assessment and intervention date and type<br>4. Date of planned discharge plan<br>5. Actual discharge date and actions |
| Occupational Therapy - Roving – Royal Infirmary of Edinburgh | December 2019 | The target of increased Roving winter resource at Royal Infirmary of Edinburgh would be aimed at general medical and boarding patients. These patients are currently scoring low on prioritisation parameters and are getting delayed response time from OT. Their average LOS subsequently is higher. Roving will have the specific role to target and screen these patient borders and give them a higher prioritisation status; earlier intervention and improved discharge planning.<br>Measurement is aimed at collecting data on:<br>1. Point of admission<br>2. Point of transfer to boarding ward and when referral received.<br>3. Response time of OT assessment and intervention<br>4. Date of planned discharge plan<br>5. Actual discharge |
| **Lothian Unscheduled Care Service (LUCS) and the Flow Centre** | | |
| Reduce Length of Stay for patients awaiting repatriation transport to their home board | December 2019 | • Bed days saved for repatriations<br>• Utilisation rates – Demand from service/ capacity utilised |
| **Focus on flow through Acute Care**<br>Through adherence to discharge trajectories, earlier in the day discharges and improvements through ED flow. | | |

| Winter Initiative | Live Date | Context/Quantifiable Impact |
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| **Midlothian Health and Social Care Partnership** | | |
| Single Point of Contact Older People Services | November 2019 | • Local ownership of patients will reduce length of patient journey as a result of local planning and system knowledge of capacity and options available.<br>• Reduced Length of Stay in Royal Infirmary of Edinburgh, Midlothian Community Hospital and Highbank Intermediate Care<br>• Reduced delays<br>• Easy to navigate system to reduce time to refer for Royal Infirmary of Edinburgh |
| **Edinburgh Health & Social Care Partnership** | | |
| Festive Practice | December 2019 | • Improvements to ED flow by drawing activity away from the front door during public holidays. |
| **St. John's Hospital** | | |
| Efficiency of Discharge Lounge in supporting DDD | January 2020 | • This scheme will allow the discharge lounge to increase opening hours, with staff attending huddle, prioritising and pulling patients into lounge. This expands on the work which is a focus for the site, in improving discharges to earlier in day, thus reducing patients waiting for beds<br>• Monitoring impact will be through evidenced through:<br>o Site discharge profile hour by hour<br>o Reduction in breaches associated with bed waits<br>o Improvement in pre 12 discharge |
| Expansion of discharge hub & DDD | January 2020 | • This scheme will allow all back door wards to have support from discharge hub, providing support and focus in discharge planning around complex patients and will link to discharge lounge also.<br>• Monitoring impact will be undertaken by:<br>o Site discharge profile hour by hour<br>o Reduction in breaches associated with bed waits<br>o Reduction in delayed discharges<br>o Length of stay reduction |

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| Managing patient flow 3- PAA | January 2020 | • This initiative continues to support GP flow going through Primary Assessment Area (PAA), rather than being diverted to ED. This allows for an expansion of the current model to meet the later demand surge that the site experiences in the evening, allowing patients to be assessed and treated as ambulatory unless identified as need to be admitted. This will continue to reduce admissions into MAU and assist with delays in patients being allocated beds between PAA and ED.<br><br>• Monitoring impact will be undertaken by:<br>o Breaches associated with bed waits<br>o PAA time to bed allocation<br>o Admission and discharge profile of MAU<br>o Any diverts to ED of PAA flow<br>o Time of discharge |
| **Royal Infirmary of Edinburgh** | | |
| Surgical Observation Unit Additional Fellow | December 2019 | • Reduced length of stay<br>• Improving time of surgical review on patients in an OOH period to maintain surgical flow throughout the front door areas – this has been recognised as a pressure in the OOH periods previously<br>• Increased patient moves into the inpatient areas<br>• Improved morning discharge profile<br>• More robust staffing profile during winter months to support flow and address the acuity that will present during the winter months |
| Surgical ANP | December 2019 | |
| AMU Medical Cover | December 2019 | |
| Ward 204: Consultant Cover | December 2019 | |
| Ward 204: Registrar Cover | December 2019 | |
| Ward 204: FY2 Cover | December 2019 | |
| Respiratory Nurse Specialist | December 2019 | |
| **Western General Hospital** | | |
| Enhanced Nursing Support to OPAT Service | January 2019 | • Supporting this bid would reduce patients attending the front door as unscheduled care activity<br>• Additional resource would also provide capacity for nursing staff to attend consultant rounds with ID at the Western General Hospital and Royal Infirmary of Edinburgh to help identify patients who are suitable for the OPAT service in a timely way and improve discharge planning within wards. |
| *Enhanced Medical cover (overnight, weekends and boarding patients)* | December 2019 | • Increased number of weekend discharges, effective management of boarding patients and average length of stay: further enhancement of weekend medical staffing would help support timely senior review of patients and support discharge. |
| **Radiology** | | |
| Radiology Winter Plan - Increased demand for diagnostic imaging | December 2019 | • Additional provision is proposed to ensure patient flow is not impacted by any delays to diagnosis for admission and discharge.<br>• Additional reporting capacity is provided for the three month period as WLI sessions |

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| | | and some extended days, to keep on top of the additional workload and avoid delays in reporting.<br>• Additional Radiographer cover, CSW/RDA and portering will meet front door additional demand and maintain inpatient flow through CT/MRI/US. |
| **Pharmacy** | | |
| Western General Hospital<br>Same as Royal Infirmary of Edinburgh above | | • Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives:<br>o Number of medicines reconciliation with error rate<br>o Volume of patients assessed/reviewed by clinical pharmacists<br>o No of IDLs & IPSs reviewed and error rate<br>o Number of Interventions<br>o Number of High Risk Patients<br>o Increase in capacity of over labelling service<br>o Time of receipt of requests to pharmacy<br>Turnaround time of prescriptions from pharmacy performance |
| **Lothian Unscheduled Care Service (LUCS) and the Flow Centre** | | |
| Increase number of alternative pathways for patients attending front door areas. Reduce time waiting for repatriation transport. Increase transport for discharges and transfers from acute sites | December 2019 | • % alternatives booked through Flow Centre<br>• Increase availability of alternative pathways<br>• Bed days saved for repatriations<br>• Utilisation rates – Demand from service/ capacity utilised<br>• Number of patients transferred or discharged from sites across NHS Lothian |
| **Seasonal Flu, Staff Protection and Outbreak Resourcing**<br>Ensure that there are adequate plans in place to manage the outbreak and vaccinations of multiple staff and patient groups as well as contingency planning for Norovirus outbreak control measures. | | |
| **Winter Initiative** | **Live Date** | **Context/Quantifiable Impact** |
| **Midlothian** | | |
| Local Flu Campaign | October 2019 | • Midlothian Staff flu uptake was the Partnerships best ever at 59.9% in 18-19 Lothian wide. There have been reports that the additional clinics and clinics running in new areas were well received and attended.<br>• Locally the Partnership built on NHSL 'Be Incredible' social media campaign with regular social media messages that began early October. This included a YouTube and Face Book video of Clinical Director being vaccinated which had over 5000 views and 26 shares.<br>• Uptake amongst Over 65s continues to increase across the board at 74.9%, almost |

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| | | reaching the WHO target of 75%. Uptake amongst those at risk remains a challenge across the board at 43% for the year 18/19.<br>• Comparing data from 2017 and 2018 there was a reduction in potentially preventable admissions due to flu. There was a change in the age profile of those that were admitted with an increase in the number of those aged 80+ and an increase in occupied bed days. |
| **Public Health** | | |
| Housebound Flu | September 2019 | • Last season 6,700 Housebound patients were vaccinated. The aim is to match this uptake for 2019/20<br>• The effect of not delivering the influenza vaccination to housebound patients could potentially impact on healthcare pressures – this can be evidence by the increase in acute winter admissions in 2017 when influenza virus was more potent and the vaccine less effective<br>• A benefit of the centrally coordinated housebound vaccination programme could free up time for GP and District Nurse teams for other clinical activities<br>• The timely launch of the programme and administration of the vaccine must be taken in to account as the immune response to vaccination takes about 2 weeks to fully develop<br>• The programme is delivered by NHS L Bank staff vaccinators and this group of staff maintain their competencies and can be utilised to deal with flu outbreaks eg Nursing Home |
| Staff Flu Programme | September 2019 | • Last season 17,200 staff were vaccinated. 15,800 NHS L staff (59% uptake) and 1400 of staff from social care partners<br>• The NHS Lothian uptake for 2018/19 increased from the 51% achieved during 2017/18 season. For this coming season the aim is to improve uptake of clinical staff<br>• The main benefit of delivering the staff flu programme is to maximise reduction of flu transmission in addition to providing individual protection. This will potentially reduce staff sickness rates and minimise local disruption/impact on local service delivery<br>• This service also assists with the data collection and reporting process – could potentially enhance response rates should there be an outbreak |
| Point of care testing for influenza in emergency medical patients (children and adults) attending A/E and MAU at the 4 hospital sites across Lothian. | October 2019 | • Rapid diagnosis, in this case POCT has been shown to reduce length of stay by 1 day. In NHS Lothian length of stay has been compared in periods where POCT is available to time periods where it is not and has found that length of stay is reduced overall in periods where POCT is available by 1 day.<br>• Additionally the following impacts will be evidenced following funding of POCT Flu Testing:<br>o Reduced bed closures<br>o Improved patient flow<br>o less patient moves |

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| | | o correct and appropriate use of antivirals<br>o reduced spend of antivirals for prophylaxis owing to ward patients being exposed to flu<br>Reduced nosocomial cases |
| **Preparedness for Additional Surge Capacity across Health and Social Care services**<br>Planned dates for the introduction of additional acute, OOH and Social care services is agreed and operational before the anticipated surge period. | | |
| **Winter Initiative** | **Live Date** | **Context/Quantifiable Impact** |
| **St. John's Hospital** | | |
| 1. Managing acute patient flow 1- ward 18 staffing | January 2020 | • All 3 of these schemes are interlinked and relate to medicine taking capacity from ward 18 and cohorting medical patients into this area. To reduce impact on Head &Neck activity, DOSA will be used to supplement capacity and will move to a 7 day service between January- March, thus requiring additional staff.<br>• To ensure that this is safe for patients and staff enhanced staffing is required in ward 18, to supplement the required care needs of this group of patients. Additionally medical staffing will be required to be increased to support this group of patients and any other patients that are boarding outside of medicine on the site.<br>• Metrics which will be used:<br>o Number of breaches associated with bed waits<br>o Length of Stay<br>o Time of discharge<br>o Complaints/ compliments<br>o Boarding numbers |
| 2. Managing acute patient flow 2- medical staffing | January 2020 | |
| 3. Managing patient safety and dependency- DOSA | January2020 | |
| Supporting Acute ORS flow over Winter | January 2020 | • Historically the demand for Orthopaedic rehabilitation increases over winter months. This would allow for the addition 6 unfunded beds in ward 14 to open, to allow pull of West Lothian Orthopaedic patients requiring rehabilitation to be pulled over onto site, instead of being delayed at Royal Infirmary Edinburgh or other Orthopaedic centres and allow access to rehabilitation earlier in their journey.<br>• Metrics which will be used:<br>o Time to repatriation on site<br>o Reduced length of stay |
| **Royal Infirmary of Edinburgh** | | |
| DSU Winter Capacity | December 2019 | • Enhanced site resilience in anticipation of increased attendances and admissions. |
| **Western General Hospital** | | |
| Enhanced Medical cover (overnight, weekends and | January 2020 | • Support system wide patient flow and the reduction of the number of delayed discharges in acute beds, optimising hospital capacity for acute admissions. |

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| boarding patients)<br>This proposal is to open 21 beds flexibly in Ward 15 to support delayed discharge patients | | • To mitigate the risk associated with the reduction of 26 beds following ward 71 closure |
| Additional MDT Support for Medicine of the Elderly Team | January 2020 | • Reduction in length of stay and number of delayed discharges<br>• Improvement in Planned Discharge Dates in collaboration with MDTs<br>• Support MDTs in the early initiation of realistic conversations with families to manage expectations<br>• Support the reduction - to support length of stay post 71 ward closure |
| **Workforce**<br>It is essential that the appropriate levels of staffing are in place across the whole system to facilitate efficient and effective patient care, to ensure consistent discharge during weekends and the holiday periods. | | |
| **Pharmacy** | | |
| St. Johns<br>Extending hours would support safe supply of discharge medicines and manage staff welfare which requires additional manpower NOT additional hours to existing staff. | December 2019 | • Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives:<br>o Number of medicines reconciliation with error rate<br>o Volume of patients assessed/reviewed by clinical pharmacists<br>o No of IDLs & IPSs reviewed and error rate<br>o Number of Interventions<br>o Number of High Risk Patients<br>o Increase in capacity of over labelling service<br>o Time of receipt of requests to pharmacy<br>o Turnaround time of prescriptions from pharmacy performance |
| **Therapy Services** | | |
| Occupational Therapy - Ward 15 - Western General | December 2019 | Impact is aimed at providing maintenance therapy to those who are awaiting NH or POC. The aim is to prevent de-conditioning / deterioration whilst continuing to work on improving function and reducing package of care requirements or requirements for complex discharge planning.<br>Measurement will be aimed at:<br>1. Scoring functional capacity using pre and post measures of function to assess incremental gains or deterioration during length of stay<br>2. Improved patient experience |
| Adult Physiotherapy - Western General Hospital Ward 15 | December 2019 | Collecting data on those patients awaiting a Package of Care or Nursing Home placement. Physiotherapy to maintain/progress patients functional and mobility status and prevent de-conditioning whilst in hospital and increase patients' resilience at point of discharge.<br><br>Collate impact of physiotherapy on:<br>1. reduction in falls |

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| | | 2. reduced requirement for analgesia<br>3. reduction in re-admission rates |

**Edinburgh Health Social Care Partnership**
**Winter Planning Submissions 2019/20**

| Title | Lead | Amount Requested | Amount Awarded | Amount Spent | | NHS Spend | CEC Spend | Slippage |
|---|---|---|---|---|---|---|---|---|
| Festive Practice | Eileen McGuire | £25,830.00 | £25,830 | £10,830 | | £10,830 | £0 | £15,000 |
| CRT+ | Orla Prowse | £32,000.00 | £23,227 | £18,088 | | £18,088 | £0 | £5,139 |
| Winter Support Team | Fiona Wilson; Julie McNairn | £164,786.00 | £180,858 | £53,949 | | | £53,949 | £126,909 |
| Social Work to Support Home First Model | Fiona Wilson; Steph Craig | £101,866.00 | £101,866 | £79,348 | | | £79,348 | £22,518 |
| AWI | Colin Beck; Ian Waitt | £35,000.00 | £17,500 | £16,047 | | | £16,047 | £1,453 |
| Open House | Stef Milenkovic | £22,000.00 | £28,038 | £28,038 | | £28,038 | | £0 |
| NEW Additional Bid to support care homes | Alana | £158,342.00 | £158,342 | £158,342 | | | £158,342 | £0 |
| **TOTAL** | | **£539,824.00** | £535,661 | £364,642 | | £56,956 | £307,686 | £171,019 |
| | | | | | | | **Available** | **£293,619.00** |