Edinburgh Integration Joint Board

# REPORT

## Preparations for Winter 2020-2021

Edinburgh Integration Joint Board

15 December 2020

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| **Executive Summary** | The purpose of this report is to present the following:<br><br>1. Preparations for Winter 2020/21 are at an advanced stage. The flu campaign is nearing completion, and the enhanced community services are either operational, or are soon to be.<br><br>2. The NHS Lothian Winter Planning cycle commenced earlier this year. The Partnership submitted requests for funding in June 2020 to enhance capacity over the winter period. Five proposals, which were identified as priorities by Edinburgh HSCP, were accepted and an allocation of £287,467.50 confirmed on 21 July 2020 which is detailed in paragraph 11. It should be noted that a reduced level of funding was available this year as NHS Lothian decided that remaining monies were to be held back pending national direction from Scottish Government as a result of the pandemic.<br><br>3. Edinburgh HSCP also funded an additional £75,467.50 to other initiatives supporting caring for vulnerable residents and unpaid carers over the winter period.<br><br>4. Prior to receiving formal guidance from the Scottish Government, the Lothian Unscheduled Care Committee asked HSCPs to complete a bespoke Winter Readiness Plan. This was submitted by Edinburgh HSCP on 20 October 2020 and a copy is available on request.<br><br>5. 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 John Connaghan, Interim Chief Executive, NHS Scotland, wrote to the Chief Officers of Health & Social Care |

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| | Partnerships and the Chief Executive of NHS Lothian on 22 October 2020 regarding preparing for Winter 2020/21<br>6. Edinburgh HSCP completed the Checklist for Winter Preparedness for 2020/21 and this was submitted to Scottish Government on 2 November 2020. |

| **Recommendations** | It is recommended that the Edinburgh Integration Joint Board (EIJB):<br>1. Note progress with the plans for Winter 2020/21<br>2. Accept this report as a source of reassurance that the Partnership has developed a robust winter strategy; taking on board learning from our evaluation of the previous winter campaign and a review of the local response to the COVID-19 pandemic<br>3. Note that the preparations for Winter 2020/21 are interlinked with other aligned workstreams such as the Redesign of Urgent Care (RUC) and Home First, and align with the remobilisation plan. |
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## 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 15 December 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. This has been amplified this year with the onset of the COVID-19 pandemic and the prospect of resurgence during the winter period alongside a potential no deal EU Exit.

3. John Connaghan, Interim Chief Executive NHS Scotland, wrote to the Chief Officers of Health & Social Care Partnerships and the Chief Executive of NHS Lothian on 22 October 2020 confirming the additional funding that would be made available to Lothian for winter 2020/21 (Appendix 1). This is to be used to support the costs of ensuring that health and social care services are positioned to respond to these challenges, focussing on the following priorities:
   - Optimising discharge home as first choice ensuring patients are discharged as soon as they are medically fit, wherever appropriate and enhancing care in the community
   - Avoiding admission with services developed to provide care at home across seven days, hospital at home, discharge to assess, specialty review at rapid access clinics and a single point of access for social care
   - Reducing attendances by managing care closer to home or at home wherever possible including step-up facilities for assessment, reablement and rehabilitation, professional-to-professional referral services, support out-of-hours, managing long-term conditions to avoid unnecessary exacerbation utilising digital and remote monitoring where possible
   - Sufficient staffing across acute, primary and social care settings including over the weekends and festive period with access to senior decision makers to prevent delays in discharge and ensure patient flow
   - Surge capacity with the ability to flex up capacity when required.

4. The letter requested that NHS Boards and HSCPs submit a self-assessment against a checklist of winter preparedness by 2 November 2020 incorporating:
   - Resilience
   - Unscheduled/Elective Care
   - Out of Hours
   - Norovirus

- COVID-19, seasonal Flu, staff protection and outbreak resourcing
- Respiratory pathway
- Integration of key partners/services.

5. A copy of the completed Edinburgh HSCP Checklist for Winter Preparedness 2020/21 is attached at Appendix 2.

6. A national Winter Planning and Response Board is being formed and will act as a strategic group focussing on the oversight of the winter delivery plan; providing support to the resilience and response across health and social care and co-ordinating and deploying national resources in response to local pressures.

7. The Edinburgh HSCP Winter Planning Group has multi-agency and pan-system representation, including membership from acute sites, Social Care Direct, and includes leads for flu, carers, third sector, resilience, and communications. The group leads on the planning, monitoring and evaluation of preparations for winter. Monthly meetings are scheduled to run throughout the year.

## Main Report

8. Preparing for winter 2020/21 has again evolved from the processes used in previous years, building on the successes while incorporating key learning points, not only from the winter campaign but the Partnership response to the pandemic.

9. The Partnership was invited by Lothian Unscheduled Care Committee to develop a prioritised list of no more than three proposals for additional winter funding. These were to be submitted by 19 June 2020 and prioritised according to set criteria including:

    - Joint working
    - Home First approach
    - Seven-day working/discharge
    - Admission avoidance

- Patient safety/person-centred approach to care
- Essential in the delivery of red and green pathways for COVID-19.

10. Subsequent to this, the Partnership was asked to submit any other bids for funding by 1 July 2020. A communication was sent to targeted stakeholders including operational managers, locality managers, members of the Partnership's Winter Planning Group, the Carer Support Team, Strategic Planning Managers and the Chief Nurse asking that they liaise with staff and partners to generate proposals.

11. As a result of this two-stage process, five out of the eight proposals submitted by the Partnership were successfully funded and these are outlined below.

| **Title** | **Outline of proposal** | **Total funding (£)** |
|---|---|---|
| Discharge to Assess – Occupational Therapy | 4 Occupational Therapy posts to provide additional rehabilitation capacity, reducing length of stay, and supporting better outcomes in a shorter period. | £60,378.00 |
| Home First Therapists – RIE/WGH | 2 Occupational Therapy and 2 Physiotherapy posts based in Home First team at RIE/WGH working with acute therapy and medical staff to facilitate reduced length of stay, early supported discharge, and identify those needing intermediate care | £60,378.00 |
| Hub Social Worker Enhancement | 8 Social Worker posts to enable assessments to be carried out earlier in the hospital pathway to facilitate discharge home, or in the community to avoid admission | £88,965.34 |
| Respiratory Home First | 2 Physiotherapy and 1 Occupational Therapy posts to increase capacity within Hub to deliver CRT+ supporting not only patients with COPD but those acute chest infections and to fund support for Long COVID via the Single Point of Contact | £48,536.17 |
| Reablement Coordinators | 2 Home Care Coordinator posts to support early assessment, care planning and scheduling | £29,210.00 |
| **Total** | | **£287,467.50** |

12. Additional funding has also been made available through the Partnership to further increase Discharge to Assess capacity through the recruitment of additional community care assistants. Third sector organisations are also being funded to provide support for vulnerable residents who are at risk of admission and readmission, and unpaid carers for whom the festive period can be particularly challenging.

| **Title** | **Outline of proposal** | **Allocation** |
|---|---|---|
| Discharge to Assess – Assistant Practitioners | 4 Assistant Practitioner posts to increase service capacity and generate additional ten discharges | £43,401.00 |
| EVOC Open House | Bringing together organisations focussing on mental health and wellbeing, vulnerability as a result of COVID-19 and food poverty, co-ordinated to support those at risk of admission or readmission due to lowered resilience or social isolation. | £28,139.50 |
| VOCAL Carer Support | Support to approximately 100 unpaid carers through series of emotional support groups, learning and development events, drop-in sessions, recreational activities, short-breaks. | £3,927.00 |
| **Total** | | **£75,467.50** |

13. As of 20/11/2020, recruitment progress against each of the additional funded posts is as follows:

- Discharge to Assess – Occupational Therapy: 1 has been recruited and 3 still in progress. Options have only just become available to fill some of these posts permanently which will be much more attractive
- Home First Therapist – RIE/WGH: Both physiotherapy posts have been recruited to; one member of staff started on 16/11/2020, and the other is due to start on 07/12/2020. Both occupational therapy posts have been recruited to from existing, experienced staff but there has not been successful recruitment for backfill and therefore options of in-house staff bank and external agency are being explored. The enhanced service is due to start on 30/11/2020

- Hub Social Worker Enhancement: 4 posts have been recruited to and staff commenced on 02/11/2020. We will shortly be deploying the additional social work resource to support winter beds, Home First and key pathways.
- Respiratory Home First: All staff are in place and the enhanced service commenced on 16/11/2020
- Reablement Coordinators: Existing staff have been offered additional weekend working to cover this. Staff have been identified and the enhanced service will begin on 28/11/2020
- Discharge to Assess – Assistant Practitioners: All posts have been recruited to, but start dates are still to be confirmed. This is likely to be early - mid December.

14. In October 2020, Lothian Unscheduled Care Committee requested that the Partnership, along with other systems, report on preparations for winter 2020/21 and a copy of this is included as Appendix 3

**Reducing Delayed Discharges**

15. Following NHSL Gold Command Meeting on 17/11/2020, it was agreed through discussions with HSCP Chief Officers that the trajectory position each HSCP should be working towards is their April 2020 Census position. For December, the table below illustrates the shift in target position from the previous remobilisation trajectories. There are to be ongoing discussions with each HSCP to agree a position for March 2021, however, the expectation will be similar to the April 2020 position.

| HSCP | | Previous Remobilisation October Trajectory | April 2020 Census Position (Agreed for December) |
|---|---|---|---|
| **Edinburgh** | December 20 | 115 | 49 |
| | March 21 | 95 | - |

16. Further work is now underway, over and above that which is included in this paper, to mobilise the additional capacity with which to achieve this new target.

17. We are increasing capacity for home-based rehabilitation through Discharge to Assess which will impact on whole system flow, increasing the number of discharges from 40-50 per week up to 60 per week. In addition, hours of operation are being expanded from five to seven days which will enable discharges to take place over the weekend. Same-day triage for health referrals for non bed-based rehabilitation will achieve a diversion rate of 66%, ensuring a more appropriate use of intermediate care services.

18. There will be an enhanced acute Home First Navigator team with closer links to discharge hubs , ward-based staff and locality hubs working at four key points in the patient pathway , implementing Planned Date of Discharge (PDD) and enabling weekend discharges

19. Appointment of a Home First lead for acute team development will enable work on team development, roles and responsibilities, development of standard operating procedures, performance metrics and reporting.

20. Social Work capacity will be enhanced by 4 WTE (one per locality) to support surge activity. This will enable Hubs to meet the additional demand and ensure all assessments are carried out within 48 hours.

21. Continue to prioritise available care at home capacity to support delayed discharges and unblocking our reablement teams to ensure flow through acute to the community. An enhanced rate is also being applied to any packages of care on the delayed discharge list.

22. A block contract arrangement for 32 Safehaven beds at Northcare Suites/Northcare Manor has been extended for a further six months as part of contingency planning arrangements and will facilitate interim care needs for complex package arrangements

**Reducing Emergency Admissions**

23. Through the Redesign of Urgent Care (RUC) there will be improved access to urgent, same-day, community care services, with a 4-hour response time for Older People, Respiratory, Mental Health, MSK/Falls and Urgent Social Care as an alternative to an A&E attendance/minor injuries service or admission.

24. Winter prevention team capacity will be boosted to enable alternatives to admission for people with non-acute care needs where care has broken down or is required at short notice.

25. Home First Navigators in the Flow Centre will coordinate the redirection of individuals requiring an urgent social care response, including Care at Home.

26. Community-based management of COPD and acute chest infections through CRT+ will support admissions avoidance and reductions in readmissions. Work is also underway with the Scottish Ambulance Service to develop a pathway similar to Hospital at Home, enabling the Flow Centre to direct activity to the Community Respiratory Team.

27. A Hospital at Home pilot pathway for the frail elderly, developed in conjunction with Scottish Ambulance Service and Medicine of the Elderly, started in November 2020 and will enable assessment to be carried out closer to home. This will help avoid admission in a group that may have a poor experience within an acute care setting in addition to risk of infection, deconditioning, loss of independence and high mortality.

**Supporting People to Remain at Home**

In addition to the above, there a number of other initiatives which will ensure residents are able to receive the care and support they require over the winter period

28. The role of the Community Respiratory Team is being expanded to provide a community-based recovery and rehabilitation for Long COVID via the Single Point of Contact.

29. EVOC Open House will bring together a number of third sector organisations focussing on mental health and wellbeing to support people who are vulnerable due to COVID-19 and food poverty, and those at risk of admission or re-admission during the festive months due to lower resilience or social isolation. Delivered within Community Hubs and/or innovation sites it will offer additional ring-fenced befriending, telephone befriending, and telephone medication prompts to older people who are either engaged with Home First, the Hubs or other community-based, HSCP services and/or a being discharged from a hospital setting.

30. VOCAL is being funded to provide a service supporting approximately 100 unpaid carers in Edinburgh over the Christmas and New Year period. It will offer a range of emotional support groups and drop-in sessions, learning and development events on how to manage the festive season, recreational events and short-break respite. Contingency plans are being put in place for how to deliver this online in the event of a second lockdown situation.

31. Winter service leads are working closely with ATEC24 to ensure that there can be rapid access to equipment and TEC where required, enabling people to remain in their own homes

32. New care service specifications have been put in place this year that ensure continuity of care for service users under 65 on discharge from hospital. Terms and conditions have been changed so that no packages of care can be terminated without a managed transition to a new provider.

33. The Partnership continues to resource a sustainability scheme to help cover costs of voids in care homes, PPE, staffing and other COVID-related costs

**Ensuring business continuity**

34. Consideration is being given to concurrent resilience events such as severe weather, seasonal flu and covid, understanding how they may potentially impact on service availability and ensure this is reflected in the planning process.

35. Edinburgh HSCP Severe Weather Resilience Plan has been updated including escalation protocols, key contacts and transport arrangements to ensure continuity of service.

36. Resilience plans are in place for all NHS services managed by the Partnership and will be available in the event of an incident during winter. Plans for CEC services managed by the Partnership are in development.

37. Annual leave arrangements for all managers and team leads across the four localities, hospital and hosted services, as well as the Executive Management Team will be mapped ahead of the festive period. There will be clearly defined points of contact across the system; providing assurance that there will be adequate leadership in place for the purpose of immediate decision-making, responding to any unexpected situations that may arise as well as programmed activity.

**Coping with periods of peak demand across the system**

38. Additional capacity has been created in Discharge to Assess, Home First, CRT+ and Social Work to support areas where peak demand is expected over winter There was early recruitment to ensure staff are in place for start of winter, which is considered as being November rather than normal December start

39. There is potential to create surge capacity or flex use of beds in Edinburgh HSCP hospitals however workforce requirements would need to be taken into account to ensure safe care can be provided if opening additional capacity is required.

40. In primary care, CTAC staff can be mobilised if required to do home visits, freeing up district nurse and GP capacity. This was used during lockdown and worked well.

41. We receive regular updates from NHS Lothian Public Health and Infection Prevention and Control teams enabling the Partnership to target activity in response to any surge in flu activity or local outbreaks.

42. The Partnership has been engaging a number of new care at home providers as well as a further three providers who can quickly be on boarded to create additional 300 hours capacity in the system.

**Managing any further increase in community transmission of COVID-19**

43. The COVID-19 Resilience Protocol considers the concurrent risk of winter weather planning and this will be tested in November through a Partnership table top exercise.

44. We have additional capacity at Liberton Hospital/Astley Ainslie Hospital (designed 'red' areas) should there be a need to isolate patients who have tested positive or known contacts from within existing patient population.

45. We are also ensuring bad-weather activity complies with general safety and COVID-specific requirements

46. NSS Hub and our CEC Clocktower will continue to provide PPE for any care provider when supply chains fail. The Clocktower is currently working to six week stockpile of provision and the majority of care homes have submitted sustainability claims to recoup costs previously incurred during the summer.

47. The Partnership has worked closely with all care home managers to ensure visiting plans are robust, thoroughly risk assessed and that support is available from our RRT and Care Home Support Team to ensure effective infection control measures are in place and homes remain open to both visits and admissions.

**Flu Vaccinations**

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

49. The Chief Medical Officer issued a letter to NHS Board on 7 August 2020 outlining arrangements for the 2020/21 seasonal flu vaccination programme (Appendix 4). This has been extended to offer vaccination to households of those who are shielding, social care staff who deliver direct personal care and all those aged 55-64 years old. Some of those aged 55-64 are otherwise eligible due to qualifying health conditions or employment. Scottish Ministers have also indicated that the programme should be extended to those aged 50-54, if vaccine supply allows and this will be reviewed as the programme progresses

50. The Edinburgh HSCP flu vaccination programme for winter 2020/21 is being delivered in a variety of ways depending on the nature and needs of the group being targeted and it is expected that approximately 90% of vaccinations will be carried out by the Partnership:

- There are a range of drive-through and walk-in clinics being held on sites across the city, working seven-days a week for a period of eight weeks People in Edinburgh who are eligible for vaccination are being contacted by letter and/or text message to advise them of the benefits and that they can find out about arrangements in their area by calling NHS Inform, on the NHS Inform website, or by calling their local practice
- General practices in Edinburgh have been allocated dates when registered patients who fall into the categories eligible for vaccination may attend. To limit queues and facilitate social distancing there are hour-long slots across the day with patients attending in groups by surname. In addition, there will be opportunistic testing carried out for any patients attending the practice in person
- Pregnant women may also receive their vaccination through maternity services
- Unpaid carers are being encouraged to contact their local practice to ensure they receive their vaccinations
- Vaccinations for the housebound and care home residents are being carried out by the district nursing teams in the city

- Children of primary school age will be vaccinated through the community vaccination team, and those aged two to five years through the Children's Partnership although some who cannot have the nasal flu vaccination may need to attend their GP practice
- NHS and Social Care staff are able to attend the drive-through and walk-in clinics but are not limited to a particular date or time, providing flexibility around work commitments
- There are also a number of peer vaccinators (nursing staff) who are able to administer the vaccination to any staff, regardless of whether they are employed by the NHS or City of Edinburgh Council, within their teams

51. There is a new cohort of individuals aged 50-54 who may also be eligible for vaccination depending on availability of vaccines and this will be reviewed in Phase 2 later in the year.

**Communication**

52. As a Partnership, we will promote preventative or operational messages around seven key topics; winter resilience messages and arrangements, flu vaccination, falls prevention, hospital avoidance/signposting, anticipatory care planning, keeping safe and healthy over winter, and support and advice for carers. There will be a greater focus on preventative messaging this year than in previous years.

53. We will target communications to some of our most vulnerable residents, who are among the largest users of health and social care resources, including vulnerable older people, people who receive a care at home service, people who receive technology enabled care and equipment from us , people with long-term health conditions and people who are at higher risk of falls

54. The most effective route to such a wide audience is through the health and social care workers, and organisations that support them to live their daily lives. For that reason, we plan to communicate with our primary audiences through general practice, social work, occupational and physical therapists, pharmacies, care at home agencies, care home staff and ATEC24.

55. In addition we will link with the Carer Support Team to ensure that carer organisations are kept informed and to support unpaid carers who often struggle at this time of year.

56. We will keep the Partnership workforce informed through regular internal communications and a briefing to staff on winter arrangements, including the flu vaccination programme

57. NHS Lothian will promote the Scottish Government's winter campaign. The Partnership will support this region-wide winter campaign using EHSCP social media channels

## Implications for Edinburgh Integration Joint Board

### Financial

58. NHS Lothian was allocated a total of £1.451 million to support the costs of ensuring health and social care services are prepared for Winter 2020/21,

59. A total of £287,467.50 was awarded to five winter proposals put forward by the Partnership as outlined earlier in this report. An additional £75,467.50 has been made available to other initiatives to support caring for vulnerable residents and unpaid carers over the winter period.

### Legal / risk implications

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

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

62. Experience from previous years leads us to expect a spike of delayed discharges due to staff absence, influenza and norovirus. Failure to achieve the delayed discharge targets would impact on system wide flow.

63. A potential increase in prevalence of COVID-19 may also impact on admissions and staff availability.

64. We would also expect a surge in respiratory-related admissions and re-admissions over the winter months.

**Equality and integrated impact assessment**

65. An integrated impact assessment was undertaken in November 2020 to consider both the positive and negative outcomes for people with protected characteristics and other groups.

66. Local residents will continue to benefit from the provision of person-centred care, with improved access to services in a timely manner and providing care closer to home. Admission to hospital will be avoided wherever possible and the quality of discharge and home care support will be enhanced. Additional support being put in place through EVOC Open House and VOCAL will support the vulnerable and unpaid carers, reducing social isolation and increasing their resilience.

67. Increasing COVID-19 prevalence and the prospect for a further lockdown period resulting in social isolation remains a challenge however contingency plans are being put in place to ensure residents continue to receive the care and support they require.

68. Communication with groups for whom English is not their first language was highlighted as some communities are disproportionately affected by COVID-19. We are taking this on board and looking at how to strengthen communication plans. This year, the flu vaccination programme was promoted on YouTube with videos in a wide range of language representative of the local population.

**Environment and sustainability impacts**

69. As a result of the pandemic, there may be a reduction in service users travelling for treatment and ongoing care. This may be offset by an increase in staff travelling to service user's own homes.

70. Public safety will be improved through identifying vulnerable people in the community and ensuring support is in place, protecting their interests during periods of severe weather

71. Improving infection control through care management at home

72. Improving physical environment through improved links with ATEC24 to provide equipment as required

73. There is the potential for the impact of severe weather and service disruption to be minimised as a result of the pandemic – priority road clearance and gritting, access to emergency food supplies as required

## Consultation

74. Winter plans have been developed in very close consultation with relevant parties through the NHS Lothian Unscheduled Care Committee and the EHSCP Winter Planning Group.

75. A communication plan is being developed for the Partnership to ensure that staff in health and social care, partner organisations, the public and visitors to the city are aware of the services available over the festive period and how to access these.

76. The key target groups are people using the largest proportion of health care resources, primarily vulnerable older people, people who receive care at home, people with long-term health conditions, and unpaid carers.

## Report Author

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## Appendices

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| Appendix 1 | Preparing for Winter 2020/21 Letter from Interim Chief Executive, NHS Scotland |
| Appendix 2 | Preparing for Winter 20/20/2: Supplementary Checklist of Winter Preparedness Self-Assessment |
| Appendix 3 | Health and Social Care: Preparation for Winter Response |
| Appendix 4 | Adult Flu Immunisation Programme Letter from Chief Medical Officer |

Interim Chief Executive NHSScotland

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To: Chief Executives and Chief Officers

Cc: Chair of Health Board
Unscheduled Care Executive Lead

22 October 2020

Dear Calum Campbell,

**Preparing for Winter 2020/21**

Winter preparedness planning plays a key role in ensuring Boards are ready to meet the additional challenges likely to be faced this winter. I am aware, from the Board re-mobilisation plans and recent feedback conversations, that planning for the risks and challenges winter will bring is well underway locally.

Similar to previous years, we will be asking Boards to confirm their winter preparedness arrangements to the end of March 2021 caveated against the anticipated risks. These should include a resurgence of COVID-19 including surge bed capacity, severe weather, winter illnesses, and a no deal EU Exit – arising individually or potentially concurrently.

We would expect that these will build on arrangements set out in your re-mobilisation plan and that these would be based on learning from previous years, but with increased emphasis on digital health, Hospital@Home, enhanced community response and capacity as well as an evolving and central role for Primary Care.

As previously advised, Boards should prioritise Test and Protect arrangements over winter. I have written separately regarding contact tracing staffing expectations per Board. Contact tracing remains a vital line of defence in managing the pandemic and all Boards are required to play their role in the national collective effort.

Of equal importance this year is the expansion of the flu programme, which protects the most vulnerable and supports the NHS. As you will appreciate, this is even more vital in the context of the Covid-19 pandemic. The Chief Medical Officer issued a letter to Health Boards on the 7 August setting out the arrangements for the 2020/21 seasonal flu vaccination programme. We expect your local plans should take account the potential impact of seasonal flu, and contain workforce modelling for the management of demand on services and impact to staffing. As well as eligibility being expanded this year, we also expect that there will be high demand for the seasonal flu vaccine, due to increased public awareness of the risks of infectious diseases as a result of the Covid-19 pandemic. We expect that Board plans will reflect the increased capacity necessary to deliver this. Learning from Seasonal Flu should contribute to the development of plans for delivery of the Covid Vaccination.

Alongside this, we plan to work with Boards on a process to assess and monitor sufficiency and effectiveness of plans. This will include a series of learning events with work now underway to organise these. The first of which has already taken place on 29 September. Given the broader focus of winter planning this year, I have pulled together a specific team within the Performance and Delivery Directorate to support this work which draws from the health resilience unit, the unscheduled care team and the board sponsorship team.

We recognise the challenges hospitals are facing in enhancing capacity for surge beds due to the need to maintain physical distancing and safe spacing in our hospitals. We would expect any need for surge capacity to be risk assessed against infection control requirements. To reduce capacity pressures in acute sites we would expect particular focus this winter on providing care closer to or at home and same day emergency care. It is essential you work closely with Scottish Ambulance Service to ensure the necessary transport arrangements are in place to support transport home, or to care homes, to avoid the need for admission.

Of particular importance this year will be the local implementation of a 'single point of access' for Urgent Care through NHS24 and onwards to local Flow Navigation Centres for early clinical decision making. This is a key part of the Redesign of Urgent Care Programme, which will help mitigate the risks presented by increased emergency presentations and hospital associated infection. As part of the winter planning process we expect all Boards to submit regular readiness assessments so we can evaluate, progress and address challenges as well as share lessons learned.

Further funding will be allocated in the coming weeks for your improvement work and the Redesign of Urgent Care to ensure patients are seen in most appropriate clinical environment and the rate of attendance is smoothed to avoid overcrowding and reduce attendances.

This year the festive break takes place over weekends, therefore there is an added imperative to ensure weekend staffing is optimised across the service to ensure quality of care and patient safety is maintained. As outlined in the winter guidance checklist, we would expect you to ensure weekend staffing is optimised across the service every weekend over winter and that a process is agreed between partners to maximise weekend and next day discharge.

**Funding**

The indicative **winter** funding your Health Board and Integration Joint Board will receive is **£1.451 million** to support the costs of ensuring our health and care services are in the best position to respond to these unprecedented winter challenges. We expect this additional resource will be focused on the following priorities -

- **Optimising discharge home as first choice** ensuring patients are discharged as soon as they are medically fit, wherever appropriate and enhancing care in the community.
- **Avoiding admission** with services developed to provide care at home across 7 days, hospital at home, discharge to assess, specialty review at rapid access clinics and a single point of access for social care
- **Reducing attendances** by managing care closer to home or at home wherever possible including community step up facilities for assessment, reablement and rehabilitation, prof to prof referral services, support OOH, managing long term

conditions to avoid unnecessary exacerbation utilising digital and remote monitoring where possible

- **Sufficient staffing** across acute, primary and social care settings including over the weekends and festive period with access to senior decision makers to prevent delays in discharge and ensure patient flow. You should assure yourselves that recommendations in the four day public holiday review are fully embedded.
- **Surge Capacity** with the ability to flex up capacity when required including an ICU surge plan; using System Watch to develop detailed demand and capacity projections to inform planning; access to rapid response teams; locally agreed triggers and escalation.

Your Board funding for **Redesign of Urgent Care and 6 Essential Actions** will be allocated by the end of the month.

As part of this year's winter planning process, a Winter Planning and Response Group is being established to identify and monitor pressures across the system. This will be co-chaired by John Connaghan, Chief Executive of NHS Scotland and Jeff Ace, Chief Executive, NHS Dumfries and Galloway. This Board will act as a Strategic Group, focused on oversight of a winter delivery plan and providing support to the resilience and response across health and social care. This group will have responsibility of co-ordinating and agreeing national resources and support deployment to assist in relation to regional/local issues and pressures to support local systems.

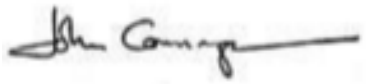
By way of immediate steps, **I invite Health Board Chief Executives, IJB Chief Officers to submit a joint letter containing your: winter checklist (Annex A), Covid surge bed capacity template (Annex B) requested separately on 15 October, infection prevention and control COVID-19 outbreak checklist (Annex C). You should also provide any additions or updates to the winter section of your Board Re-mobilisation plan.** This letter should provide a breakdown of the additional capacity and resource you intend to put in place to maintain resilience over the winter period including the costs associated with implementing your winter plan. Health Boards should continue to make provision to re-purpose up to 3,000 beds as surge capacity to support Covid-19 as required. In addition, NHS Boards should retain the ability to double their Intensive Care Unit (ICU) capacity within one week, treble in two weeks and, if required, extend this to over 700 in extremis. NHS Boards should also plan to provide non-invasive ventilatory (CPAP) support out with the ICU setting, e.g. High Dependency Unit (HDU), Respiratory Wards. NHS Boards capacity to provide CPAP for Covid Pneumonia out with ICU should match as far as possible ICU surge capacity. For clarity, the 700 ICU and CPAP 700 beds, should be a proportion of the overall 3000 re-purposed surge capacity Covid-19 bed capacity. We will arrange a series of meetings with each Board to discuss your covid surge capacity in more detail based on the returns that you have recently made.

I ask that you collectively assure yourselves within your local governance structure that these plans are fit for purpose and will support the delivery of whole-system sustainability and national strategies / targets over winter. You should publish your local winter plan by end of November.

The Scottish Government will continue to engage with you over the coming months around the assurance of local preparedness. Similar to previous years, I will establish a whole-system resilience group which will meet daily to monitor the pressures and trends in the system and where significant pressures are apparent we may call on Chief Executives to participate.

Please can you submit the above as requested by 02 November to Winter_Planning_Team_Mailbox@gov.scot. On satisfactory receipt we will continue to work with you on your planned use of winter funding as well as redesign of urgent care and 6 essentials funding.

Yours sincerely



**JOHN CONNAGHAN CBE**
Interim Chief Executive NHS Scotland

ANNEX A

# Preparing for Winter 2020/21: Supplementary Checklist of Winter Preparedness: Self-Assessment

**Priorities**

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Covid -19, Seasonal Flu, Staff Protection & Outbreak Resourcing**
6. **Respiratory Pathway**
7. **Integration of Key Partners / Services**

These checklists supplement the Preparing for Winter 2020/21 Guidance and support the strategic priorities for improvement identified by local systems from their review of last winter's pressures and performance. For the avoidance of doubt, your winter preparedness assessment should cover systems, processes and plans to mitigate risks arising from a resurgence in covid-19, severe weather, winter flu and other winters respiratory issues, and a no deal Brexit – either individually or concurrently.

The checklists also include other areas of relevance but are not exhaustive. Local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

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

## *Winter Preparedness: Self-Assessment Guidance*

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

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

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

| 1 | Resilience Preparedness<br>*(Assessment of overall winter preparations and further actions required)* | | RAG | Further Action/Comments |
|---|---|---|---|---|
| 1 | The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather, EU Exit and Covid-19 resurgence. These arrangements have built on the lessons learned from previous events, and are regularly tested to ensure they remain relevant and fit for purpose.<br><br>Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans.<br><br>*The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The Preparing for Emergencies Guidance sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.* | ☐<br><br>☐ | | |
| 2 | Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios, including Covid-19 reasonable worst case scenarios.<br><br>Risk assessments take into account staff absences including those likely to be caused by a range of scenarios including seasonal flu and/or Covid-19 as outlined in section 5 and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner.<br><br>The Health Board and HSC partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios. | ☐<br><br>☐<br><br>☐ | | |

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| 3 | The NHS Board and HSCPs have appropriate policies in place should winter risks arise. These cover:<br>• what staff should do in the event of severe weather or other issues hindering access to work, and<br>• how the appropriate travel and other advice will be communicated to staff and patients<br>• how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis.<br><br>*Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.* | ☐ | | |
| 4 | The NHS Board's and HSCPs websites will be used to advise on changes to access arrangements during Covid-19, travel to appointments during severe weather and prospective cancellation of clinics. | ☐ | | |
| 6 | The NHS Board, HSCPs and relevant local authorities have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors. | ☐ | | |
| 7 | The NHS Board and HSCPs have considered the additional impacts that a 'no deal' EU withdrawal on 1 January 2021 might have on service delivery across the winter period. | ☐ | | |
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| **2** | **Unscheduled / Elective Care Preparedness**<br>*(Assessment of overall winter preparations and further actions required)* | | **RAG** | **Further Action/Comments** |
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| **1** | **Clinically Focussed and Empowered Management** | | | |
| 1.1 | Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective | ☐ | | |

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| | activity.<br><br>*To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.*<br><br>*Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.* | | | |
| 1.2 | Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked. | ☐ | | |
| 1.3 | A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU.<br><br>*This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.*<br><br>*Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay* | ☐ | | |
| 1.4 | Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period.<br><br>*All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.* | ☐ | | |
| **2** | **Undertake detailed analysis and planning to effectively manage scheduled elective,unscheduled and COVID activity (both short and medium-term) based on forecast emergencyand elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.** | | | |

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| 2.1 | Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergencyand elective provision are fully integrated, including identification of winter surge beds for emergency admissions<br><br>*Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.*<br><br>*Weekly projections for Covid demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity.*<br><br>*Plans in place for the delivery of safe and segregated COVID care at all times.*<br><br>*Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.*<br><br>*NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.* | ☐ | | |
| 2.2 | Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter / COVID surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work.<br><br>*This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution.*<br><br>*Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for* | ☐ | | |

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| | *elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.*<br><br>*Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical prioritisation and planning assumptions* | | | |
| **3** | **Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.** | | | |
| 3.1 | System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October.<br><br>*This should take into account predicted peaks in demand, including impact of significant events on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*. | ☐ | | |
| 3.2 | Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services. | ☐ | | |
| 3.3 | Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc.<br><br>*NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations* | ☐ | | |
| 3.4 | Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. | ☐ | | |

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| | *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.* | | | |
| | **Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of healthcare associated infection and crowded Emergency Departments.**<br><br>**Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.** | | | |
| | To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate.<br><br>Referrals to the flow centre will come from:<br>• NHS 24<br>• GPs and Primary and community care<br>• SAS<br>• A range of other community healthcare professionals.<br><br>If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide visable appointments / timeslots at A&E services.<br><br>The impact on health-inequalties and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments. | ☐ | | |

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| | Professional to professional advice and onward referral services should be optimised where required<br><br>Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission. | ☐ | | |
| **4** | **Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge to shift the discharge curve to the left and ensure same rates of discharge over the weekend and public holiday as weekday.** | | | |
| 4.1 | Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process.<br><br>*Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.*<br><br>*Utilise Criteria Led Discharge wherever possible.*<br>*Supporting all discharges to be achieved within 72 hours of patient being ready.*<br><br>*Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.* | ☐ | | |
| 4.2 | To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate.<br><br>*Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to* | ☐ | | |

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| | *undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.* | | | |
| 4.3 | Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon.<br><br>*Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.*<br><br>*Extended opening hours during festive period over public Holiday and weekend* | ☐ | | |
| 4.4 | Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre-Christmas discharge<br><br>*There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes* | ☐ | | |
| **5** | **Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.** | | | |
| 5.1 | Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels.<br><br>*This will be particularly important over the festive holiday periods.*<br><br>*Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.*<br>*Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.*<br>*Assessment capacity should be available to support a discharge to assess model across 7 days.* | ☐ | | |

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| 5.2 | Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible.<br><br>*Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*<br><br>*All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible* | ☐ | | |
| 5.3 | Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge.<br><br>*Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.* | ☐ | | |
| 5.4 | All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances.<br><br>*KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.* | ☐ | | |
| 5.5 | Covid-19 Regional Hubs fully operational by end November. Additional lab capacity in place through partner nodes and commercial partners by November.<br>Turnaround times for processing tests results within 24/48 hours. | | | |
| **6.0** | **Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.** | | | |
| 6.1 | Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector and into the Scottish Government. | ☐ | | |

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| | *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.*<br><br>*Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.* | | | |
| 6.2 | Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent.<br><br>*SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around direction to the appropriate service are effectively communicated to the public.*<br><br>*The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.*<br><br>*The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.*<br><br>*Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns* | ☐ | | |

| **3** | **Out of Hours Preparedness**<br>*(Assessment of overall winter preparations and further actions required)* | | **RAG** | **Further Action/Comments** |
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| 1 | The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays.<br><br>*This should include an agreed escalation process.*<br><br>*Have you considered local processes with NHS 24 on providing pre-prioritised calls during OOH periods?* | ☐ | | |
| 2 | The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and | ☐ | | |

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| | demand management are prioritised over the festive period. | | | |
| 3 | There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed. | ☐ | | |
| 4 | There is reference to direct referrals between services.<br><br>*For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?* | ☐ | | |
| 5 | The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records. | ☐ | | |
| 6 | There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa | ☐ | | |
| 7 | In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period. | ☐ | | |
| 8 | Ensure there is reference to provision of dental services, that services are in place either via general dental practices or out of hours centres<br><br>*This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.* | ☐ | | |
| 9 | The plan displays a confidence that staff will be available to work the planned rotas.<br><br>*While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.* | ☐ | | |
| 10 | There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24.<br><br>*This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.* | ☐ | | |

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

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

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| 6 | IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker. | ☐ | | |
| 7 | Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge. | ☐ | | |
| 8 | NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period.<br>*While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.* | ☐ | | |
| 9 | The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple bays / wards over a couple of days.<br><br>*As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.* | ☐ | | |
| 10 | There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.<br><br>*HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.* | ☐ | | |
| 11 | The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus. | ☐ | | |

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| 12 | Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of Covid-19. | ☐ | | |

| **5** | **Covid-19, Seasonal Flu, Staff Protection & Outbreak Resourcing**<br>*(Assessment of overall winter preparations and further actions required)* | | **RAG** | **Further Action/Comments** |
|---|---|---|---|---|
| 1 | Staff, particularly those working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients and other staff, as recommended in the CMO's seasonal flu vaccination letter published on 07 Aug 20 https://www.sehd.scot.nhs.uk/cmo/CMO(2020)19.pdf<br><br>*This will be evidenced through end of season vaccine uptake submitted to PHS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.* | ☐ | | |
| 2 | All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible.<br><br>*It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders* | ☐ | | |

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| | *with NHS Boards fully support vaccine delivery and uptake.*<br>*Vaccine uptake will be monitored weekly by performance & delivery division.* | | | |
| 3 | Workforce in place to deliver expanded programme and cope with higher demand, including staff to deliver vaccines, and resource phone lines and booking appointment systems. | | | |
| 4 | Delivery model(s) in place which:<br><br>• Has capacity and capability to deal with increased demand for the seasonal flu vaccine generated by the expansion of eligibility as well as public awareness being increased around infectious disease as a result of the Covid-19 pandemic.<br>• Is Covid-safe, preventing the spread of Covid-19 as far as possible with social distancing and hygiene measures.<br>• Have been assessed in terms of equality and accessibility impacts<br><br>*There should be a detailed communications plan for engaging with patients, both in terms of call and recall and communicating if there are any changes to the delivery plan.* | | | |
| 5 | The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. | ☐ | | |

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| | *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)* | | | |
| 6 | PHS weekly updates, showing the current epidemiological picture on Covid-19 and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity.<br><br>*PHS and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.* | ☐ | | |
| 7 | NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows:<br><br>• Adults aged over 65<br>• Those under 65 at risk<br>• Healthcare workers<br>• Unpaid and young carers<br>• Pregnant women (no additional risk factors)<br>• Pregnant women (additional risk factors)<br>• Children aged 2-5<br>• Primary School aged children<br>• Frontline social care workers<br>• 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household | ☐ | | |

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| | • Eligible shielding households<br><br>The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This will include regular reporting that will commence from the end of week commencing 12th October. We will adopt a the Public Health Scotland model, which is a pre-existing manual return mechanism that has been used in previous seasons with NHS Boards to collate Flu vaccine uptake data when vaccination is out with GP practices. | | | |
| 8 | Adequate resources are in place to manage potential outbreaks of Covid-19 and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods.<br><br>*NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.* | ☐ | | |
| 9 | Tested appointment booking system in place which has capacity and capability to deal with increased demand generated by the expansion of eligibility and increased demand expected due to public awareness around infectious disease as a result of the Covid-19 pandemic. | | | |
| 10 | NHS Boards must ensure that all staff have access to and are adhering to the national COVID-19 IPC and PPE guidance and have received up to date training in the use of appropriate PPE for the safe management of patients.<br><br>Aerosol Generating Procedures (AGPs)<br>In addition to this above, Boards must ensure that staff working in areas where Aerosol Generating Procedures (AGPs) are likely to be undertaken - such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) - are | ☐ | | |

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| | fully aware of all IPC policies and guidance relating to AGPs; are FFP3 fit-tested; are trained in the use of this PPE for the safe management of suspected Covid-19 and flu cases; and that this training is up-to-date.<br><br>***Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's 'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013). https://www.hse.gov.uk/pUbns/priced/hsg53.pdf*** | | | |
| 11 | NHS Boards must ensure that the additional IPC measures set out in the CNO letter on 29 June staff have been implemented. This includes but is not limited to:<br>• Adherence to the updated extended of use of face mask guidance issued on 18 September and available here.<br>• Testing during an incident or outbreak investigation at ward level when unexpected cases are identified (see point 9).<br>• Routine weekly testing of certain groups of healthcare workers in line with national healthcare worker testing guidance available here (see point 9).<br>• Testing on admission of patients aged 70 and over. Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster.<br>• Implementation of COVID-19 pathways (high, medium and low risk) in line with national IPC guidance.<br>• Additional cleaning of areas of high volume of patients or areas that are frequently touched.<br>• Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September.<br>• Consideration given to staff movement and rostering to minimise staff to staff transmission and staff to patient transmission.<br>• Management and testing of the built environment (e.g. water | ☐ | | |

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| | systems) that have had reduced activity or no activity since service reduction / lockdown – in line with extant guidance. | | | |
| 12 | Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf<br><br>In addition to this, key healthcare workers in the following specialities should be tested on a weekly basis: oncology and haemato-oncology in wards and day patient areas including radiotherapy; staff in wards caring for people over 65 years of age where the length of stay for the area is over three months; and wards within mental health services where the anticipated length of stay is also over three months.<br><br>*Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-covid-19-healthcare-worker-testing/* | ☐ | | |

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| 13 | The PHS COVID-19 checklist must be used in the event of a COVID-19 incident or outbreak in a healthcare setting. The checklist is available here: https://www.hps.scot.nhs.uk/web-resources-container/covid-19-outbreak-checklist/<br><br>The checklist can be used within a COVID ward or when there is an individual case or multiple cases in non-COVID wards. | ☐ | | |
| 14 | Ensure continued support for routine weekly Care home staff testing<br><br>This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results. | ☐ | | |

| **6** | **Respiratory Pathway**<br>*(Assessment of overall winter preparations and further actions required)* | | **RAG** | **Further Action/Comments** |
|---|---|---|---|---|
| **1** | **There is an effective, co-ordinated respiratory service provided by the NHS board.** | | | |

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

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| | *skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).* | | | |
| 2.2 | All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team. | ☐ | | |
| **3** | **People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.** | | | |
| 3.1 | Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease.<br><br>*Spread the use of ACPs and share with Out of Hours services.*<br><br>*Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.*<br><br>*SPARRA Online: Monthly release of SPARRA data,*<br><br>*Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.* | ☐ | | |
| **4** | **There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board** | | | |

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| 4.1 | Staff are aware of the procedures for obtaining/organising home oxygen services.<br><br>Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860)<br><br>Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period.<br><br>Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated.<br><br>*Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.* | ☐<br><br>☐<br><br>☐<br><br>☐ | | |
| **5** | **People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.** | | | |
| 5.1 | Emergency care contact points have access to pulse oximetry.<br>*Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.* | ☐ | | |

| 7 | Key Roles / Services | | RAG | Further Action/Comments |
|---|---|---|---|---|
| | Heads of Service | ☐ | | |
| | Nursing / Medical Consultants | ☐ | | |
| | Consultants in Dental Public Health | ☐ | | |
| | AHP Leads | ☐ | | |

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|---|---|---|---|---|
| | Infection Control Managers | ☐ | | |
| | Managers Responsible for Capacity & Flow | ☐ | | |
| | Pharmacy Leads | ☐ | | |
| | Mental Health Leads | ☐ | | |
| | Business Continuity / Resilience Leads, Emergency Planning Managers | ☐ | | |
| | OOH Service Managers | ☐ | | |
| | GP's | ☐ | | |
| | NHS 24 | ☐ | | |
| | SAS | ☐ | | |
| | Other Territorial NHS Boards, eg mutual aid | ☐ | | |
| | Independent Sector | ☐ | | |
| | Local Authorities, incLRPs & RRPs | ☐ | | |
| | Integration Joint Boards | ☐ | | |
| | Strategic Co-ordination Group | ☐ | | |
| | Third Sector | ☐ | | |
| | SG Health & Social Care Directorate | ☐ | | |

**ANNEX B**

## Covid Surge Bed Capacity Template

| | | Baseline ICU Capacity | Double Capacity and Commitment to deliver in one week | 'Triple plus' Capacity Commitment to deliver in two weeks | ICU Max Surge Beds | Y - Correct / N Incorrect with comment | Please list assumptions & consequences to other service provision to meeting these requirements |
|---|---|---|---|---|---|---|---|
| PART A: ICU | Please confirm that your NHS Board can deliver the stated level of ICU Capacity in the time periods set out | 29 | 54 | 92 | 113 | | |

| | | | |
|---|---|---|---|
| PART B: CPAP | Please set out the maximum number of COVID patients (at any one time) that could be provided CPAP in your NHS Board, should it be required | | |
| PART C: Acute | Please set out the maximum number of acute beds that your NHS Board would re-provision for COVID patients (share of 3,000 nationally), should it be required | | |

**ANNEX C**

Health Protection Scotland

# Infection Prevention and Control COVID-19 Outbreak Checklist

**(Refer to the National Infection Prevention and Control Manual (NIPCM) for further information http://www.nipcm.hps.scot.nhs.uk/ )**

NHS National Services Scotland

**This COVID-19 tool is designed for the control of incidents and outbreak in healthcare settings.**

**Definitions: 2 or more confirmed or suspected cases of COVID within the same area within 14 days where cross transmission has been identified.**
**Confirmed case: anyone testing positive for COVID**
**Suspected case: anyone experiencing symptoms indicative of COVID (not yet confirmed by virology)**

**This tool can be used within a COVID ward or when there is an individual case or multiple cases.**

**Standard Infection Control Precautions;**
**Apply to all staff, in all care settings, at all times, for all patients when blood, body fluids or recognised/unrecognised source of infection are present.**

| **Patient Placement/Assessment of risk/Cohort area** | **Date** | | | | |
|---|---|---|---|---|---|
| Patient placement is prioritised in a suitable area pending investigation such as for a single case i.e. single room with clinical wash hand basin and en-suite facilities | | | | | |
| Cohort areas are established for multiple cases of **confirmed** COVID (if single rooms are unavailable). Suspected cases should be cohorted separately until confirmed. Patients should be separated by at least 2 metres if cohorted. | | | | | |
| Doors to isolation/cohort rooms/areas are closed and signage is clear (undertake a patient safety risk assessment for door closure). | | | | | |
| If failure to isolate, inform IPCT. **Ensure all patient placement decisions and assessment of infection risk (including isolation requirements) is clearly documented in the patient notes and reviewed throughout patient stay.** | | | | | |
| Patient placement is reviewed as the care pathway changes. NB: Patients may be moved into suspected or confirmed COVID-19 cohorts or wards to support bed management. | | | | | |
| **Personal Protective Clothing (PPE)** | | | | | |
| Droplet precautions: Staff providing direct care must wear disposable aprons, gloves, FRSM and eye/face protection, when in the patients' immediate care environment. If in a cohort staff should wear a FRSM when not providing direct care.<br><br>Airborne precautions: High risk area or performing AGPs: use a FFP respirator and consider the need for a gown/coverall. | | | | | |
| **Safe Management of Care Equipment** | | | | | |

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| Single-use items are in use where possible. | | | | | |
| Dedicated reusable non-invasive care equipment is in use and decontaminated between uses. Where it cannot be dedicated ensure equipment is decontaminated following removal from the COVID-19 room/cohort area and prior to use on another patient. | | | | | |
| **Safe Management of the Care Environment** | | | | | |
| All areas are free from non-essential items and equipment. | | | | | |
| **At least twice daily** decontamination of the patient isolation room/cohort rooms/areas is in place using a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl.). | | | | | |
| **Increased frequency** of decontamination (at least twice daily)is incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g. “frequently touched" surfaces such as door/toilet handles and locker tops, over bed tables and bed rails. | | | | | |
| **Terminal decontamination** is undertaken following patient transfer, discharge, or once the patient is no longer considered infectious. | | | | | |
| **Hand Hygiene** | | | | | |
| Staff undertake hand hygiene as per WHO 5 moments: using either ABHR or soap and water | | | | | |
| **Movement Restrictions/Transfer/Discharge** | | | | | |
| Patients with suspected/confirmed COVID should not be moved to other wards or departments unless this is for essential care such as escalation to critical care or essential investigations.<br>Discharge home/care facility:<br>Follow the latest advice in COVID-19 - guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings. | | | | | |
| **Respiratory Hygiene** | | | | | |
| **Patients are supported with hand hygiene and provided with disposable tissues and a waste bag** | | | | | |
| **Information and Treatment** | | | | | |
| Patient/Carer informed of all screening/investigation result(s). | | | | | |
| Patient Information Leaflet if available or advice provided? | | | | | |
| Education given at ward level by a member of the IPCT on the IPC COVID guidance? | | | | | |
| Staff are provided with information on testing if required | | | | | |

ANNEX A

# Preparing for Winter 2020/21: Supplementary Checklist of Winter Preparedness: Self-Assessment

**Priorities**

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Covid -19, Seasonal Flu, Staff Protection & Outbreak Resourcing**
6. **Respiratory Pathway**
7. **Integration of Key Partners / Services**

These checklists supplement the Preparing for Winter 2020/21 Guidance and support the strategic priorities for improvement identified by local systems from their review of last winter's pressures and performance. For the avoidance of doubt, your winter preparedness assessment should cover systems, processes and plans to mitigate risks arising from a resurgence in covid-19, severe weather, winter flu and other winters respiratory issues, and a no deal Brexit – either individually or concurrently.

The checklists also include other areas of relevance but are not exhaustive. Local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

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

## *Winter Preparedness: Self-Assessment Guidance*

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

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

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

| 1 | Resilience Preparedness<br>*(Assessment of overall winter preparations and further actions required)* | | RAG | Further Action/ Comments |
|---|---|---|---|---|
| 1 | The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather, EU Exit and Covid-19 resurgence. These arrangements have built on the lessons learned from previous events, and are regularly tested to ensure they remain relevant and fit for purpose.<br><br>Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans.<br><br>*The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The Preparing for Emergencies Guidance sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.* | ☐<br><br>☐ | | The Edinburgh Health and Social Care Partnership (EHSCP) Resilience Lead and Co-ordinator reviews its Severe Weather Plan yearly with the assistance of Resilience Specialists.<br><br>It is reviewed again after each severe weather incident (e.g. floods, high winds, etc) debrief to ensure that any lessons learned is incorporated into the plan.<br><br>A Severe Weather Group was also set up in 2019 with members from Council, NHS Lothian and EHSCP to further strengthen resilience response and share resources during winter weather related incidents.<br><br>Should there be a significant surge in COVID, the central Command Centre model which was in place during lockdown, will be reinstated. This was well tested over the summer.<br><br>Resilience plans are in place for NHS Services, and plans for CEC services will be in place by early December. The plans set out arrangements for services in the |

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| | | | | event of incidents of disruption, including any potential impact of Brexit. The Partnership also has representation on the relevant committees focusing on potential impacts of Brexit. |
| 2 | Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios, including Covid-19 reasonable worst case scenarios.<br><br>Risk assessments take into account staff absences including those likely to be caused by a range of scenarios including seasonal flu and/or Covid-19 as outlined in section 5 and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner.<br><br>The Health Board and HSC partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios. | ☐<br><br>☐<br><br>☐ | | EHSCP Tactical Plan considers every essential service within the Partnership and covers various risk-assessed scenarios, including seasonal flu and COVID.<br><br>Partial - Annual update exercise of Business Continuity plans for EHSCP's NHS Services are nearly complete and Council Services are currently carrying out Business Impact Assessments as part of a systems migration to BusinesContinuity2 that make available all Council EHSCP Business Continuity Plans available online. This work is being actively monitored through the Council's Internal Audit programme and has specific risk findings set against the completion of this work in 2020.<br><br>Severe Weather Group - members from Council, NHS Lothian and EHSCP to further strengthen resilience response and share resources during weather related incidents. |

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| 3 | The NHS Board and HSCPs have appropriate policies in place should winter risks arise. These cover:<br>• what staff should do in the event of severe weather or other issues hindering access to work, and<br>• how the appropriate travel and other advice will be communicated to staff and patients<br>• how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis.<br><br>*Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.* | ☐ | | CEC and NHS have adverse weather policies. This is included in the Severe Weather plan |
| 4 | The NHS Board's and HSCPs websites will be used to advise on changes to access arrangements during Covid-19, travel to appointments during severe weather and prospective cancellation of clinics. | ☐ | | Communication plans and contacts are in place to alert staff, patients and service users of any disruption. |
| 6 | The NHS Board, HSCPs and relevant local authorities have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors. | ☐ | | This is included the Council's Severe Weather plan. |
| 7 | The NHS Board and HSCPs have considered the additional impacts that a 'no deal' EU withdrawal on 1 January 2021 might have on service delivery across the winter period. | ☐ | | EHSCP has considered the impacts of service delivery across the winter period. This is listed in a Brexit Risk Register that is regular updated and shared with both NHS Lothian and Council partners. |

| 2 | **Unscheduled / Elective Care Preparedness**<br>*(Assessment of overall winter preparations and further actions required)* | | RAG | Further Action/ Comments |
|---|---|---|---|---|
| 1 | **Clinically Focussed and Empowered Management** | | | |
| 1.1 | Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity.<br><br>*To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.*<br><br>*Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.* | ☐ | | Clear operational lines of escalation are in place within EHSCP |
| 1.2 | Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked. | ☐ | | Daily teleconferences will be scheduled if there are significant pressures across the system |
| 1.3 | A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU.<br><br>*This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.*<br><br>*Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay* | ☐ | | Not applicable – NHS Lothian to complete |
| 1.4 | Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. | ☐ | | Care Home admissions are managed centrally matched to available capacity and information about capacity in private care homes is also utilised to |

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| | *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.* | | | match service users to places dependant on price and funding available. Should exceptional pressures develop these will be escalated to EMT.<br><br>Sheena Muir is in regular contact with the AAH Discharge Hub throughout the day especially over winter and has knowledge/early sight of any specific issues which could impact on flow and assist the team in finding solutions. There are no plans to increase the capacity in Liberton over winter. Any escalations will be via Tom Cowan to the EMT/Chief Officer. |
| **2** | **Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID activity (both short and medium-term) based on forecast emergency and elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.** | | | |
| 2.1 | Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions<br><br>*Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.*<br><br>*Weekly projections for Covid demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity.*<br><br>*Plans in place for the delivery of safe and segregated COVID care at all times.*<br><br>*Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take* | ☐ | | Not applicable – NHS Lothian to complete |

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| | *account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.*<br><br>*NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.* | | | |
| 2.2 | Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter / COVID surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work.<br><br>*This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution.*<br><br>*Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.*<br><br>*Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical prioritisation and planning assumptions* | ☐ | | Not applicable – NHS Lothian to complete |

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| **3** | **Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.** | | | |
| 3.1 | System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October.<br><br>*This should take into account predicted peaks in demand, including impact of significant events on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*. | ☐ | | EHSCP will map annual leave arrangements for all teams to ensure there is adequate cover in place. There will be clearly defined points of contact across the system for the duration of the festive period; providing assurance there is adequate leadership in place for the purpose of immediate decision-making, responding to any unexpected situations that may arise as well as programmed activity. |
| 3.2 | Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services. | ☐ | | As above |
| 3.3 | Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc.<br><br>*NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations* | ☐ | | EHSCP now has a tactical resilience plan and an Incident Management Team. The resilience plan includes collaborative links with Police Scotland, for example during severe weather.<br><br>Festive service planning in place with EVOC Open House health and well-being programme, and VOCAL support for unpaid carers. Contingency plans will be in place should there be a further lockdown period. |

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| 3.4 | Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered.<br><br>*Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.* | ☐ | | This is communicated via NHS Lothian Primary Care Contracts Office (PCCO) at Waverley Gate. PCCO communicate community pharmacy hours of service to relevant parties, including updating NHS Inform. |
| | **Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of healthcare associated infection and crowded Emergency Departments.**<br><br>**Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.** | | | |
| | To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate.<br><br>Referrals to the flow centre will come from:<br>• NHS 24<br>• GPs and Primary and community care<br>• SAS<br>• A range of other community healthcare professionals.<br><br>If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide visable appointments / timeslots at A&E services.<br><br>The impact on health-inequalties and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments. | ☐ | | Not applicable – NHS Lothian to complete (under the Redesign of Urgent Care workstream) |

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| | Professional to professional advice and onward referral services should be optimised where required<br><br>Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission. | ☐ | | Work is ongoing as part of the Redesign of Urgent Care Phase 2 workstream to redirect appropriate community pathways through the Flow Centre, including, for EHSCP, for CRT, MSK, and the Prevention Team. This work is also looking at the existing COPD SAS pathway and how to better utilise this |
| **4** | **Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge to shift the discharge curve to the left and ensure same rates of discharge over the weekend and public holiday as weekday.** | | | |
| 4.1 | Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process.<br><br>*Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.*<br><br>*Utilise Criteria Led Discharge wherever possible.*<br>*Supporting all discharges to be achieved within 72 hours of patient being ready.*<br><br>*Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.* | ☐ | | Proactive MATT meetings daily to support hospital flow and onsite presence of Home First navigators on acute sites<br><br>Home First Flow Navigators in the WGH site to support early pull working with front door and with wards<br><br>Home First Navigators working with discharge hub in WGH to manage people on acute medical wards.<br><br>Discharge to Assess to create an alternative pathway to admission<br><br>Home First Prevention Care to support people up to 72 hours in crisis as an alternative to admission. |
| 4.2 | To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, | ☐ | | The MDTs will be focussed on 7 day discharges and that all discharges take place as early in |

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| | and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate.<br><br>*Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.* | | | the day as possible. As long as the discharge takes place in day time hours then the bed can be utilised on the same day. Many of the patients being discharged require SAS transport so morning discharges cannot always be guaranteed. Discharges can take place over the weekend if planned in advance to allow for discharge medications to be prepared (no on site pharmacy staff or medical staff at Liberton at the weekend) but this is dependent on ongoing care arrangements being in place if required. |
| 4.3 | Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon.<br><br>*Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.*<br><br>*Extended opening hours during festive period over public Holiday and weekend* | ☐ | | Not applicable – NHS Lothian to complete |
| 4.4 | Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre-Christmas discharge<br><br>*There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes* | ☐ | | The NHS Lothian Community Pharmacy Core Group review demand and adjust Community Pharmacy opening hours accordingly. Pharmacists and Technicians are deployed across GP Practices to support pharmacotherapy services, medicines reconciliation at discharge and acute prescription requests. |

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| **5** | **Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.** | | | |
| 5.1 | Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels.<br><br>*This will be particularly important over the festive holiday periods.*<br><br>*Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.*<br>*Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.*<br>*Assessment capacity should be available to support a discharge to assess model across 7 days.* | ☐ | | EHSCP will work with third and independent organisations to ensure that they can maintain workloads over the festive period to ensure whole system flow along with pulling patients from Reablement to create capacity post Christmas when the demand will surge. |
| 5.2 | Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible.<br><br>*Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*<br><br>*All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible* | ☐ | | Therapy capacity has been increased to support Discharge to Assess. This will provide additional rehabilitation, supporting better outcomes in a shorter duration. In addition, further Community Care Assistant posts have been funded, increasing capacity within the service and generating an additional ten discharges, taking that up to a total of 60 per week.<br><br>Additional AHP resource has been secured for winter for the Home First teams based in the RIE and WGH, as well as increased social work capacity in the locality hubs<br><br>Home First Prevention Care will support people at home as |

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| | | | | an alternative to hospital for up to 72 hours.<br><br>Reablement will run over the festive period and will prepare for surge actions for the post Festive Surge.<br><br>Patients will be considered for all pathways, discharge to assess, reablement, hospital at home as alternative to a lengthy admission and to prevent a delayed discharge We will work with our independent providers to move as many cases onto to create capacity in the reablement team so that we can respond to the winter surge. |
| 5.3 | Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge.<br><br>*Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.* | ☐ | | The Long Term Conditions (LTC) Programme have collaborated with Effective Communication for Health, third sector organisations and H&SCP staff to support ACP conversations and models for sharing information across the integrated system.<br><br>Covid-19 ACP guidance and resources have been developed for healthcare professionals, GP practice teams and care homes.<br>• *ACPs in Care Homes 7 Steps to ACP*<br>• COVID-19: Effective communication for professionals (RED-MAP resources)<br>• *ACP and Coronavirus: for GP practices (Update)* |

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| | | | | A suite of ACP resources have been developed to support health teams working in the community to create Covid19 ACP/KIS *ACP Community Bundle* A working group has been set up to establish a community bundle for social care teams.<br><br>People with COPD who are at high risk of hospital admission/ readmission are proactively identified and reviewed within a multi-disciplinary team – KIS request created and shared with their GP. Jan 2019 COPD KIS Audit carried out-763 people with COPD, known to CRT audited. 304 who did not have a KIS - requested strapline in KIS special notes to share across the system – that first point of contact is community respiratory team. |
| 5.4 | All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances.<br><br>*KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.* | ☐ | | There are 141,985 Key Information Summaries (KIS) in place for high risk individuals in Edinburgh, an increase of 200% compared to March 2019.<br><br>260 third sector and health and social care staff have been trained to improve ACP during this period.<br><br>Long Term Conditions Programme are currently supporting VOCAL, Edinburgh Carer Support Team, |

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| | | | | Genetics, Homecare, Medicine of Elderly, district nursing teams and the Flow Centre to improve ACP pathways. This includes adopting a 'Think Ahead' approach, identifying high risk individuals that would benefit from an ACP/KIS, resulting in increased quality, quantity and access to ACPs via KIS. 400 KEY magnets and wallet cards were issued to people who are at risk of hospital admission to prompt emergency services that they have a KIS. Emergency cards were issued to patients and carers by the carer support team to alert that a KIS is in place. |
| 5.5 | Covid-19 Regional Hubs fully operational by end November. Additional lab capacity in place through partner nodes and commercial partners by November. Turnaround times for processing tests results within 24/48 hours. | | | Not applicable – NHS Lothian to complete |
| **6.0** | **Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.** | | | |
| 6.1 | Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector and into the Scottish Government.<br><br>*Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.*<br><br>*Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.* | ☐ | | EHSCP Communications Plan is being developed and will include this |

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| 6.2 | Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent.<br><br>*SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around direction to the appropriate service are effectively communicated to the public.*<br><br>*The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.*<br><br>*The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.*<br><br>*Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns* | ☐ | | This will be included within EHSCP's Communications Plan.<br><br>NHS Lothian will lead on external communications for messaging to avoid hospital admissions and reduce impact on acute sites.<br><br>Partnership communications will focus primarily on the workforce, which supports the most vulnerable service users, to promote targeted preventative messages (e.g. care at home workers, care homes, long term conditions etc).<br>Both partner organisations will be heavily involved in resilience communications. |

| **3** | **Out of Hours Preparedness**<br>*(Assessment of overall winter preparations and further actions required)* | | **RAG** | **Further Action/Comments** |
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| 1 | The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays.<br><br>*This should include an agreed escalation process.*<br><br>*Have you considered local processes with NHS 24 on providing pre-prioritised calls during OOH periods?* | ☐ | | Not applicable – NHS Lothian to complete |
| 2 | The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period. | ☐ | | Not applicable – NHS Lothian to complete |
| 3 | There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed. | ☐ | | Additional capacity has been put in place provide 7-day working in areas of key demand |

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| | | | | Operational managers will ensure that there is sufficient capacity to provide front-line services over the festive period. |
| 4 | There is reference to direct referrals between services.<br><br>*For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?* | ☐ | | Not applicable. Edinburgh HSCP has no OOH other than the emergency social work. Other services will link with LUCS. |
| 5 | The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records. | ☐ | | Processes are in place to enable safe information governance and referral |
| 6 | There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa | ☐ | | Pharmacists have established professional to professional lines in place and LUCS has access to the Community Pharmacy Palliative Care Network of pharmacies providing an emergency call out service. NHS24 algorithms updated to include details of the community pharmacy first service, treating UTI and impetigo infections. |
| 7 | In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period. | ☐ | | Emergency mental health assessment is provided 24/7 via MHAS at REH. Referral is via phone call; and includes self-referral.<br><br>Intensive Homecare Treatment Team can provide intensive crisis service into people's homes following an MHAS referral. The crisis centre is a Third sector commissioned service that is operational 52 weeks of the year and provides people with advice and support, it also has the capacity for people to stay over in the building. |

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| | | | | This service is accessed by people in distress, services can refer but it is a not clinical area and people need to be self-determined |
| 8 | Ensure there is reference to provision of dental services, that services are in place either via general dental practices or out of hours centres<br><br>*This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.* | ☐ | | PCCO lead on this for HSCPs |
| 9 | The plan displays a confidence that staff will be available to work the planned rotas.<br><br>*While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.* | ☐ | | Currently in process of booking festive shifts. Work underway with LUCs to determine medical staffing |
| 10 | There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24.<br><br>*This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.* | ☐ | | Not applicable – NHS Lothian to complete |
| 11 | There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services. | ☐ | | Discharge to Assess team hours of operation will be expanded to cver 7-day working, facilitating weekend discharges<br><br>Home First navigator posts have been established within the RIE and WGH (2) who work closely with the In-Reach Nurses (4) in a Home First Team. This winter the teams will be enhanced by 6 staff who will work closely with the Discharge Hubs, the Locality Hubs and Ward Based staff, |

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| | | | | supporting weekend discharges. Social work capacity will be enhanced by 8WTE (4 social workers per locality). This will support winter surge, enable social worker to link with patients, their families and clinical staff to carry out an assessment earlier in the hospital pathway to facilitate discharge or in the community to avoid admission. The social workers would ensure that there are still discharges over weekends and provide cover over the public holiday period<br><br>Hospital at Home team is collaborating with SAS and acute services to develop a pathway for the frail elderly, enabling assessment to be carried out closer to home. This will help avoid admissions in a group that may have a poor experience within acute settings associated with their underlying frailty, dementia and co-morbidity, in addition to risk of infection, deconditioning, loss of independence and high mortality |
| 12 | There is evidence of joint working between the Board and NHS 24 in preparing this plan.<br><br>*This should confirm agreement about the call demand analysis being used.* | ☐ | | Not applicable – NHS Lothian to complete |

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| 13 | There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan.<br><br>*This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.* | ☐ | | Not applicable – NHS Lothian to complete |
| 14 | There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan.<br><br>*This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.* | ☐ | | The Winter Planning Group includes multi-agency and pan-system representation, including membership from acute sites, Social Care Direct, and includes leads for flu, carers, third sector, resilience, and communications. The group leads on the planning, monitoring and evaluation of the Winter plans. Members of the group have all contributed to preparing the plan and this checklist. |
| 15 | There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic flu and other emergency plans, including provision for an escalation plan.<br><br>*The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.* | ☐ | | EHSCP recently undertook an exercise to update Resilience Plans for all NHS services managed by the Partnership. These are being submitted to NHS Lothian by 31 October 2020, and will be available on EHSCP Shared Drives, and the NHS Lothian Civil Contingencies Shared Drive in the event of an incident during winter |

| **4** | **Prepare for & Implement Norovirus Outbreak Control Measures**<br>*(Assessment of overall winter preparations and further actions required)* | | **RAG** | **Further Action/Comments** |
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| 1 | NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings<br><br>*This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.* | ☐ | | All EHSCP staff have access to appropriate guidance depending on care setting and report cases via local reporting systems e.g. huddles, Care Inspectorate reporting.<br><br>Norovirus to be added to daily care home SitRep reporting. |
| 2 | Infection Prevention and Control Teams (IPCTs) will be supported in the execution of a Norovirus Preparedness Plan before the season starts.<br><br>*Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which nursing and care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in these settings.* | ☐ | | Not applicable – NHS Lothian to complete |
| 3 | PHS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards and that frontline staff are aware of their responsibilities with regards prevention of infection. | ☐ | | In hospital settings staff are required to access most up-to-date information on line with the exception of daily outbreak records which are kept as paper copies through the course of the outbreak.<br><br>In other settings paper copies may be held locally for ease of access. |
| 4 | NHS Board communications regarding bed pressures, ward closures, etc are optimal and everyone will be kept up to date in real time.<br><br>*Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.* | ☐ | | Local SitRep reporting is in place detailing capacity and any pressures.<br><br>Staff also have access to NHS Lothian Infection Control SitRep which is circulated at least twice a day or more frequently if necessary. This advises on ward closures. |

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| 5 | Debriefs will be provided following individual outbreaks or at the end of season to ensure system modifications to reduce the risk of future outbreaks.<br><br>*Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.* | ☐ | | Outbreak management systems in place for all settings – Problem Assessment Groups (PAG), Incident Management Teams (IMT). These are led by the Infection, Prevention and Control Team. |
| 6 | IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker. | ☐ | | This information is available and shared as appropriate |
| 7 | Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge. | ☐ | | Not applicable – NHS Lothian to complete |
| 8 | NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period.<br>*While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.* | ☐ | | Not applicable – NHS Lothian to complete |
| 9 | The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple bays / wards over a couple of days.<br><br>*As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.* | ☐ | | Surge capacity planning is incorporated in EHSCP resilience plans |
| 10 | There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.<br><br>*HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.* | ☐ | | Not applicable – NHS Lothian to complete |

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| 11 | The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus. | ☐ | | Materials are available on NHS Lothian intranet and CEC Orb for staff to access.<br><br>Any communications are cascaded through the operational and professional lines to front line staff. |
| 12 | Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of Covid-19. | ☐ | | Not applicable – NHS Lothian to complete |

| **5** | **Covid-19, Seasonal Flu, Staff Protection & Outbreak Resourcing**<br>*(Assessment of overall winter preparations and further actions required)* | | **RAG** | **Further Action/Comments** |
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| 1 | Staff, particularly those working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients and other staff, as recommended in the CMO's seasonal flu vaccination letter published on 07 Aug 20 https://www.sehd.scot.nhs.uk/cmo/CMO(2020)19.pdf<br><br>*This will be evidenced through end of season vaccine uptake submitted to PHS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.* | ☐ | | It has been recommended that all health and social care staff are vaccinated and this has been offered via peer vaccination within wards / departments and booked appointments. |
| 2 | All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible.<br><br>*It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal* | ☐ | | There are a range of drive-through and walk-in clinics being held on sites across the city, working seven-days a week for a period of eight weeks. NHS and Social Care staff are able to attend the drive-through and walk-in clinics but are not limited to a particular date or time, providing |

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| | *flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.*<br>*Vaccine uptake will be monitored weekly by performance & delivery division.* | | | flexibility around work commitments<br><br>There are also a number of peer vaccinators (nursing staff) who are able to administer the vaccination to any staff, regardless of whether they are employed by the NHS or CEC, within their teams |
| 3 | Workforce in place to deliver expanded programme and cope with higher demand, including staff to deliver vaccines, and resource phone lines and booking appointment systems. | | | The Partnership has sufficient vaccinators in place who have received appropriate training. |
| 4 | Delivery model(s) in place which:<br><br>• Has capacity and capability to deal with increased demand for the seasonal flu vaccine generated by the expansion of eligibility as well as public awareness being increased around infectious disease as a result of the Covid-19 pandemic.<br>• Is Covid-safe, preventing the spread of Covid-19 as far as possible with social distancing and hygiene measures.<br>• Have been assessed in terms of equality and accessibility impacts<br><br>*There should be a detailed communications plan for engaging with patients, both in terms of call and recall and communicating if there are any changes to the delivery plan.* | | | The programme for winter 2020/21 is being delivered in a variety of ways depending on the nature and needs of the group being targeted and it is expected that approximately 90% of vaccinations will be carried out by the Partnership:<br>o There are a range of drive-through and walk-in clinics being held on sites across the city, working seven-days a week for a period of eight weeks<br>o People in Edinburgh who are eligible for vaccination are being contacted by letter and/or text message to advise them of the benefits and that they can find out about arrangements in their area by calling NHS Inform, on the NHS Inform website, or by calling their local practice<br>o General practices in Edinburgh have been allocated dates when registered patients who fall into the categories eligible for |

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| | | | | vaccination may attend. To limit queues and facilitate social distancing there are hour-long slots across the day with patients attending in groups by surname. In addition, there will be opportunistic testing carried out for any patients attending the practice in person<br>o In addition to the above, pregnant women may also receive their vaccination through maternity services and unpaid carers are being encouraged to contact their local practice to ensure they receive their vaccinations<br>o Vaccinations for the housebound and care home residents are being carried out by the district nursing teams in the city<br>o Children of primary school age will be vaccinated through the community vaccination team, and those aged two to five years through the Children's Partnership although some who cannot have the nasal flu vaccination may need to attend their GP practice<br>o In addition, vaccinations are also available through pharmacies but clinics are the preferred route in most cases<br>o The vaccination programme is being supported by Volunteer Edinburgh. |

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| 5 | The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period.<br><br>*If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)* | ☐ | | Regular updates from NHS Lothian Public Health and Infection Prevention and Control Teams regarding outbreaks and availability of flu vaccines to enable us to target activity. |
| 6 | PHS weekly updates, showing the current epidemiological picture on Covid-19 and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity.<br><br>*PHS and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.* | ☐ | | Regular updates from NHS Lothian Public Health and Infection Prevention and Control Teams regarding outbreaks and availability of flu vaccines. |
| 7 | NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows:<br><br>• Adults aged over 65<br>• Those under 65 at risk<br>• Healthcare workers<br>• Unpaid and young carers<br>• Pregnant women (no additional risk factors)<br>• Pregnant women (additional risk factors)<br>• Children aged 2-5<br>• Primary School aged children<br>• Frontline social care workers<br>• 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household | ☐ | | Not applicable – NHS Lothian to complete |

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| | • Eligible shielding households<br><br>The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This will include regular reporting that will commence from the end of week commencing 12th October. We will adopt a the Public Health Scotland model, which is a pre-existing manual return mechanism that has been used in previous seasons with NHS Boards to collate Flu vaccine uptake data when vaccination is out with GP practices. | | | |
| 8 | Adequate resources are in place to manage potential outbreaks of Covid-19 and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods.<br><br>*NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.* | ☐ | | Resilience planning is in place to mitigate the risk of multiple events occurring simultaneously. This includes prioritisation to essential services only. |
| 9 | Tested appointment booking system in place which has capacity and capability to deal with increased demand generated by the expansion of eligibility and increased demand expected due to public awareness around infectious disease as a result of the Covid-19 pandemic. | | | Edinburgh HSCP has tested appointment systems with the Community Covid-19 Testing Centres and Drive Through Flu Vaccination Programme. Full evaluation still required. |
| 10 | NHS Boards must ensure that all staff have access to and are adhering to the national COVID-19 IPC and PPE guidance and have received up to date training in the use of appropriate PPE for the safe management of patients.<br><br>Aerosol Generating Procedures (AGPs)<br>In addition to this above, Boards must ensure that staff working in areas where Aerosol Generating Procedures (AGPs) are likely to be undertaken - such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) - are fully aware of all IPC policies and guidance relating to AGPs; are FFP3 fit-tested; are trained in the use of this PPE for the safe management of suspected Covid-19 and flu cases; and that this training is up-to- | ☐ | | All staff have access to PPE and training. This is monitored via safety huddles, Care Inspectorate, care home support teams, PQIs, IPCTs and informally by team leads, senior charge nurses, care home managers. |

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| | date.<br><br>***Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's 'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013). https://www.hse.gov.uk/pUbns/priced/hsg53.pdf*** | | | |
| 11 | NHS Boards must ensure that the additional IPC measures set out in the CNO letter on 29 June staff have been implemented. This includes but is not limited to:<br>• Adherence to the updated extended of use of face mask guidance issued on 18 September and available here.<br>• Testing during an incident or outbreak investigation at ward level when unexpected cases are identified (see point 9).<br>• Routine weekly testing of certain groups of healthcare workers in line with national healthcare worker testing guidance available here (see point 9).<br>• Testing on admission of patients aged 70 and over. Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster.<br>• Implementation of COVID-19 pathways (high, medium and low risk) in line with national IPC guidance.<br>• Additional cleaning of areas of high volume of patients or areas that are frequently touched.<br>• Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September.<br>• Consideration given to staff movement and rostering to minimise staff to staff transmission and staff to patient transmission.<br>• Management and testing of the built environment (e.g. water systems) that have had reduced activity or no activity since service reduction / lockdown – in line with extant guidance. | ☐ | | All requirements and measures are in place throughout the Partnership |

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| 12 | Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf<br><br>In addition to this, key healthcare workers in the following specialities should be tested on a weekly basis: oncology and haemato-oncology in wards and day patient areas including radiotherapy; staff in wards caring for people over 65 years of age where the length of stay for the area is over three months; and wards within mental health services where the anticipated length of stay is also over three months.<br><br>*Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-covid-19-healthcare-worker-testing/* | ☐ | | This is discussed as part of the Problem Assessment Group (PAG) / Incident Management Team (IMT) processes and implemented accordingly.<br><br>Testing is in place in all identified areas within EHSCP. |
| 13 | The PHS COVID-19 checklist must be used in the event of a COVID-19 incident or outbreak in a healthcare setting. The checklist is available here: https://www.hps.scot.nhs.uk/web-resources-container/covid-19-outbreak-checklist/<br><br>The checklist can be used within a COVID ward or when there is an individual case or multiple cases in non-COVID wards. | ☐ | | IPCT lead the use of this checklist and feed into PAGs |
| 14 | Ensure continued support for routine weekly Care home staff testing<br><br>This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results. | ☐ | | Weekly testing remains in place via Lighthouse Lab for Edinburgh care homes.<br><br>There are currently tests underway in East Lothian and Midlothian to transfer to NHS Labs. This has a requirement for significant admin resource but the intention is to roll out within Edinburgh care homes too. |

| **6** | **Respiratory Pathway**<br>*(Assessment of overall winter preparations and further actions required)* | | **RAG** | **Further Action/Comments** |
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| **1** | **There is an effective, co-ordinated respiratory service provided by the NHS board.** | | | |
| 1.1 | Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area. | ☐ | | Multi-disciplinary Community Respiratory Hub is well established in Edinburgh. Annually, GPs, Out of Hours, SAS receive winter reminder of service available supplemented by mouse mats and dashboard stickers to prompt clinicians to access this highly effective community service. Fortnightly MDT meetings held in two hospital sites to discuss patients at risk and strengthen links between hospital units and community services.<br>Between April 2019– March 2020 704 people who were at immediate high risk of hospital admission were assessed by the Community Respiratory Team within the hub. 90%of these people were able to be safely kept at home |
| 1.2 | Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate. | ☐ | | Multi-disciplinary Community Respiratory Hub operates 7 day week, 8am-6pm weekdays and 9am-4pm weekends with acute response to COPD exacerbations. 90min response pathway in place for COPD exacerbations referred from Scottish Ambulance Service and Flow Centre. Prof to Prof support line set up with Respiratory Consultant for Community Respiratory Hub to escalate decision making if necessary and/or fast track to hot clinic during winter period. |

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| | | | | The community Respiratory Hub will increase staffing capacity to support a larger group of patients to include those with acute respiratory illness over the winter period, including at the weekend. Enhanced staffing is also planned for over the festive weekend periods to support respiratory care in the community. |
| 1.3 | Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times.<br><br>*Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..*<br><br>*Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.*<br><br>*Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).* | ☐ | | Individuals at high risk of admission identified via COPD frequent attender database. High risk patients reviewed at consultant led multi-disciplinary team meeting (two hospital sites) using care bundle checklist.<br><br>ACP/KIS generated for high risk patients shared across the health system via TRAK alert and ACP created using KIS. Special notes of KIS created to alert all staff across the health system to contact Community Respiratory Team for COPD exacerbation.<br><br>Patients issued with self management ACP and 'Think COPD Think CRT' fridge magnet to prompt them to<br><br>**'MyCOPD'** is an app to support people living with Chronic Obstructive Pulmonary Disease (COPD) to remotely self-manage their condition. 20 patients are being supported by our |

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| | | | | pulmonary rehab team to manage their condition using this app. |

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| 1.4 | Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients.<br><br>*Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.* | ☐ | | Key messages are sent to all patients with COPD known to CRT including fridge magnet of CRT contact details as first point of contact should the patient feel unwell with their COPD. Simple advice given by all HCPs to keep warm and hydrated over the winter period |
| **2** | **There is effective discharge planning in place for people with chronic respiratory disease including COPD** | | | |
| 2.1 | Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation.<br><br>*Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).* | ☐ | | Community respiratory Hub will support the discharge plan by ensuring a holistic assessment and management plan is put in place, This may include medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation.<br><br>High risk individuals identified proactively using Frequent Attender database. Care bundle checklist in place to prompt for support required for stop smoking, pharmacy review (including inhaler technique), psychology support. Dedicated third sector COPD co-ordinator in post to support house bound patients and provide support on wider issues such as housing, financial support, keeping warm, disability information. |

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| 2.2 | All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team. | ☐ | | Dedicated pharmacist within community respiratory hub. Medication review will be carried out at initial assessment by the Community Respiratory Hub. Access to specialist pharmacy review available if required |
| **3** | **People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.** | | | |
| 3.1 | Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease.<br><br>*Spread the use of ACPs and share with Out of Hours services.*<br><br>*Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.*<br><br>*SPARRA Online: Monthly release of SPARRA data,*<br><br>*Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.* | ☐ | | Individuals with COPD at high risk of admission are proactively identified via COPD frequent attender database which is refreshed every 6-8 weeks. KIS accessible by primary & secondary care, LUCS and SAS out of hours. TRAK alert as prompt for prompt to acute services COPD KIS in place.<br><br>COPD patients issued with ACP self management plan and 'Think COPD Think CRT' fridge magnet to prompt contacting CRT in event of exacerbation as alternative to emergency services. 750 of patients actively managing their condition using LiteTouch telehealth – with dedicated CRT support line should their condition deteriorate. |

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| **4** | **There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board** | | | |
| 4.1 | Staff are aware of the procedures for obtaining/organising home oxygen services.<br><br>Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860)<br><br>Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period.<br><br>Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated.<br><br>*Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.* | ☐<br><br>☐<br><br>☐<br><br>☐ | | Patients with COPD should aim to have oxygen saturations on air of 88% or above at rest if doesn't have LTOT at home.<br><br>If a patient is acutely unwell with lower oxygen saturations they should be referred to hospital for treatment which may include acute oxygen therapy<br><br>If a patient is stable and oxygen saturations on air are 88% or below then they should be referred for an LTOT assessment at the respiratory outpatient clinic. There is no evidence for only ambulatory oxygen for patients with COPD.<br><br>Once a patient receives LTOT they will be given the appropriate system for their requirements. |
| **5** | **People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.** | | | |
| 5.1 | Emergency care contact points have access to pulse oximetry.<br>*Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.* | ☐ | | Currently 750 CRT patients on Lite Touch/ Self Referral have a pulse oximeter at home. There is capacity for this to increase and pulse oximeters are available**.** |

| 7 | Key Roles / Services | | RAG | Further Action/Comments |
|---|---|---|---|---|
| | Heads of Service | ☐ | | |
| | Nursing / Medical Consultants | ☐ | | |
| | Consultants in Dental Public Health | ☐ | | Not applicable, done through PCCO |
| | AHP Leads | ☐ | | |
| | Infection Control Managers | ☐ | | |
| | Managers Responsible for Capacity & Flow | ☐ | | |
| | Pharmacy Leads | ☐ | | |
| | Mental Health Leads | ☐ | | |
| | Business Continuity / Resilience Leads, Emergency Planning Managers | ☐ | | |
| | OOH Service Managers | ☐ | | |
| | GP's | ☐ | | |
| | NHS 24 | ☐ | | |
| | SAS | ☐ | | |
| | Other Territorial NHS Boards, eg mutual aid | ☐ | | Not applicable |
| | Independent Sector | ☐ | | |
| | Local Authorities, inc LRPs & RRPs | ☐ | | |
| | Integration Joint Boards | ☐ | | |
| | Strategic Co-ordination Group | ☐ | | Through Chief Officer |
| | Third Sector | ☐ | | |
| | SG Health & Social Care Directorate | ☐ | | Through Chief Officer |

**ANNEX B**

## Covid Surge Bed Capacity Template

| | | Baseline ICU Capacity | Double Capacity and Commitment to deliver in one week | 'Triple plus' Capacity Commitment to deliver in two weeks | ICU Max Surge Beds | Y - Correct / N Incorrect with comment | Please list assumptions & consequences to other service provision to meeting these requirements |
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| PART A: ICU | Please confirm that your NHS Board can deliver the stated level of ICU Capacity in the time periods set out | 29 | 54 | 92 | 113 | | |

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| PART B: CPAP | Please set out the maximum number of COVID patients (at any one time) that could be provided CPAP in your NHS Board, should it be required | | |
| PART C: Acute | Please set out the maximum number of acute beds that your NHS Board would re-provision for COVID patients (share of 3,000 nationally), should it be required | | |

**ANNEX C**

**Infection Prevention and Control COVID-19 Outbreak Checklist**

**(Refer to the National Infection Prevention and Control Manual (NIPCM) for further information http://www.nipcm.hps.scot.nhs.uk/ )**

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| **This COVID-19 tool is designed for the control of incidents and outbreak in healthcare settings.**<br><br>**Definitions: 2 or more confirmed or suspected cases of COVID within the same area within 14 days where cross transmission has been identified.**<br>**Confirmed case: anyone testing positive for COVID**<br>**Suspected case: anyone experiencing symptoms indicative of COVID (not yet confirmed by virology)**<br><br>**This tool can be used within a COVID ward or when there is an individual case or multiple cases.** | | | | | |
| **Standard Infection Control Precautions;**<br>**Apply to all staff, in all care settings, at all times, for all patients when blood, body fluids or recognised/unrecognised source of infection are present.** | | | | | |
| **Patient Placement/Assessment of risk/Cohort area**<br>**Date** | | | | | |
| Patient placement is prioritised in a suitable area pending investigation such as for a single case i.e. single room with clinical wash hand basin and en-suite facilities | | | | | |
| Cohort areas are established for multiple cases of **confirmed** COVID (if single rooms are unavailable). Suspected cases should be cohorted separately until confirmed. Patients should be separated by at least 2 metres if cohorted. | | | | | |
| Doors to isolation/cohort rooms/areas are closed and signage is clear (undertake a patient safety risk assessment for door closure). | | | | | |
| If failure to isolate, inform IPCT. **Ensure all patient placement decisions and assessment of infection risk (including isolation requirements) is clearly documented in the patient notes and reviewed throughout patient stay.** | | | | | |
| Patient placement is reviewed as the care pathway changes. NB: Patients may be moved into suspected or confirmed COVID-19 cohorts or wards to support bed management. | | | | | |
| **Personal Protective Clothing (PPE)** | | | | | |
| Droplet precautions: Staff providing direct care must wear disposable aprons, gloves, FRSM and eye/face protection, when in the patients' immediate care environment. If in a cohort staff should wear a FRSM when not providing direct care.<br><br>Airborne precautions: High risk area or performing AGPs: use a FFP respirator and consider the need for a gown/coverall. | | | | | |

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| **Safe Management of Care Equipment** | | | | | |
| Single-use items are in use where possible. | | | | | |
| Dedicated reusable non-invasive care equipment is in use and decontaminated between uses. Where it cannot be dedicated ensure equipment is decontaminated following removal from the COVID-19 room/cohort area and prior to use on another patient. | | | | | |
| **Safe Management of the Care Environment** | | | | | |
| All areas are free from non-essential items and equipment. | | | | | |
| **At least twice daily** decontamination of the patient isolation room/cohort rooms/areas is in place using a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl.). | | | | | |
| **Increased frequency** of decontamination (at least twice daily)is incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g. “frequently touched" surfaces such as door/toilet handles and locker tops, over bed tables and bed rails. | | | | | |
| **Terminal decontamination** is undertaken following patient transfer, discharge, or once the patient is no longer considered infectious. | | | | | |
| **Hand Hygiene** | | | | | |
| Staff undertake hand hygiene as per WHO 5 moments: using either ABHR or soap and water | | | | | |
| **Movement Restrictions/Transfer/Discharge** | | | | | |
| Patients with suspected/confirmed COVID should not be moved to other wards or departments unless this is for essential care such as escalation to critical care or essential investigations.<br>Discharge home/care facility:<br>Follow the latest advice in COVID-19 - guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings. | | | | | |
| **Respiratory Hygiene** | | | | | |
| **Patients are supported with hand hygiene and provided with disposable tissues and a waste bag** | | | | | |
| **Information and Treatment** | | | | | |
| Patient/Carer informed of all screening/investigation result(s). | | | | | |
| Patient Information Leaflet if available or advice provided? | | | | | |
| Education given at ward level by a member of the IPCT on the IPC COVID guidance? | | | | | |
| Staff are provided with information on testing if required | | | | | |

# Health & Social Care: Preparation for Winter Response

| NHS Lothian | Please note Site / HSCP / Service - EDINBURGH HSCP |
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**Introduction**

To continue to improve winter planning across Health & Social Care we are asking partners across the Health and Social care systems to describe their winter responses to the upcoming 2020/21 through the Unscheduled Care Committee. The Winter period for 2020/21 is from December 2020 until March 2021 with funding allocated for these four months.

We expect this year's your return to include:

- How your plan builds upon the joint working between system partners (e.g. Acute and HSCP, SAS etc). How responses to delivering consistent 7 day services focus on a Home First approach
- How the site will work with partners to ensure there is adequate capacity across alternatives to admission
- How local teams will take a person centred approach to care delivery
- How local teams will deliver care across red, amber and green pathways in relation to COVID-19

Returns will also be used to inform Scottish Government, updates to the Board, CMT as required.

Completed reviews should be sent to Louise Baillie by 19th October 2020.

| 1 | **Business Continuity** ***(response from all areas)*** |
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| **1.1** | **Describe the escalation plans in place across periods of peak demand** |
| | • EHSCP recently undertook an exercise to update Resilience Plans for all NHS services managed by the Partnership. These are being submitted to NHS Lothian by 31 October 2020, and will be available on EHSCP Shared Drives, and the NHS Lothian Civil Contingencies Shared Drive in the event of an incident during winter<br>• All general practices have updated Resilience Plans and are refreshing Buddy Plans in light of COVID-19 and for winter preparedness<br>• Video consultation through the NHS Near Me system is now more widely available in general practice and will ease pressure during the winter period<br>• Edinburgh Primary Care Support Team have a dedicated email where practices can report issues or seek advice<br>• NHS Lothian Primary Care Tactical group is still meeting with representatives from Edinburgh Primary Care Team in attendance. This allows for shared action planning for severe weather and problem solving winter pressure issues in Primary Care across Lothian<br>• There is no specific update as yet on availability of drug supplies in the event of a no-deal however NHS Lothian has senior pharmacy representation at a national level and is monitoring the situation<br>• EHSCP has a Severe Weather Plan, which is updated annually, and includes key principles such as escalation protocols, key contacts and transport sharing arrangements via a 'Transport Hub'.<br>• As part of the EHSCP Severe Weather Resilience Plan, the organisation will coordinate the provision of 4x4 vehicles across the localities which can 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 otherwise prevent travel to these homes.<br>• Annual leave arrangements for all managers and team leads across the four localities, hospital and hosted services, as well as the Executive Management Team will be mapped ahead of winter. There will be clearly defined points of contact across the system for the duration of the festive period; providing assurance there is adequate leadership in place for the purpose of immediate decision-making, responding to any unexpected situations that may arise as well as programmed activity.<br>• Should there be a significant surge in COVID, the central Command Centre model which was in place during lockdown, will be reinstated |

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| | • On-call arrangements introduced for EHSCP out of hours |

| 1.2 | How will these be tested prior to Winter? |
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| | • The Severe Weather Resilience Plan was initially developed following the "Beast from the East" weather system which occurred in February and March 2018, and took account of learning from that incident. It has then been updated year on year. It has not been tested again as there has not been a further incidence of severe weather.<br>• The Festive Staffing spreadsheet was used in both 2018/19 and 2019/20 and is an effective tool for cover arrangements and points of contact in each service. It therefore does not require to be tested prior to winter.<br>• The Command Centre was in operation during COVID and is therefore a well tested approach in Edinburgh<br>• Annual planning for leave over winter is well established. |
| **1.3** | **Key actions planned prior to Winter delivery** |
| | • The EHSCP Severe Weather Resilience Plan will be updated taking into account learning from the Partnership's response to COVID-19. These are still being collated and considered however it has become clear that there was a need for NHS and City of Edinburgh systems to dovetail more fully to ensure a response to any future joint operation is more streamlined.<br>o It is also important that all stakeholders understand how the plan works, both at their own local level, but also in terms of the bigger picture<br>o There should be good understanding of the need to prioritise key Partnership locations, including PPE distributions hubs, localities and care homes when planning for activities such as road clearance by ploughs<br>o We need to ensure that bad-weather activity is COVID-19 safe, and have already looked at how patient transport using the fleet is compliant both with general safety and COVID-specific requirements<br>o Out-of-hours contact processes should be set out in more detail, taking in account recent changes, and<br>o Consideration is being given to concurrent resilience events such as severe weather, seasonal flu and covid, understanding how they may potentially impact on service availability and ensure this is reflected in the planning process.<br>• Lessons learned from COVID-19 pandemic incident response are also being considered as we update our Incident Management Plan. COVID-19 Resilience Protocol considers the concurrent risk of winter weather planning and this will be tested in November through a Partnership table top exercise.<br>• In the run up to winter, EHSCP is also re-establishing its Resilience Planning Group<br>• The Chief Officer is leading a Partnership Planning event on 26/10/2020 to discuss this winter plan and our |

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| | preparedness for winter. Any further iterations of this plan will be informed by discussion at that event<br>• There may also be additional learning from the national Winter Preparedness (Winter Surge & Escalation Planning) event on 29 October 2020 which will inform this plan.<br>• Annual leave arrangements for all managers and team leads across the four localities, hospital and hosted services, as well as the Executive Management Team will be mapped ahead of winter. There will be clearly defined points of contact across the system for the duration of the festive period; providing assurance there is adequate leadership in place for the purpose of immediate decision-making, responding to any unexpected situations that may arise as well as programmed activity. |

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| **2** | **Joint Working across the directorates, sites and system *(response from all areas)*** |
| **2.1** | **Describe the specific plans in place to support joint working across the Site/HSCP to deliver care** |
| | • The Winter Planning Group includes multi-agency and pan-system representation, including membership from acute sites, Social Care Direct, and includes leads for flu, carers, third sector, resilience, and communications. The group meets monthly. Service leads are asked to provide monthly updates on activity, highlighting successes and lessons learned, and identifying potential risks or concerns. A rolling risk register will be maintained and shared at each meeting for discussion<br>• Concurrent risk planning of a No-Deal EU Exit (eg loss of key supplies or cost increase) and COVID-19 must be considered as part of Winter Weather planning. This work is underway through the EHSCP Resilience Team<br>• A Redesign of Urgent Care Pathways group has been convened, which meets weekly, to deliver the ambitions of the Phase 2 Redesign of Urgent Care programme, and is led by the Home First Strategic Lead<br>• We have established Home First Navigator posts at the RIE and WGH who work closely with the In-Reach Nurse within a Home First team, and will be working closely with the Discharge Hubs this winter<br>• Two additional reablement co-ordinators, based at home but working across the city and with a contact into both the RIE and WGH sites, will work on a rota to ensure seven-day discharge from admissions and planned discharges from wards<br>• Occupational and physiotherapists will be co-located at RIE and WGH to work with the Edinburgh Home First Team and support acute colleagues to consider home as the rehabilitation pathway. Having presence on site will allow |

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| | face-to-face conversations, and working with the patients and acute colleagues to build confidence in the community model. We anticipate that this will reduce the length of time a patient is in hospital to ensure flow through the winter period when there is increased demand<br>• We are enhancing the number of social workers for winter and this will enable them to link with patients, their families and clinical staff to carry out an assessment earlier in the hospital pathway to facilitate discharge or in the community to avoid admission. Working closely with clinical colleagues at an early stage, it will enable an earlier flow through to community services from acute settings and ensure management of additional demand during winter<br>• CRT+ will work closely with colleagues in secondary care to support the management of people with COPD or acute chest infection. CRT+ is also working with and through the Flow Centre to develop an improved Urgent Care Pathway with the Scottish Ambulance Service<br>• The winter prevention team will work closely with hospital front-door teams, the Flow Centre and Reablement Teams to provide an alternative to admission for people with non-acute care needs where care may have broken down or be required at short notice for a period of up to 72 hours<br>• The Partnership Hospital at Home team is collaborating with Scottish Ambulance Service and colleagues in Medicine of the Elderly to develop a pathway for the frail elderly, enabling assessment to be carried out closer to home. This will help avoid admissions in a group that may have a poor experience within acute settings associated with their underlying frailty, dementia and co-morbidity, in addition to risk of infection, deconditioning, loss of independence and high mortality<br>• We are linking in with partner organisations to ensure that there is support in place for unpaid carers and vulnerable members of our population through mental health and wellbeing, counselling, and activity programmes as detailed in item 12 below. |

| 2.2 | **How have you engaged with system wide partners to develop your Site/HSCP specific response to winter challenges?** |
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| | • Winter planning for 2020/21 has again evolved from the processes used in previous years, building on successes while incorporating key learning points, not only from the winter campaign but the Partnership response to the pandemic<br>• EHSCP was asked to develop a pre-prioritised list of no more than 3 bids for winter funding to submit to the Lothian Unscheduled Care Committee, in the first instance by 19 June 2020, prioritising them according to set criteria including:<br>1. Joint working<br>2. Home First approach<br>3. 7 day working / discharge<br>4. Admission Avoidance<br>5. Patient safety / person centred approach to care<br>6. Essential in the delivery of red and green pathways for COVID-19<br>• Following this, EHSCP was then asked to submit any other bids for winter funding, and a communication was sent to a targeted range of key internal stakeholders, including operational managers, locality managers, members of Winter Planning Group, the Carer Support Team, Strategic Planning Managers and the Chief Nurse to generate proposals<br>• As a result of this two-stage process, five out of the eight proposals submitted by the Partnership were successfully funded, which are detailed elsewhere in this plan<br>• Two further bids have been funded by EHSCP, using existing budgets, to support unpaid carers and third sector organisations during the winter period |
| **2.3** | **Key actions planned prior to Winter delivery?** |
| | • Services will consider their needs for additional equipment so that the ATEC24 Community Equipment Store can be adequately prepared, particularly if equipment will be needed by an individual at short notice<br>• EU Exit and COVID-19 planning particularly around the supply of PPE between NSS, NHS Lothian SMART Centre and CEC Clocktower<br>• CEC Transport arrangements and gritting route agreement consultation |

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| | • Services have been asked to gear up their recruitment to be ready for "go live" by 2 November 2020, rather than the usual start date at the beginning of December. The majority of services have confirmed that they will be in a position to do this. |

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| **3.0** | **a.) Safe & effective admission / discharge continues in the lead-up to and over the Winter period.** |
| | **b.) The risk of patients being delayed on their pathway is minimised. *(response from all areas)*** |
| **3.1** | **How will the service focus on a Home First approach to discharge and/or pull into the community** |
| | • The Home First model in Edinburgh has progressed over the last year and had significant impact improving our performance around delayed discharge. To ensure we have pathways in place to support this approach we have enhanced community-based resources through discharge to assess, winter prevention, additional social work capacity and hospital at home, among others. |
| | • The model of hospital flow had shifted because of our response to COVID-19 and whilst there has been a slight worsening of performance with regards to delays in July to September as community services remobilised, we aim to deliver a more closely managed and monitored Home First service commencing with the appointment of two, six-month posts to lead and develop the operational aspects of this to commence in November |
| | • Discharge to Assess has been rolled out over the last year within EHSCP to support increased ongoing rehabilitation in the person's own home as an alternative to bed-based rehabilitation which can result in a longer stay and the risk of hospital acquired infection. Discharge to Assess Edinburgh was introduced and funded through the Partnership to support the reduction in 52 beds across the acute sites. The Discharge to Assess Edinburgh teams are contributing to whole system flow and the Home First model, taking 40-50 new referrals a week as well as maintaining a caseload of patients requiring ongoing rehabilitation. As the majority of referrals to Home First come from hospital-based occupational therapists with a focus on functional recovery , four additional OT posts have been created to provide additional rehabilitation, supporting better outcomes in a shorter duration. In addition, a further four Community Care Assistant posts have been funded, increasing capacity within the service and generating an additional ten discharges, taking that up to a total of 60 per week. We anticipate that service demand will grow over the winter and additional resources are being put in place to manage this, further reducing length of stay and the risk of delayed discharge. In light of COVID-19 and physical distancing guidance there will be an increased pressure on beds for those who are acutely well with a reduced footprint which again increases the |

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| | need for getting people home as soon as possible and transferring their care to the community. |
| | • Accessing care services and restarting packages of care following a hospital admission remains a challenge to enable discharges to happen seven days a week. Appointment of two reablement co-ordinators over the winter will allow early assessment, care planning and scheduling to be completed seven days a week and facilitate discharge. |
| | • A high proportion of the people referred for bed-based rehabilitation are known to services in Edinburgh and the best outcome would be home directly with discharge to assess, district nursing, homecare, physio at home or many other options. We need to support acute therapists to think Home First particularly around their confidence in delivering ongoing rehabilitation and recovery in the person's own home as an alternative to bed- based care, and risk management. We will locate occupational and physiotherapists within the Home First team at RIE and WGH, working with acute therapy and medical colleagues to support early and safe discharge for those who need admission or attend the front-door. They will also appropriately identify people who may need intermediate care, bed-based rehabilitation. Therapists will be moved from current hubs and placed in the hospital setting, with posts in the community being backfilled. This will allow pull to the locality, and a link between the patient and the team they are moving onto after their acute phase. It is anticipated that this will reduce the length of time a patient is in hospital to ensure flow through the winter period when there is increased demand. |
| | • An additional eight FTE social worker posts have been created and are linked to the locality hubs. This will enable assessments to be carried out earlier in the hospital pathway to facilitate discharge, or in the community to avoid admission. The aim will be to ensure home is the first place that is considered for discharge and manage expectations around that. It will also allow early conversations with families to assist and influence their preparedness for the individuals discharge from hospital. We anticipate this model will reduce the number of people going from hospital to a care home, due to the early intervention and active engagement with person, their families and clinical staff. Working closely with clinical colleagues at an early stage, it will enable an earlier flow through to community services from acute settings and ensure management of additional demand during winter. The social workers would ensure that there are still discharges over weekends and provide cover over the public holiday period |

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| | • The Enhanced Community Respiratory Team (CRT+) has been successful in previous years in relieving pressure on primary care and acute services by accepting referrals for patients not only with COPD but with acute chest infections. This service will continue during winter 2020/21, reducing the demand on GPs by taking on a lead role in the management of this group, and aiming to prevent admission to hospital.<br>• The service is also aiming to create a pathway similar to Hospital at Home, which allows the Flow Centre to direct activity to CRT. The pathway initially would have capacity of one patient per day with a 60-90 min response rate and it is hoped that this will be in place mid/late November.<br>• CRT+ also supports patients being discharged from hospital if an admission is required. In addition, the service will be extended to deliver the post-COVID Recovery Advice Line (with Pulmonary Rehabilitation). This self-referral route for patients who have confirmed or suspected COVID in the community provides broad support for recovery and rehabilitation. Both CRT and Pulmonary Rehabilitation are key services within the Edinburgh Community Respiratory Hub, working closely together and linking to acute services to optimise patient-centred care. |
| **3.2** | **How has the site/system worked together to develop alternatives to admission?** |
| | • The national redesign of urgent care programme aims to improve access to urgent care pathways so people receive the right care, in the right place, at the right time. Phase 2 of this programme in Edinburgh will be implemented from November 2020 and focus on having sustainable urgent care pathways, improving patient and professional experience, reducing hospital admissions and providing care closer to home<br>• This work is being led by the Partnership Transformation Team and will look at:<br>o Defining and cataloguing the community pathways and referral criteria eg falls, frailty, respiratory, hospital at home teams with an agreed response time by HSCP<br>o Considering which alternatives should be scaled up over the winter period<br>o Defining the interface between NHS 24, HSCPs and Lothian Flow Centre, and<br>o Identifying and establishing a single point of access to HSCP, and<br>o Designing the urgent care pathway. |

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| | • Linking in with Phase 2 of the Urgent Care programme, the Hospital at Home team is collaborating with Scottish Ambulance Service and acute services to develop a pathway for the frail elderly, enabling assessment to be carried out closer to home. This will help avoid admissions in a group that may have a poor experience within acute settings associated with their underlying frailty, dementia and co-morbidity, in addition to risk of infection, deconditioning, loss of independence and high mortality. Specialist advice from the Medicine of the Elderly clinicians to the ambulance service with a realistic medicine approach will improve the patient experience with reduced need for ambulance conveyance and admissions. In addition the Hospital at Home team are providing education and training through MS Teams. The ambulance service triage will deal with calls appropriate for self-management or other more suitable pathways such as respiratory support. They will complete a clinical assessment, identify pre-existing problems and function and access the ECS and the KIS/ACP if completed. The ambulance service will discuss suitable patients with Hospital at Home. This is being tested from November in a defined postcode area in Edinburgh and can potentially be expanded further for winter if successful |
| | • The winter prevention team was established in 2019/20 and successfully focussed on providing care to prevent admissions for individuals with non- acute care needs where care may have broken down or be required at short notice for a period of up to 72 hours. Team capacity will be boosted for winter 2020/21 and focus on pushing the Home First model, enabling people to remain at home rather than being admitted and then face delays it a package of care cannot be found quickly. The team will link with colleagues across the system including:<br>o Reablement Teams across the city to transfer any requirement for continuing needs identified within the 72-hour period<br>o Flow Centre Navigator to identify appropriate referrals meeting service criteria<br>o Hospital front-door staff to offer an alternative to admission which will also allow flow into assessment areas pushing a recover model as an alternative to admission. |
| | • An intermediate care unit has been established at Milestone House, combining staff from primary and secondary care, social work and third sector partners to support people who have a blood-borne virus or are vulnerable, possibly due to homelessness or substance misuse issues, and facing a personal crisis point. Originally set up as a result of COVID-19 to serve the needs of homeless people with COVID being discharged from hospital, it now has a broader remit and been funded for a further six months so it can continue through the winter. A short-term residential stay with support and input from the multi-disciplinary, multi-agency team can help to avoid hospital |

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| | admission or re-admission in a group that can have complex care needs. |
| **3.3** | **Key actions planned prior to Winter delivery?** |
| | • Recruitment is underway to ensure that, where possible, staff are in place for the start of winter |

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| **4** | **Strategies for additional surge capacity across Health & Social Care Services *(response from all areas)*** |
| | • As part of the pre-winter planning this year we have not removed discretionary arrangements to support covid related capacity demands in acute. This includes prioritising available care at home capacity to support delayed discharges and unblocking our reablement teams to ensure flow through acute to the community. An enhanced rate is also being applied to any packages of care on the delayed discharge list<br>• We have been engaging a number of new care at home providers and have options available to us including increasing caps on service to providers joining us in the last six months, as well as a further three providers who can quickly be on boarded to create additional 300 hours capacity in the system<br>• A new tiered approach to working with providers has been introduced and our approach can flex to accommodate surge. For example, we can adjust the list so that financial approvals are not required<br>• A new service specification for support to the under 65s has been introduced – this ensures payment for hospital admissions where these are unplanned for at least seven days, and longer (at the discretion of the locality). This financial support to providers helps ensure that care is available upon discharge. Terms and conditions have also been changed so that no packages of care can be terminated without a managed transition to a new provider. This ensures that available capacity can be directed at any surge and meeting unmet need, rather than directed at re-provisioning existing care arrangements.<br>• A SLW uplift has been applied to all care at home providers, including a backdated payment. This supports their financial stability as organisations and encourages worker retention<br>• A block contract arrangement for 32 Safehaven beds at Northcare Suites/Northcare Manor have been extended for a further six months as part of contingency planning arrangements. However, care home capacity remains positive and there are over 309 vacancies available in the external market. There are over 500 when taking into account internal vacancies and those temporarily unavailable due to restrictions. Vacancies for social work funded placements also remains significantly high. Admissions to care homes have reduced by an average of about 20 a |

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| | month so any surge in demand will be managed within current capacity arrangements.<br>• The Partnership is currently, in conjunction with the Chief Nurse, exploring safe options to re-mobilise four beds for short notice admissions in advance of winter, the intention being to prevent breakdown of care arrangements and hospital admissions. |
| **4.1** | **How will surge capacity be made available in periods of peak demand across the site/system over the Winter period** |
| | • Potential to create surge capacity in EHSCP Hospitals:<br>o Liberton Hospital – could create additional capacity in ward 3 which is currently the designated 'red' area for COVID-19 should there be a need to isolate either positive patients or known contacts from within our existing bed numbers. Using the ward for standard surge capacity could impact on the ability to isolate 'red' patients. Workforce requirements would need to be taken into account to ensure safe care can be provided if the opening of any additional capacity is required.<br>o Astley Ainslie Hospital – could flex use of existing staffed beds and also create additional capacity in Mears ward which is the designated 'red' area on the site should there be a need to isolate either positive patients or known contacts from within our existing bed numbers. Workforce requirements would need to be taken into account to ensure safe care can be provided if the opening of additional capacity is required.<br>o HBCCC units – additional surge capacity cannot be created in these units but there is potential to flex use of the beds to meet demand<br>• In primary care, CTAC staff can be mobilised if required to do home visits, freeing up district nurse and GP capacity. This was used during lockdown and worked well<br>• Regular updates from NHS Lothian Public Health, and Infection Prevention and Control Teams regarding outbreaks and availability of flu vaccines will enable the Partnership to target activity in response to any surge in flu activity or local outbreaks.<br>• In the event of another lockdown situation as a result of increasing COVID-19, the Partnership would revert to a Command Centre set-up as operated earlier in the year. |

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| **4.2** | **How will elective bed capacity be protected for emergency/urgent activity over the Winter period? (Acute Sites only)** |
| | • Not applicable |
| **4.3** | **Key actions planned prior to Winter delivery?** |
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| **5** | **Whole system activity plans for winter: Redesign of Urgent Care pathway. *(System team only)*** |
| **5.1** | **How has the implementation of a minimum viable service for phase 1 of the Redesign of Urgent Care (RUC) been delivered** |
| | • Not applicable |
| **5.2** | **Describe the critical path for subsequent phases of the RUC** |
| | • Not applicable |
| **5.3** | **What are the patient/infrastructural risks to delivery of RUC over the winter period and how have these been mitigated?** |
| | • Not applicable |

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| **6** | **Effective analysis to plan for and monitor capacity, activity, pressures and performance over Winter *(response from all areas)*** |
| **6.1** | **What analysis has informed the site/service response to Winter 2020/21? (incl. COVID-19 pathways)** |
| | • There was a detailed evaluation of performance over winter 2019/20 and recommendations made are being built into planning service provision for 2020/21. This utilised data from a variety of sources including the Hospital Flow Dashboard, NHS Lothian, ISD as well as local service evaluations which were on-going throughout the winter period<br>• The local Review of COVID-19 focussed on many areas relevant to planning of winter services such as the Home First model and the recognition that community-based services are well placed to support the management of people in their homes, thus reducing delayed discharges. It has encouraged the Partnership to look at more innovative ways of providing care which will continue as we consider how best to support citizens over winter with the prospect of a potential second lockdown period. We are also engaging with partner organisations and building |

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| | on the support that their volunteers provided during lockdown earlier in the year<br>• Winter planning will link closely with Partnership general re-mobilisation plans to ensure that the two programmes of work are in tune and aligned. |

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| **7** | **Workforce capacity plans & rotas for winter / festive period agreed by October. *(response from all areas)*** |
| **7.1** | **How will higher levels of absence (potentially due to COVID-19, isolation etc.) be managed by the site/service during Winter to protect patient care?** |
| | • Annual leave arrangements for all managers and team leads across the four localities, hospital and hosted services, as well as the Executive Management Team will be mapped ahead of winter. There will be clearly defined points of contact across the system for the duration of the festive period; providing assurance there is adequate leadership in place for the purpose of immediate decision-making, responding to any unexpected situations that may arise as well as programmed activity.<br>• In the event of a second lockdown we would revert to the Command Centre approach used earlier in the year.<br>• The EHSCP COVID-19 workforce planning group set up at an early stage had 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. |
| **7.2** | **How has the site/service increased key workforce in areas of key demand? (front doors/back doors/community)** |
| | • A number of successful bids were submitted to increase workforce capacity in key areas to support the expected increase in demand over the winter period<br>• Recruitment has started earlier to ensure that, where possible, the required level of support is in place before the start of winter |

| 8 | **Discharges at weekends** ***(response from acute sites)*** |
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| **8.1** | **How well consistent levels of discharges be managed across weekends and during the festive period? (bank holidays)** |
| | • Clinical team decision making is mainly limited to Monday to Friday due to current staffing models but discharges from all EHSCP hospitals can take place at the weekend and over public holidays if any ongoing care requirements can commence or where appropriate families are asked to 'bridge' care until arrangements are in place.<br>• None of the EHSCP hospitals have on-site 24/7 medical models so admissions at weekends and public holidays need to be planned to ensure the transfer from acute services is clinically safe. Arrangements are in place to consider and accept weekend transfers into Intermediate Care and Astley Ainslie should this be required. |
| **8.2** | **Key actions planned prior to Winter delivery?** |
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| 9 | **Communication plans** ***(response from all areas)*** |
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| **9.1** | **How will site based communication be enhanced over periods of peak demand?** |
| | • Communications are managed within operational teams with key messages being cascaded through normal channels<br>• Communication plans and contacts are in place to alert staff, patients and service users of any disruption. |
| **9.2** | **How will system level communication be enhanced over periods of peak demand?** |
| | • As a Partnership, we will promote preventative or operational messages around seven key topics; winter resilience messages and arrangements, flu vaccination, falls prevention, hospital avoidance/signposting, anticipatory care planning, keeping safe and healthy over winter, and support and advice for carers<br>• We will target communications to some of our most vulnerable residents, who are among the largest users of health and social care resources, including vulnerable older people, people who receive a care at home service, people who receive technology enabled care and equipment from us , people with long-term health conditions and people who are at higher risk of falls<br>• The most effective route to such a wide audience is through the health and social care workers, and organisations that support them to live their daily lives. For that reason, we plan to communicate with our primary audiences |

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| | through general practice, social work, occupational and physical therapists, pharmacies, care at home agencies, care home staff and the partnership Telecare team<br>• In addition we will link with the Carer Support Team to ensure that carer organisations are kept informed and to support unpaid carers who often struggle at this time of year.<br>• We will keep the Partnership workforce informed through regular internal communications such newsletters from the Chief Operating Officer and a briefing to staff on winter arrangements, including the flu vaccination programme.<br>• The Partnership also supports NHS Lothian's region-wide winter campaign using EHSCP social media channels<br>• In the event a major incident being declared, the EHSCP Command Centre will have a Communications Officer to lead on staff wide communications |
| **9.3** | **Key actions planned prior to Winter delivery?** |
| | • Easy read briefings are being prepared for each service and these will be communicated to stakeholders across winter to ensure they are aware of local service provision and how to access it<br>• The communication plan for winter 2020/21 will be finalised and messaging will start after the school mid-term holiday week<br>• The Lead for Winter Planning in EHSCP is having weekly meetings with the Chief Officer and Head of Operations. This will be increased in frequency as required over the winter. |

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| **10** | **Delivering seasonal flu vaccination to public and staff and availability of Point of Care (POC) Testing.** ***(response from all areas)*** |
| **10.1** | **How will the flu vaccination programme be delivered to staff, patients and vulnerable citizens? (incl. Care Homes etc.)** |
| | • The programme for winter 2020/21 is being delivered in a variety of ways depending on the nature and needs of the group being targeted and it is expected that approximately 90% of vaccinations will be carried out by the Partnership:<br>o There are a range of drive-through and walk-in clinics being held on sites across the city, working seven-days |

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| | a week for a period of eight weeks<br>o People in Edinburgh who are eligible for vaccination are being contacted by letter and/or text message to advise them of the benefits and that they can find out about arrangements in their area by calling NHS Inform, on the NHS Inform website, or by calling their local practice<br>o General practices in Edinburgh have been allocated dates when registered patients who fall into the categories eligible for vaccination may attend. To limit queues and facilitate social distancing there are hour-long slots across the day with patients attending in groups by surname. In addition, there will be opportunistic testing carried out for any patients attending the practice in person<br>o In addition to the above, pregnant women may also receive their vaccination through maternity services and unpaid carers are being encouraged to contact their local practice to ensure they receive their vaccinations<br>o Vaccinations for the housebound and care home residents are being carried out by the district nursing teams in the city<br>o Children of primary school age will be vaccinated through the community vaccination team, and those aged two to five years through the Children's Partnership although some who cannot have the nasal flu vaccination may need to attend their GP practice<br>o NHS and Social Care staff are able to attend the drive-through and walk-in clinics but are not limited to a particular date or time, providing flexibility around work commitments<br>o There are also a number of peer vaccinators (nursing staff) who are able to administer the vaccination to any staff, regardless of whether they are employed by the NHS or CEC, within their teams<br>o In addition, vaccinations are also available through pharmacies but clinics are the preferred route in most cases<br>o There is a new cohort of individuals aged 50-54 who may also be eligible for vaccination depending on availability of vaccines and this will be reviewed in Phase 2 later in the year<br>o The vaccination programme is being supported by Volunteer Edinburgh. |
| **10.2** | **How will POC testing be implemented in Acute settings to ensure effective cohorting of patients?** |
| | • Not applicable |

| 10.3 | **Key actions planned prior to Winter delivery?** |
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| | • The influenza vaccination drive-through and walk-in clinics started operating on 26 September 2020 and to date approximately 30,000 people have attended<br>• The district nursing programme targeting the housebound and care homes is expected to have been completed by the end of November. |

| 11 | **Readiness to implement schemes from November 2020** ***(response from all areas)*** |
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| **11.1** | **Which schemes could start in November 2020 if possible? (No issues with recruitment etc anticipated)** |
| | • CRT+ will be in a position to start at the beginning on November. While recruitment won't be finalised by the beginning of November, existing staff can be utilised for CRT+ and the Advice Line to ensure the service is available to start<br>• Reablement co-ordinators will be in post by the start of November with a request for volunteers going out to the existing staff pool<br>• Home First physiotherapist recruitment is complete and one member of staff will be in post for November. There are negotiations underway for the secondment of the second post. Occupational therapist recruitment is underway.<br>• For the hub social worker enhancement, one will be in post by 1 November, and potentially two others at that time. Interviews are being held for other posts<br>• Applications for Discharge to Assess occupational therapist post close on 22 October and interviews will take place the following week |

| 12 | **Additional Detail** ***(response from all areas)**** *Include any additional arrangements in place to support patient care and delivery over the Winter period* |
|---|---|
| | • Funding has been made available for an Open House Partnership, involving a number of voluntary organisations focussing on mental health and well-being, and vulnerability due to COVID-19 and food poverty, with be co-ordinated to support vulnerable people, and those at risk of admission or re-admission during the festive months. The Partnership will support delivery of additional ring-fenced befriending, telephone befriending, and telephone |

| | |
|---|---|
| | medication prompts capacity to older people who are either engaged with Home First, Locality Hubs or other community-based, HSCP services and/or are being discharged from a hospital setting. It will offer a shared and co-ordinated service, delivered within the Locality Hubs and/or Innovation sites to ensure that those at additional risk of readmission due to lowered resilience or social isolation can be supported<br>o capacity at Caring in Craigmillar's Phonelink Service will allow patients to be discharged early where a package of care can be substituted for a telephone medication prompt, welfare calls and other support directly through community organisations - eg through the VG Food Fund in the event of a second COVID-19 wave/restrictions<br>o during the winter increased numbers of people raise concerns about their mental health, often facing crises which can result in hospitalisation. Additional capacity at The Stafford Centre will offer support that can help to reduce pressure on the Emergency Department by increasing confidence to manage at home and offering a direct alternative to hospitalisation.<br>• Funding has been made available to VOCAL to provide a service supporting approximately 100 unpaid carers in Edinburgh over the Christmas and New Year period. It will offer two, six- session emotional support groups; two learning and development events on how to manage the Christmas season; open office to allow carers to drop in and provide emotional support, recreational activities and a SMART meeting; four short breaks; craft sessions weekly for six weeks and two taught craft sessions including craft materials. The programme will include socially distanced support allowing carers who wish it, an opportunity to get a break outside their home, as well as online support for those who prefer to isolate. Should physical event become unfeasible or in the event of a lockdown situation, this provision will be moved online and contingency planning for this eventuality is being carried out at the moment. |

Chief Medical Officer Directorate

E: immunisationprogrammes@gov.scot

The Scottish Government

Dear Colleagues

## ADULT FLU IMMUNISATION PROGRAMME 2020/21

1. We are writing to provide you with information about the adult seasonal flu immunisation programme.

2. We would like to begin by thanking you for all the hard work you are doing as part of the health and social care response to the global Covid-19 pandemic. We know that this has been an extremely challenging time for staff across the health and social care sector.

3. Given the impact of Covid-19 on the most vulnerable in society, it is imperative that we do all that we can to reduce the impact of seasonal flu on those most at risk. It is therefore essential that we have effective plans in place to deliver the flu immunisation programme this winter to protect those at risk, prevent ill health in the population and minimise further impact on the NHS and social care services.

## Planning

4. We recognise that delivering the programme this year will be more challenging than ever before because of the impact of Covid-19 on our health and social care sector. We are working through the Scottish Immunisation Programme Group to develop guidance on vaccination service delivery to ensure that all who will benefit most from the flu vaccine will have the opportunity to receive it in a timely manner while maintaining good Infection Prevention & Control practices and appropriate physical distancing. The provision of appropriate Personal Protective Equipment (PPE) to those involved in the delivery of the flu vaccination programme will also form an important part of the programme planning. Please refer to the Covid-19 guidance available at: https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/infection-prevention-and-control-ipc-guidance-in-healthcare-settings/#title-container .

**From Chief Medical Officer**
**Chief Nursing Officer**
**Chief Pharmaceutical Officer**
Dr Gregor Smith
Professor Fiona McQueen
Professor Rose Marie Parr

**07 August 2020**
SGHD/CMO(2020)19

**For action**
Chief Executives, NHS Boards
Medical Directors, NHS Boards
Nurse Directors, NHS Boards
Primary Care Leads, NHS Boards
Directors of Nursing & Midwifery, NHS Boards
Chief Officers of Integration Authorities
Chief Executives, Local Authorities
Directors of Pharmacy
Directors of Public Health
General Practitioners
Practice Nurses
Immunisation Co-ordinators
CPHMs
Scottish Prison Service
Scottish Ambulance Service
Occupational Health Leads

**For information**
Chairs, NHS Boards
Infectious Disease Consultants
Consultant Physicians
Public Health Scotland
Chief Executive, Public Health Scotland
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**Further Enquiries**

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William Malcolm
Public Health Scotland
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5. While General Practice will have an essential role to play in the flu immunisation programme, its capacity is likely to be substantially constrained by the need to maintain good Infection Prevention & Control practices and appropriate physical distancing measures. As set out in John Connaghan's letter of 14 May, flu immunisation preparation is a key clinical priority for Boards and Partnerships. A whole system response, bringing in other parts of the health system, is required if a successful programme is to be delivered.

6. We would expect us all to draw on learning from our experience with Covid-19 and be mindful on how best to deliver a vaccination programme that is prioritised towards protecting the most vulnerable.

**Key Objectives**

7. The flu programme is a strategic and Ministerial priority. The key objectives of the 2020/21 adult flu programme are summarised below

    - To protect those most at risk from flu in the coming season and to ensure that the impact of potential co-circulation of flu and Covid-19 is kept to an absolute minimum.
    - To plan to deliver the programme building on lessons learnt from previous years and our experience of Covid-19, recognising that arrangements may need to change and putting in place the resource needed to deliver the programme at scale.
    - To increase flu vaccine uptake across all eligible groups with particular focus on those who are aged 65 years and over; those aged 18-64 years in clinical risk groups, as well as pregnant women (at all stages of pregnancy). Full details of eligibility for flu immunisation this season is set out in **Annex A**.
    - To extend the national programme to offer vaccination to households of those who are shielding, social care staff who deliver direct personal care and **all** those aged 55-64 years old. Some of those aged 55-64 are otherwise eligible due to qualifying health conditions or employment.
    - To maximise uptake amongst frontline health and social care workers which may require creativity and innovation but is critical to safeguard staff, but also those in their care.

8. The Scottish Government has procured additional vaccine to cover increased uptake amongst existing cohorts, in light of Covid-19, as well as to provide vaccine supply to introduce additional eligible groups to the programme.

9. Scottish Ministers have indicated that the programme should be extended to those aged 50-54, if vaccine supply allows. We will review this in line with uptake rates and vaccine supply as the programme progresses.

10. A separate letter has been issued for the childhood flu immunisation programme, available at https://www.sehd.scot.nhs.uk/cmo/CMO(2020)17.pdf.

11. More information on the flu vaccines for this upcoming season as well as vaccine composition is provided below in **Annex B.**

**Extension of the programme**

12. Scottish Ministers have decided to extend the eligibility of the flu immunisation programme to social care workers providing direct personal care, households of those shielding and **all** 55-64 year olds this year. Some of those groups may already be eligible due to being part of one or more other cohorts e.g. those aged 55-64 may be otherwise eligible due to qualifying health conditions or employment.

13. The rationale for expanding to all 55-64 year olds, beyond those who are already eligible through qualifying health conditions or employment, is that it will help to protect an age group who are more vulnerable to both Covid-19 and seasonal flu than those in younger age groups; and will lower the risk for members of this group, of getting concurrent infection with both viruses. The vaccination of those aged 55-64 years who would not be otherwise eligible should commence in a second phase of the programme later in the season as detailed below.

14. Individuals who have been shielding have already been identified at being at a high risk from Covid-19. The health risks are heightened should they contract both Covid-19 and seasonal flu at the same time. Given that a high proportion of those shielding are either over 55, or else have an underlying health condition, it is likely that many of them are already eligible for the seasonal flu vaccine. However, there are some people shielding whose underlying condition may cause them to have a sub-optimal response to the flu vaccine. Vaccinating those who live in households with those in the shielding group for Covid-19 should provide additional indirect protection to individuals who are shielding.

15. The intention is that eligibility would be defined by the shielding list in place at the time of vaccination. Further detail on this will follow.

16. The Covid-19 pandemic has had an effect on every aspect of public health, including vaccine supply at a global level. This means that the Scottish Government has had to make difficult decisions about how we expand eligibility. The pandemic has also meant that situations can change hugely at very short notice. We will adapt our approach to any changes that occur throughout flu season, always prioritising those most at risk from seasonal flu, and always additionally seeking to protect the NHS as far as possible.

17. To allow us to be responsive to the changing context, we will review the availability of vaccine after uptake levels become clear within existing cohorts, household members of those shielding, and frontline social care workers. At that point we will decide whether there is sufficient vaccine supply to allow us to extend eligibility to 50-54 year olds.

18. Scottish Government will remain in regular dialogue with delivery partners through the Scottish Immunisation Programme Group and will update on any significant developments.

## Phased approach

19. All those initially eligible should be given flu vaccination as soon as possible so that individuals are protected when flu begins to circulate. This is the case for all high-risk cohorts, excluding 55-64 year olds not otherwise eligible, and means starting to vaccinate in late September/October as in previous years.

20. For those aged 55-64, not otherwise eligible due to qualifying health conditions or employment, this will mean starting in December, at the latest. This phased approach is aligned to the availability of vaccines, and prioritisation of the cohorts who are most at risk from the seasonal flu. We will provide further advice, should the programme be extended later in the season to those aged 50-54.

21. NHS Boards and GP practices should aim to schedule their immunisation services to match vaccine supply, as outlined above, if possible: beginning in late September/October, and completing vaccination by the end of November for most high-risk cohorts; and beginning in December at the latest, and completing at the end of January for 55-64 year olds not otherwise eligible.

## Health and Social Care Workers

22. Timely immunisation of all health and social care workers in direct contact with patients/clients will be a critical component in our efforts to protect the most vulnerable in our society.

23. High rates of staff vaccination will help to protect individual staff members but also reduce the risks of transmission of flu viruses within health and social care premises which will contribute to the protection of individuals who may have suboptimal response to their own immunisations. Furthermore, it will help to maintain the workforce and minimise disruption to services that provide patient/client care by aiming to reduce staff sickness absence.

24. Senior clinicians, NHS Managers, Directors of Public Health, Local Authorities and Integration Authorities should ensure this work aligns with the prioritisation already being given to our Covid-19 response to the care sector as a means to prevent transmission of the flu virus in an already vulnerable group.

## Communication materials

25. The national media campaign (TV, radio, press, digital and social media) will seek to increase uptake rates amongst all groups and retain high uptake rates amongst groups who may now be more cautious about getting vaccinated. Research and insight work will underpin the campaign in light of Covid-19 and potentially changing attitudes to vaccination.

26. A national toolkit will be produced to support the promotion of the flu vaccine to health and social care workers and provide resources such as invitation emails, posters and suggested social media posts. We are also working in partnership with professional bodies and membership organisations to try to increase uptake rates.

27. The public should be signposted to http://www.nhsinform.scot/flu for up to date information on the programme.

28. Workforce education materials will soon be made available at https://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/public-health/health-protection/seasonal-flu.aspx.

**Resources**

29. NHS Boards are asked to ensure that immunisation teams are properly resourced to develop and deliver the extended programme.

30. Any additional costs related to adapting immunisation programmes to meet Covid-19 requirements (e,g. physical distancing, PPE) should be recorded in NHS Boards' Local Mobilisation Plans, now called Covid-19 finance returns. This is in the form of a single row figure in the return.

31. Additional costs should also be submitted to the Scottish Government policy team directly with a breakdown of spend. The policy team will shortly issue a template to be submitted. Please ensure that costs are not double counted for services already delivered.

**Action**

32. NHS Boards and GP practices, are asked to note and implement the arrangements outlined in this letter for the 2020/21 adult seasonal flu immunisation programme. It is important that every effort is made this year to maximise uptake as this winter, more than ever, the flu vaccine is going to be a key intervention to reduce pressure on the NHS and protect the most vulnerable in our population.

33. We have procured additional vaccine to support higher uptake, however, ongoing and effective management at a local level is also required. NHS Boards should fully consider the needs of their eligible cohorts and plan appropriately and timeously in order to successfully deliver the programme.

34. We would ask that action is taken to ensure as many people as possible are vaccinated early in the season, and before flu viruses begin to circulate. The benefits of flu vaccination should be communicated and vaccination made as easily accessible as possible. This excludes those 55-64 year olds who are not otherwise eligible, as the commencement of vaccination of this group should be in December at the latest.

35. Integration Authority Chief Officers and Local Authorities are asked to work closely to communicate and promote the flu vaccination programme to social care workers providing direct personal care, and to ensure that they are supported to access the service. A separate letter will be issued to social care membership organisations to communicate the expansion directly to social care providers.

36. We would like to take this opportunity to express our gratitude for your continuing support in planning and delivering the flu immunisation programme and a heartfelt thank you for all your hard work in these most challenging of circumstances.

Yours sincerely,

| | | |
|---|---|---|
| *Gregor Smith* | *Fiona McQueen* | *Rose Marie Parr* |
| Interim Chief Medical Officer | Chief Nursing Officer | Chief Pharmaceutical Officer |

**Annex A**

## FLU VACCINE: PRIORITISING UPTAKE AND ELIGIBILITY

### Prioritising flu vaccine uptake

37. Flu vaccination is one of the key interventions we have to reduce pressure on the health and social care system this winter. Since March 2020 we have seen the impact of Covid-19 on the NHS and social care, and this coming winter we may be faced with co-circulation of viruses causing Covid-19 and flu. We understand that planning this year is more challenging with the uncertainties of staff absences, and how long policies around physical distancing and alternative models of schooling will remain in place. However, it is more important than ever to make every effort to deliver flu vaccination.

38. Those most at risk from flu are also most vulnerable to concurrent infection with Covid-19. The people most at risk from flu are already eligible to receive the flu vaccine, and in order to protect them as effectively as we can, their vaccination should be prioritised.

39. We should also prioritise the vaccination of eligible health and social care workers, to protect them and minimise the likelihood of them spreading Covid-19 and flu to those they care for. We anticipate that concerns about Covid-19 may increase demand for flu vaccination in all groups this year, whilst others may have additional safety concerns around getting vaccinated.

40. All those eligible should be given flu vaccination as soon as possible so that individuals are protected when flu begins to circulate. This is the case for all high-risk cohorts excluding 55-64's not otherwise eligible, and means starting to vaccinate in late September/October.

41. For those aged 55-64, not otherwise eligible through qualifying health conditions or employment, this will mean starting in December, at the latest. This phased approach is aligned to the availability of vaccines, and prioritisation of the cohorts who are most at risk from the seasonal flu. We will provide further advice, should the programme be extended later in the season to those aged 50-54.

42. NHS Boards and GP Practices should aim to schedule their immunisation services to match vaccine supply, as outlined above, if possible: beginning in late September/October and completing vaccination by the end of November for high-risk cohorts; and beginning in December at the latest, and completing at the end of January for 55-64 year olds not otherwise eligible.

### Pregnant women

43. Most NHS Boards and Health and Social Care Partnerships (HSCPs) will be delivering flu vaccine to pregnant women through their local maternity services this year and should keep local practices informed about their plans including how to refer women to the services as appropriate.

GP practices however retain responsibility for vaccinating this cohort until alternative arrangements are made by local NHS Boards and HSCPs.

**Existing Eligible Groups (those eligible in previous flu seasons)**

44. In 2020/21 the seasonal flu vaccine should be offered, from the commencement of the programme, to the existing cohorts set out in the table below:

| Eligible groups | Further detail |
|---|---|
| **Pre-school children aged 2-5 years; and All primary school children in P1-7** | The childhood flu CMO letter for the 20/21 programme has further details. |
| **All patients aged 65 years and over** | "Sixty-five and over" is defined as those aged 65 years and over by 31 March 2021. |
| **Chronic respiratory disease** aged six months or older | Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children who have previously been admitted to hospital for lower respiratory tract disease. |
| **Chronic heart disease** aged six months or older | Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease. |
| **Chronic kidney disease** aged six months or older | Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephritic syndrome, kidney transplantation. |
| **Chronic liver disease** aged six months or older | Cirrhosis, biliary atresia, chronic hepatitis from any cause such as Hepatitis B and C infections and other non-infective causes |
| **Chronic neurological disease** aged six months or older | Stroke, transient ischaemic attack (TIA). Conditions in which respiratory function may be compromised, due to neurological disease (e.g. polio syndrome sufferers).<br>Clinicians should offer immunisation, based on individual assessment, to clinically vulnerable individuals including those with cerebral palsy, learning disabilities, multiple sclerosis and related or similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological or severe learning disability. |
| **Diabetes** aged six months or older | Type 1 diabetes, type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet controlled diabetes. |
| **Immunosuppression** aged six months or older | Immunosuppression due to disease or treatment, including patients undergoing chemotherapy leading to immunosuppression, bone marrow transplant. HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (eg IRAK-4, NEMO, complement disorder). Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day (any age) or for children under 20kg a dose of 1mg or more per kg per day.<br>It is difficult to define at what level of immunosuppression a patient could be considered to be at a greater risk of the serious consequences of flu and should be offered flu vaccination. This decision is best made on an individual basis and left to the patient's clinician. |

| | |
|---|---|
| | Some immunocompromised patients may have a suboptimal immunological response to the vaccine.<br>Consideration should also be given to the vaccination of household contacts of immunocompromised individuals, i.e. individuals who expect to share living accommodation on most days over the winter and therefore for whom continuing close contact is unavoidable. This may include carers (see below). |
| **Asplenia or dysfunction of the spleen** | This also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction. |
| **Pregnant women** | Pregnant women at any stage of pregnancy (first, second or third trimesters). |
| **People in long-stay residential care or homes** | Vaccination is recommended for people in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow the introduction of infection, and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, university halls of residence etc. |
| **Unpaid Carers and young carers** | Someone who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability. A young carer is a child or young person under the age of 18 carrying out significant caring tasks and assuming a level of responsibility for another person, which would normally be taken by an adult. Vaccination can also be given on an individual basis at the GP's discretion following a risk assessment after discussion with the carer. |
| **Health care workers** | Health care workers who are in direct contact with patients/service users should be vaccinated. |
| **Morbid obesity (class III obesity)*** | Adults with a Body Mass Index ≥ 40 kg/m² |

45. The list above is not exhaustive, and clinicians should apply clinical judgement to take into account the risk of flu exacerbating any underlying disease that a patient may have or compromise their care due to illness of their carer, as well as the risk of serious illness from flu itself. Seasonal flu vaccine can be offered in such cases even if the individual is not in the clinical risk groups specified above.

**Call and recall of patients aged 65 and over**

46. As in previous years the Scottish Government will arrange for a national call-up letter to be sent to all those who will be aged 65 years and over by 31 March 2021. These letters will be delivered from w/c 14 September 2020.

**Call and recall of patients under 65 years "at-risk"**

47. National call-up letters for those aged under 65 at-risk are under further consideration and further information will be provided in due course.

**New Eligible Groups 20/21**

48. In 2020/21 the seasonal flu vaccine should be offered to the new cohorts set out in the table below:

| Eligible groups | Further detail |
|---|---|
| **Social care workers** | Social care workers who provide direct personal care in the following settings; adult care homes, children's residential or secure care or care at home including Personal Assistants. This is targeted at those delivering direct personal care in these settings no matter of whether they are employed by Local Authorities, private or third sector employers. |
| **Households of those shielding** | Those who **live in the same home as** individuals falling within the Covid-19 shielding group. |
| **All patients aged 55 to 64 years old** | This is defined as those who will be aged 55 to 64 years old by 31 March 2021. The older age group are covered as an existing group above. Those within this group who are not otherwise eligible (i.e those with qualifying health conditions etc) should be vaccinated in a second phase as detailed below. |

49. Health and social care workers and households of those shielding should be vaccinated from the commencement of the flu vaccination programme. Patients aged 55-64 years old, not otherwise eligible through qualifying health condition or employment, should be vaccinated in a second phase in December at the latest. This phased approach is aligned to the availability of vaccines, and prioritisation of the cohorts who are most at risk from the seasonal flu.

50. Scottish Ministers have indicated that the programme should be extended to those aged 50-54, if vaccine supply allows. We will review this in line with uptake rates and vaccine supply as the programme progresses.

**Call and recall of households of those shielding**

51. Scottish Government is currently considering the possibility of sending a national call-up letter to be sent to all households of those shielding. Further information on this will be provided in due course.

**Call and recall of patients aged 55-64**

52. Scottish Government is currently considering the possibility of sending a national call-up letter patients aged 55-64. Further information on this will be provided in due course.

**Health and Social Care Workers**

<u>Healthcare Workers</u>

53. Immunisation against flu should be considered an integral component of infection prevention and control. As in previous years, free seasonal flu vaccination should be offered by NHS organisations to all employees directly involved in delivering care. This is not an NHS service, but an occupational health responsibility being provided to NHS staff by the NHS as their employers.

54. Uptake of seasonal flu vaccination by health care workers continues to be below the CMO target - in 2019/20 in Scotland this was 53.8% in territorial boards compared with a minimum target of 60%.

55. While vaccination of NHS staff remains voluntary, we will look to all NHS Boards to do everything they can to increase uptake which should include offering the vaccine in an accessible way, helping all staff understand the seriousness of being vaccinated for themselves, their family contacts, their patients and the NHS in helping to reduce the potential for the spread of flu.

56. GP, dental and optometry practices, as well as community pharmacists, should also arrange vaccination of their staff.

Social Care Workers

57. The current Covid-19 situation has highlighted the need to ensure that front line staff across both health and social care settings do not inadvertently transmit infection and should therefore be encouraged and able to access free flu vaccination on a national basis. Scottish Ministers have therefore decided that the policy on flu vaccination for the coming and future seasons should be extended to include social care staff delivering direct personal care to patients/clients. This is in order to protect frontline social care staff and those they care for from flu and to help limit sickness absence amongst the workforce.

58. For clarity, social care staff delivering direct personal care in the following settings should be covered by this programme:
    - residential care for adults;
    - residential care and secure care for children; and
    - community care for persons at home (including housing support and Personal Assistants).

59. This is targeted at those delivering direct personal care in these settings no matter of whether they are employed by Local Authorities, private or third sector employers.

60. A Short Life Working Group was set up within the Scottish Immunisation Programme structure to coordinate expansion of the flu programme to cover social care staff who provide direct personal care. This included representation from Public Health Scotland, NHS Boards, COSLA, HSCP's, Scottish Care and the Coalition of Care and Support Providers in Scotland.

**Immunisation against Infectious Disease ('The Green Book')**

61. Further guidance on the list of eligible groups can be found in the most recent influenza chapter (chapter 19) of the Green Book available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/796886/GreenBook_Chapter_19_Influenza_April_2019.pdf

62. Chapter 12 of the Green Book provides information on what groups can be considered as directly involved in delivering care and is available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147882/Green-Book-Chapter-12.pdf

63. Any Green Book updates will be made to the linked pages above.

**ANNEX B**

## RECOMMENDED FLU VACCINES, VACCINE COMPOSITION AND ORDERING INFORMATION

### Flu vaccines for 2020/21

64. The flu vaccines that have been centrally procured for the forthcoming flu season are in line with the recommendations of the Joint Committee on Vaccination and Immunisation (JCVI) and are set out in the table below.

| **Eligible Group** | **Vaccine** |
|---|---|
| **First Phase** | |
| Individuals aged 65 years and over | adjuvanted Trivalent Inactivated Vaccine (aTIV) (Seqiris) |
| Individuals aged 18-64 years with "at-risk" conditions | cell based Quadrivalent Inactivated Vaccine (QIVc) (Flucelvax Tetra®) (Seqiris) |
| Health and Social Care Workers | cell based Quadrivalent Inactivated Vaccine (QIVc) (Flucelvax Tetra®)(Seqiris) or Egg based Quadrivalent Inactivated Vaccine (QIVe) (brand and manufacturer to be confirmed) dependent on vaccine supply and delivery schedules. |
| Households of those shielding | cell based Quadrivalent Inactivated Vaccine (QIVc) (Flucelvax Tetra®) (Seqiris) |
| Unpaid/Young carers | cell based Quadrivalent Inactivated Vaccine (QIVc) (Flucelvax Tetra®) (Seqiris) |
| **Second Phase** | |
| Individuals aged 55-64 not otherwise eligible through a qualifying health condition or employment | Egg based Quadrivalent Inactivated Vaccine (QIVe) (brand and manufacturer to be confirmed) |

65. Some flu vaccines are restricted for use in particular age groups. The Summary of Product Characteristics (SPC) for individual products should always be referred to when ordering vaccines for particular patients.

### Vaccine composition for 2020/21

66. Each year the World Health Organization (WHO) recommends flu vaccine strains based on careful mapping of flu viruses as they circulate around the world.

67. This monitoring is continuous and allows experts to make predictions on which strains are most likely to cause flu outbreaks in the northern hemisphere in the coming winter. Getting vaccinated is the best protection available against an unpredictable virus that can cause severe illness.

68. For the 2020/21 flu season (northern hemisphere winter) it is recommended that cell based quadrivalent vaccines contain the following strains-:

- an A/Hawaii/70/2019 (H1N1)pdm09-like virus;
- an A/Hong Kong/45/2019 (H3N2)-like virus;
- a B/Washington/02/2019 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

69. For the 2020/21 flu season (northern hemisphere winter) it is recommended that egg based quadrivalent vaccines contain the following strains-:

- an A/Guangdong-Maonan/SWL1536/2019 (H1N1)pdm09-like virus;
- an A/Hong Kong/2671/2019 (H3N2)-like virus;
- a B/Washington/02/2019 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

70. For further information and the full report please see: https://www.who.int/influenza/vaccines/virus/recommendations/2020-21_north/en/

**Egg-free vaccine**

71. For individuals with egg allergy the advice in the most recent influenza chapter of the Green Book should be followed: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/796886/GreenBook_Chapter_19_Influenza_April_2019.pdf

72. Any Green Book updates will be made to the linked pages above.

73. Egg-allergic adults and children over age nine years with egg allergy can also be given the quadrivalent inactivated cell based (i.e. egg-free) vaccine, Flucelvax® Tetra, which is licensed for use in this age group.

**Vaccine ordering and delivery arrangements**

74. Information on ordering and delivery arrangements for the flu vaccine will be provided within further correspondence. Details of the supply arrangements for community pharmacies supporting this year's immunisation programme will be shared directly via relevant NHS Boards.

75. Orders for the flu vaccine should be placed on the Movianto online ordering system - Marketplace: (https://ommarketplace.co.uk/Orders/Home). Log-in details used in previous seasons remain valid and should continue to be used.

76. If you have any issues with log-in arrangements or if you have new staff who require access to the system please contact Movianto Customer Services on 01234 248 623 for assistance.

77. NHS Boards and GP practices should plan appropriately and place the minimum number of orders needed, taking into consideration available fridge capacity. NHS Boards are charged for each delivery made to practices.

78. NHS Boards and GP practices must ensure adequate vaccine supplies before organising vaccination clinics.

79. When placing orders for the vaccines in Marketplace, practices should search for the type of vaccine required. For example, if vaccines are required for patients aged 18 to 64 these can be found in Marketplace by entering the search term "QIVc" or on the 'Orders' screen. If vaccines are required for patients aged 65 or over, these can be found by searching for "aTIV".

80. To make it simpler for front line staff in the coming season, all NHS Boards will be allocated the same type of vaccine for each cohort e.g QIVc for most cohorts. The exception to this is for health and social care workers where a mix of QIVc and QIVe will be allocated based on vaccine supply and delivery schedules. **Only QIVe should be used for 55-64 year olds, not otherwise eligible due to qualifying health condition or employment, and will be available for ordering later in the season.** Those who are egg-allergic should be offered the QIVc vaccine as detailed above.

81. Vaccines are available in packs of 10. On the ordering platform, please read the vaccine information carefully and order the number of packs required rather than the total volume of individual vaccines – for example, if the vaccine is available in packs of 10 and the practice wants to request a delivery of 500 vaccines, an order should be placed for 50 packs of 10.

82. Patient information leaflets for vaccines supplied in packs of 10 will be provided separately to the vaccines. These will be automatically added to orders by Movianto.

**Further information and support**

83. As with last year, a Procurement Officer within NHS National Procurement will act as a link between GP practices and Movianto to ensure any potential allocation or delivery issues can be minimised and swiftly resolved. Contact details for the Procurement Officer are as follows: NSS.fluvaccineenquiries@nhs.net

84. For queries linked to ordering and deliveries, please contact the Movianto Customer Services Team (01234 248 623). If any delivery service issues cannot be resolved satisfactorily through dialogue with Movianto, the issue should be escalated to NHS National Procurement (contact details as above) in the first instance and thereafter the Immunisation Co-ordinator within the NHS Board. If you require contact details for your NHS Board Immunisation Coordinator please email immunisationprogrammes@gov.scot .

**ANNEX C**

## CONTRACTUAL ARRANGEMENTS AND FURTHER INFORMATION

### Contractual arrangements

85. Information on payments associated with the seasonal flu and pneumococcal vaccines will be set out by Primary Care Directorate, Scottish Government in due course.

### Pneumococcal immunisation

86. Health professionals are reminded that they should check the immunisation status of those eligible for pneumococcal immunisation when such people receive the flu vaccine. Depending on the availability, the pneumococcal vaccine can be offered at the same time as the flu vaccine or at any other point in the year when vaccine becomes available. Health professionals should note to recall individuals in cases where no vaccine is immediately available. An online leaflet is available and can be accessed at: www.nhsinform.scot/pneumococcalforadults.

### Uptake Rates in 2019/20

87. It is important that every effort is made this year to ensure uptake is as high as possible. The benefits of flu vaccination amongst all eligible groups should be communicated and vaccination made as easily accessible as possible.

88. Provisional uptake data for 2019/20 suggests uptake rates of:

- 74% in people aged 65 years and over, compared with 73.7% in 2018/19;
- 42.3% in under 65's at-risk, compared with 42.4% in 2018/19;
- 53.8% for healthcare workers, compared with 51.2% in 2018/19
- 56.9% in pregnant women (with other risk factors), compared with 57.5% in 2018/19; and
- 42.9% in pregnant women (without other risk factors), compared with 44.5% in 2018/19.
- 44.7% in unpaid/young carers, compared with 45.1% in 2018/19.

Information on vaccine uptake for this season and previous seasons can be found at: https://www.hps.scot.nhs.uk/a-to-z-of-topics/influenza/. For further information regarding the HPS vaccine uptake monitoring programme, please contact nss.hpsflu@nhs.net