Edinburgh Integration Joint Board

REPORT

Evaluation of Winter Planning 2020/21

Edinburgh Integration Joint Board

22 June 2021

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board (IJB) with an update on performance over Winter 2020/21 1. Scottish Government DL (2017)19 guidance on Preparing for Winter 2017/18 is the most recent government circular outlining the requirement for Health and Social Care Partnerships to produce an action plan to ensure health and social care services are well prepared for winter. Further to this 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 regarding preparing for Winter 2020/21 2. Preparations for Winter 2020/21 were outlined at the IJB meeting on 15 December 2020 3. This report and appendices provide an overview of the suite of winter planning actions and services, and an evaluation of their impact. 4. The plan sets this in the context of the Partnership's performance for key performance indicators, compared to last winter.

Recommendations	It is recommended that the Edinburgh Joint Integration Board: 1. Note the evaluation of Winter 2020/21 contained within this paper 2. Note that a number of the successful winter initiatives have been funded recurringly 3. Note that planning is underway with regards to our key priorities for Winter 2021/22

Directions

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 22 June 2021.

Main Report

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 was amplified this year with the onset of the COVID-19 pandemic and the prospects 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 NHS Lothian for winter 2020/21. This was to be used to support the costs of ensuring that health and social care services were 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 self-assessment is included at Appendix 1.

6. 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.

7. 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.

8. 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 along with a summary of their evaluation and impacts.

Title	**Achievements and impact**
Discharge to Assess(D2A) – Occupational Therapy £61,179	There was a total of **843** referrals across Edinburgh during winter, an average of 211 per month. The D2A North team had a **55%** increase in referrals compared to the previous winter. The South team started in March 2020 therefore it is not possible to provide a full comparison with Winter 2019/20, but there was a **95%** increase in referrals in March 2021. There was an increase in referrals for both teams of over **20%** during winter from the previous 18-week period.
Home First Therapists – RIE/WGH £60,379	A total of **98** patients were supported at the RIE (six home visits) and **74** patients at the WGH (13 home visits). Data shows that for the **172** patients supported, **18%** had a positive adjustment to their length of stay and **6%** had a reduction in length of stay greater than four days. Activity had the intended consequence of increasing D2A referrals. A four-week test of change in March 2021 integrated 1 WTE Physiotherapist and 1 WTE Occupational Therapist into the boarders ward round, the aim being to reduce unnecessary bed days by improving flow and access to the best discharge pathway available. Ten patients that were case managed returned to their homes with a reduced length of stay of more than four days in **90%** of cases. There were no readmissions at 7 or 14 days.

	A Home First therapist led an ICF triage list test of change for the four months of the project, working with the AAH discharge hub to establish a robust and effective process. The evaluation of this is awaited.
Social Worker Enhancement £88,965	Data shows a reduction in 11 codes compared to Winter 2019/20 although this may be due in part to the implementation of the Discharge Hub team in 2020, with a dedicated team ensuring all referrals are validated and coded correctly. 11a codes show a reduced number of patients waiting for a community worker to be allocated, resulting in reduced length of stay. In addition, there was a reduction in average weekly delays with 11b coding. It is not possible to gauge how much of this change was attributable to COVID-19 impact. Part of the resource was used to provide support for rehabilitation needs in intermediate care facilities in five wards across Liberton Hospital and Findlay House (Fillieside) with 40 funded beds in Liberton Hospital and 24 in Fillieside. Winter funding provided 1 WTE Home First Navigator to support early discharge planning for a 12-week period. Of the 47 patients supported, **84%** were not readmitted following discharge. Data also shows a **37%** reduction in delayed discharge patients in Liberton Hospital, and a reduction of **32%** in occupied bed days, with **54%** of individuals being discharged to a care home placement. The reduction in occupied bed days would indicate success in supporting early discharge, this in the face of wider challenges arising from COVID-19: closure of wards due to infection, and testing requirements for transfer to a care home particularly as an average of 60% of care home capacity was unavailable in any given week.
CRT+ & Long-COVID Single Point of Access (SPOA) £50,188	During the service period, **23** referrals were received, **16** of which were deemed to be at risk of hospital admission **(70%).** This is a slight reduction compared to previous winters which may be due to the second period of lockdown and patients shielding. This mirrors the reduced number of respiratory-related presentations throughout the healthcare system this winter. Of those referrals received, the CRT+ service successfully supported **100%** admission avoidance at 48hrs and **83%** at 7 days. A proposal will be prepared to make these posts substantive moving forward. The Single Point of Access provided a triage point to AHP rehabilitation services for people recovering from COVID-19, with **290** referrals being received in the period from November 2020 to end of March 2021. There were **314** onward referrals made (some individuals require the input of more than one service), primarily to pulmonary rehabilitation and the Lothian Work Support Service. This project has demonstrated the success of utilising a single pathway to access existing AHP rehabilitation services for people experiencing ongoing

	symptoms post-COVID. It has, however, resulted in a significant increase in referrals to these services, compounded by the second lockdown period, increasing waiting times and making remobilisation a challenge.
Reablement Coordinators £29,211	Two Home Care Coordinator posts were funded to support early assessment, care planning and scheduling. The project was terminated at the end of January due to evidence of it having a limited impact. The initiative reduced 1 to 2 delayed discharges per week with no significant increase in weekend discharges. Over the 10 weekends the additional staff were in place, **15** discharges were completed. The needs of patients were instead met by other service pathways. It has been acknowledged by the Lothian Unscheduled Care Committee that weekend discharges remain an issue and this will be picked up a Lothian level going forward.

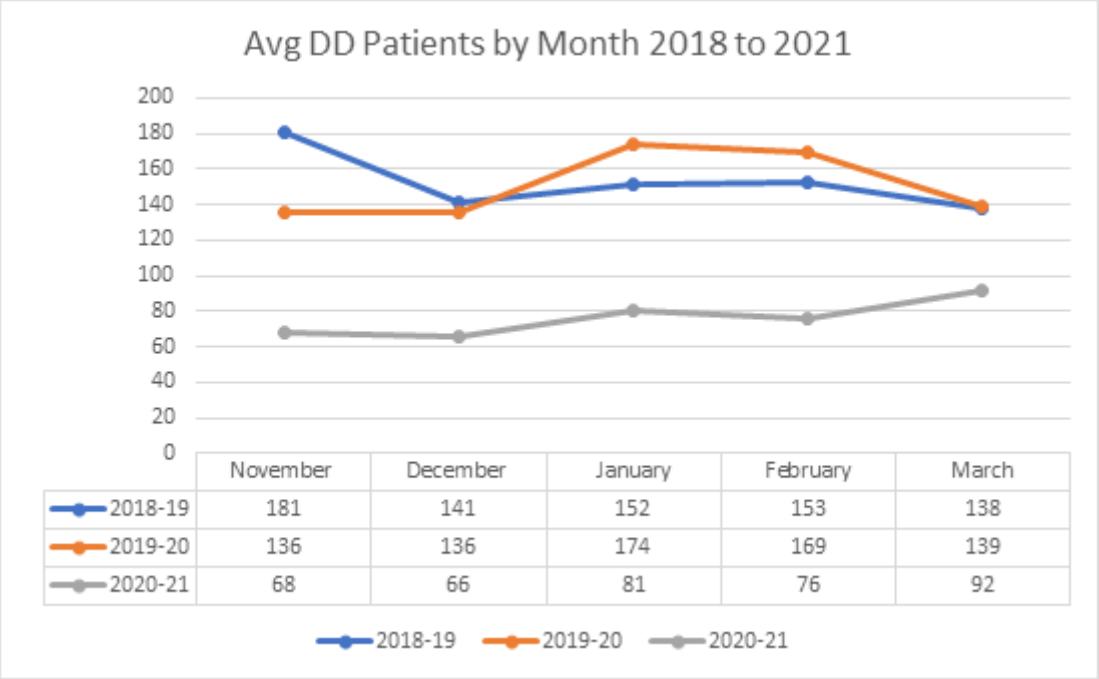
9. In addition to the above, the Partnership funded third sector organisations to provide support for vulnerable residents at risk of admission and readmission, and unpaid carers who whom the festive period can be a challenging time.

Bids	**Achievements and Impact**
Discharge to Assess (D2A) - Assistant Practitioners £43,401	Additional assistant practitioner capacity in D2A has contributed to the skill mix within the team, enabling therapists to assess patients in a more timely manner and deliver more intensive rehabilitation. The achievements and impact of D2A during winter are detailed in Section 8 above.
Open House £28,139.50	There were **46** referrals into the core programme (not including those supported by The Stafford Centre). These individuals were referred to a total of **50** activities. 59% of those supported were female, and 41% male. Support was offered to all adult age-groups, the majority being over the age of 65. This reflects a change of focus from the previous year where support to older people was prioritised. This change was made in acknowledgement of the universal financial, mental health and social challenges arising as a result of the pandemic Uptake across providers is detailed below:

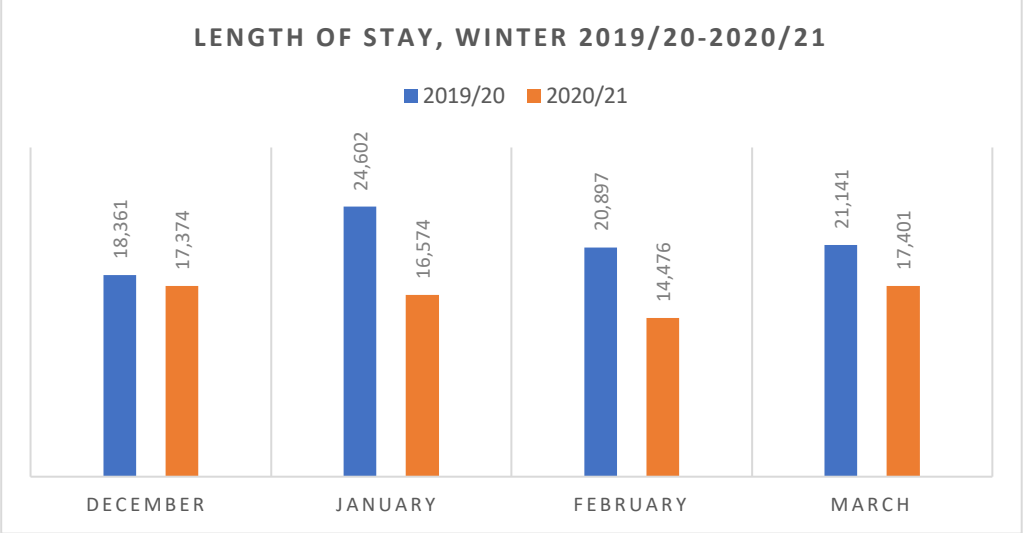
ORGANISATION	**PLACES AVAILABLE**	**UPTAKE**
Artlink	20	6
LifeCare Edinburgh	5	7
Caring in Craigmillar (Phonelink)	44	17
Health all Round	35	16
SPACE Hub at Broomhouse	10	13

	The Stafford Centre*	26 additional sessions	Average attendance of 11
VOCAL Carers Hub Surviving Christmas Programme £3,927	VOCAL had a target of 110 carer beneficiaries, and achieved a total of **112**. An online survey went sent to all recipients with 21 responses received: • 95% improved physical and mental wellbeing • 74% improved relationships • 86% improved social wellbeing • 57% improved safety in relation to caring role • 30% improved economic wellbeing • 57% better informed about issues linked to caring role • 62% improved confidence in caring role • 71% ability to continue caring		

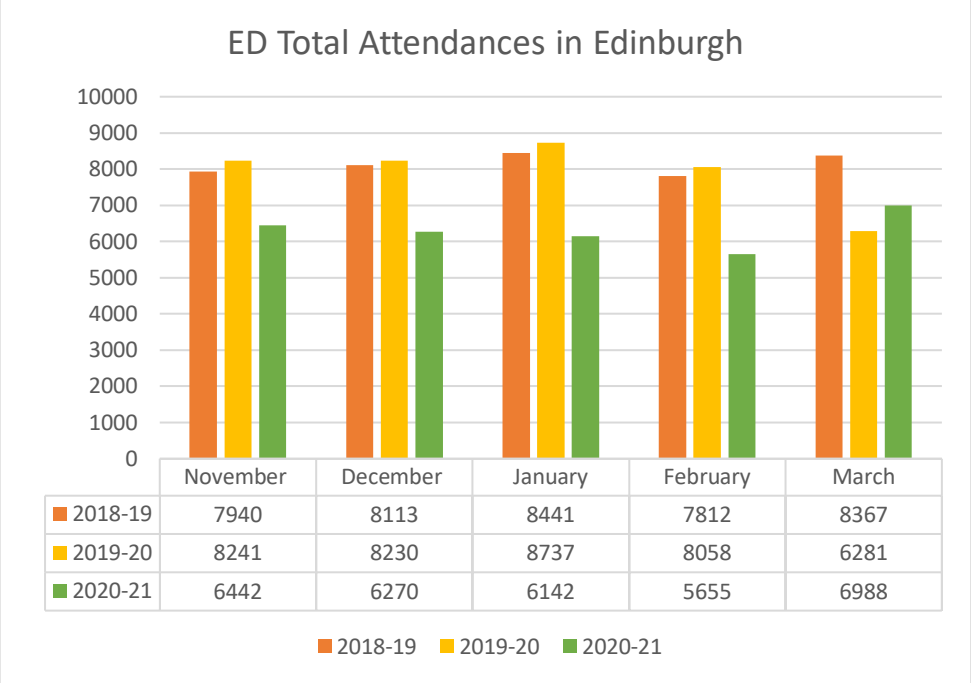
10. A comparison of delayed discharge numbers across hospitals in Edinburgh for Winter 2020/21 shows that levels are lower than in the previous two years. Delayed discharges in the City of Edinburgh for those aged 18+ and 75+ also fell below the Scottish average in November 2020.



11. Length of stay was also reduced during Winter 2020/21 compared to the previous year.

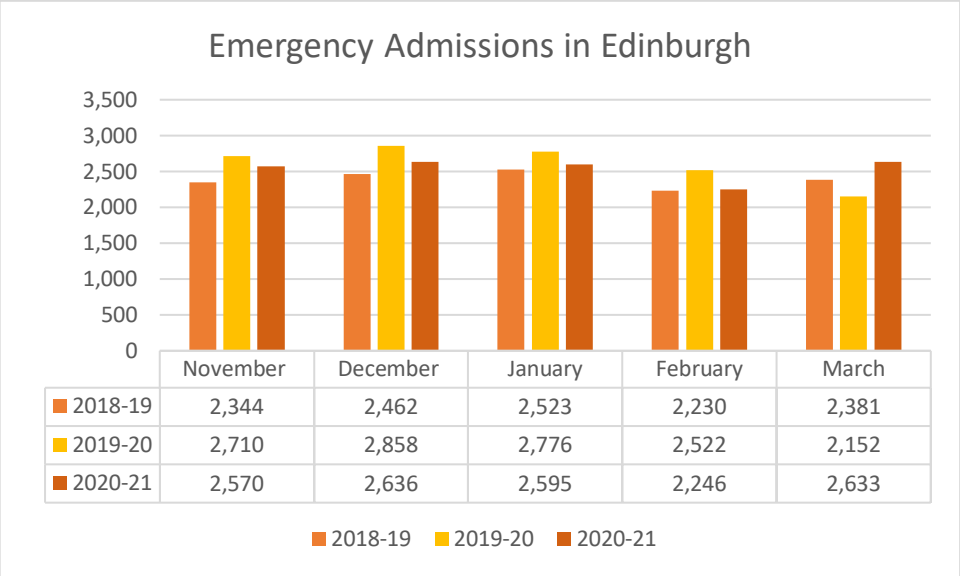


12. Emergency Department attendances were lower this year than in the previous two winters. A comparison of the past three winter periods from 2018-19 to 2020-21 is shown below:



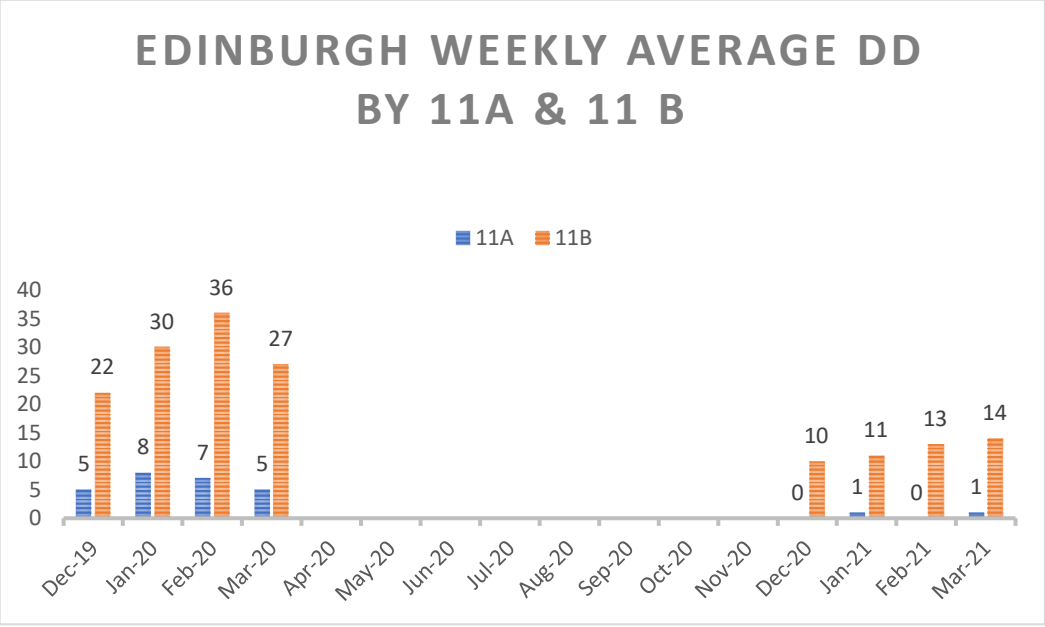
	November	December	January	February	March
2018-19	7940	8113	8441	7812	8367
2019-20	8241	8230	8737	8058	6281
2020-21	6442	6270	6142	5655	6988

13. Emergency admission in 2020/21 were lower than in 2019/20, but generally higher than in 2018/19. The graph below shows emergency admissions by month, for both the RIE and WGH sites, across the last three winters:



	November	December	January	February	March
2018-19	2,344	2,462	2,523	2,230	2,381
2019-20	2,710	2,858	2,776	2,522	2,152
2020-21	2,570	2,636	2,595	2,246	2,633

14. Weekly average delayed discharges by 11a and 11b codes for 2020/21 are shown below, compared to those for 2019/20:



15. The Unscheduled Care Committee requested evidence of impact for funded proposals in April 2021. A copy of this completed report can be found in Appendix 2.

16. In addition, the Partnership was asked to provide more limited feedback than in previous years around alignment of services and staffing levels for inclusion in the Lothian Winter Planning and Response review which was submitted to Scottish Government in May 2021. A copy of the Partnership's contribution is included at Appendix 3.

17. Phase 2 of the National Programme for Redesign of Urgent Care (RUC) was launched at the start of winter 2020. In a direct response to this national programme, pathways were developed or enhanced to ensure that an individual gets the right care by the right person at the right time and in the right place. Collaborative work was undertaken with the Flow Centre to develop a single point of access for those needing access to urgent 4 hour response in order to prevent admission. Pathways through the Flow Centre include Hospital @ Home, CRT and Urgent Therapy and Social Care (Home First). These pathways were operational in December 2020. The Home First RUC/POA workstream will further identify areas of focus that can prevent unnecessary admissions including enabling the Scottish Ambulance Service to access community pathways.

18. A request was made via the NHS Lothian Gold Command Team in December 2020 for Edinburgh HSCP to open 12 additional intermediate care beds at Liberton Hospital to support flow from acute services. 6 beds were opened in December 2020 as this was manageable within the existing 3 wards by flexing the use of beds. The remaining 6 beds could not come on stream without an additional ward being opened and this was not possible until safe staffing was in place and was achieved towards the end of January 2021 when a total of 10 extra beds were open. Safe staffing was difficult to sustain and a decision was made towards the end of March 2021 to close the extra ward as it was a more sustainable situation to have a total 46 beds over 3 wards than 50 beds across 4 wards. No additional AHP resource was sought for the additional beds which was gap given that the purpose of intermediate care is rehabilitation and reablement. Going forward early planning including all workforce requirements should take place if additional bed capacity is required.

Ensuring Business Continuity

19. Consideration was given to concurrent resilience events such as severe weather and a further lockdown period as a result of COVID-19, as came to fruition. The Edinburgh HSCP Severe Weather Resilience Plan was updated including escalation protocols, key contacts and transport arrangements made to ensure continuity of service.
20. Resilience plans were in place for all Edinburgh HSCP services, which were of good quality, robust and able to meet the needs of urgent changes over the season. These plans are being revisited at a Partnership level and winter resilience will form part of this exercise.
21. Issues did arise, however, relating to transportation. Despite being agreed, provision of 4x4 vehicles did not happen as expected during the period of bad weather. Third sector organisations were able to step into the gap but this is being investigated to ensure it does not happen again in winter 2021/22. Secondly, there was some miscommunication around the process for road clearances, possibly following on from two milder winters, but this is also being addressed with the relevant services.
22. It is intended that resilience plans for Winter 2021/22 will be finalised and in place well ahead of start of the season.

Adult Flu Vaccination Campaign

23. Responsibility for delivering the Flu Vaccination Programme was expected to move from local medical practices to the HSCPs in 2021 under the new GMS contract (2018) but this was accelerated by Edinburgh HSCP due to the COVID-19 pandemic.
24. This brought about two advertising campaigns to raise awareness of the new process for vaccinations
    - The first online campaign featured advertising on Facebook, Twitter, Google Display Network and Evening News/Scotland online which achieved 23,000 link clicks, 132,000 views and 110,000 full views of the short video explanation.
    - The second campaign focussed on advertising on Facebook and Twitter and received 6,000 link clicks, 33,000 views and 8,500 full views.

- Videos explaining the new process were commissioned in a range of languages and made available on You Tube, receiving 2,090 views.
- There was significant media coverage including BBC News, STV website, Herald, Forth One News, Telegraph, The Times, Scotsman, Evening News, Edinburgh Reporter and Edinburgh Live.
- A full breakdown of the communication campaign around the flu vaccination programme can be found in Appendix 4.

25. The Scottish Government set an ambitious target in 2020 of 75% uptake for both the 65 year and over and the 'At Risk' groups. The 'At Risk' group is defined as age 18 to 64 years with specified underlying health conditions. This gave Edinburgh a combined target of approximately 105,000 vaccinations in these two core groups.
26. Previous Lothian uptake in the 'At Risk' group was approximately 43%, and when the targets were set it was unknown whether this was realistic. The reported uptake for those aged over 65 was 73.6% and for those 'At risk' it was 47.0%. A breakdown of how these vaccinations were delivered is given below.

EHSCP Clinics	**66,601**
Community Pharmacy est.	**20,000**
Practices Opportunistic est.	**10,000**
Total Vaccine Delivered	**96,601**

27. In addition to the two main priority groups, three new groups were initially added by the government; Social Care workers, people living in same household as shielding patients and people aged 55-64 years. Data on uptake in these groups is not readily available due to coding problems but this will be addressed as part of future planning
28. A full evaluation report of the Adult Flu Campaign for 2020 is available on request

Communications

29. Over winter 2020/21 the Partnership had an extended range of audiences and messages focussing on:
    - Informing Edinburgh's citizens that there is a new way of getting flu vaccinations, informing people how to get a flu vaccination, and removing barriers and encourage people to get their flu vaccination
    - Encouraging and informing the EHSCP workforce about the staff flu vaccination programme
    - Communicating with the vulnerable people we support via the people that support them on hospital avoidance/signposting, falls prevention, anticipatory care plans, keeping safe and healthy over winter
    - Communicate festive support, flu vaccinations and winter health messages to unpaid carers
    - Using social media to promote messaging around staying healthy over winter, keeping active overwinter, and staying safe in snowy and icy weather.

30. Winter 2020/21 communications ran from August 2020 to March, with a series of targeted communications for:
    - People aged over 60 and with long term health conditions on how to get a flu vaccine
    - Frontline colleagues about getting the flu vaccine
    - Frontline colleagues on keeping themselves and clients safe and healthy over winter
    - Those most at risk of falling
    - Unpaid carers
31. A full evaluation of the communications which were undertaken and delivery against campaign objectives is available on request

Forward Planning for Winter 2021/22

32. Planning is already underway around priority actions which need to be in place for winter 2021/21. These include:
    - Enhancing hospital based social work capacity to deliver on Planned Date of Discharge ambitions and eliminate Code 11 breaches.
    - Enhance the Home Care Prevention Team realigned to localities to prevent hospital admissions where intermediate social care support is required.
    - Proactive identification of frequent attendees in each locality (via MATTs or equivalent) to offer assessment and support to frequent fallers, develop social care anticipatory care plans and identify any other opportunities to prevent ED presentations.
    - Sustainability of CRT+ if the business case for all year funding is not forthcoming.
    - Provision of Long-COVID Single Point of Access and rehabilitation if ongoing funding is not forthcoming.

Implications for Edinburgh Integration Joint Board

Financial

33. 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.

34. A total of £289,922 was awarded to five winter proposals put forward by the Partnership as outlined earlier in this report, with a total of £198,042 committed.

35. It should be noted that some proposals did not utilise the full amount of allocated funding. There was slippage in the Discharge to Assess start date due to difficulties recruiting on a short-term basis. The Reablement initiative was discontinued as it was deemed to not be an efficient use of monies due to the limited impact. A detailed breakdown of funding can be found in Appendix 4.

36. An additional £75,467 was made available by the Partnership to other initiatives to support caring for vulnerable residents and unpaid carers over the winter period.

Legal/Risk Implications

37. Ability to recruit to short-term posts that are required only for surge capacity and do not require permanency remains an issue. In some cases it has been possible to move staff from elsewhere in the organisation, although this does present the possibility of destabilising existing services if it is not possible to backfill those posts.

Equality and integrated impact assessment

38. 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.

39. The provision of language translation videos has greatly increased reach into BME and BSL communities. The involvement of MEHIS has been key to the willingness of others to share messages around winter. Videos have been picked up by third sector organisation as a tool to inform or use with their service users, and some are being used as part of English language classes for refugees and other groups. Some medical practices added videos to their websites or Facebook pages as a means to reach groups not attending in person.

40. Contact has been made with the Black and Minority Ethnic Forum to discuss how the organisation might link with them and other staff equality networks such as the BAME Corporate Network, STRIDE (LGBT), SPARC (Disabilities) and other smaller, newly formed groups, around future winter planning.

Environment and sustainability impacts

41. Gold Command delayed discharge funding has been utilised for 2WTE Occupational Therapists and 4WTE Assistant Practitioners for Discharge to Assess, a net benefit of 6 additional staff. This funding has also been utilised for three posts for Home First, however, EHSCP will work with acute services to articulate the model of care going forward, and this will be discussed with each site individually due to their differing needs.

42. A business case for permanent funding for CRT+ is being developed to take to the Lothian Unscheduled Care Programme Board, and a costed SBAR for the Long-COVID SPOA and a dedicated multidisciplinary team to support recovery from COVID-19, which would be in keeping with national guidance and recommendations, is being considered by EHSCP EMT in June 2021. It is envisaged that this would need to be in place for 12-18 months. Both will be put forward for winter funding in 2021/22 in the event that they are not supported.

43. There may be sustainability implications in maintaining improved flow post-winter. Many individuals being discharged from hospital are presenting with significant deconditioning, complexity and need. In tandem with this, the remobilisation of the hospitality sector is already having an impact on recruitment into the care sector.

44. Sustainability of CRT+ if the business case for all year funding is not forthcoming

Quality of care

45. Provision of Long-COVID Single Point of Access and rehabilitation if ongoing funding is not forthcoming

46. Increasing pressure on AHP and mental health services if dedicated service for Long-COVID is not established

Consultation

47. Winter plans were developed in close consultation with relevant parties through the NHS Lothian Unscheduled Care Committee and the EHSCP Winter Planning Group.

48. A communication plan was developed for the Partnership to ensure that health and social care staff, partner organisations, and local residents were aware of the services available over the festive period and how to access them.

49. Key target groups included people using the largest proportion of healthcare resources, primarily vulnerable older people, people who receive care at home, people with long-term health conditions, and unpaid carers.

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Background Reports

1.

Appendices

Appendix 1	EHSCP Winter Self-Assessment
Appendix 2	Unscheduled Care Committee Evidence of Impact
Appendix 3	Lothian Winter Planning & Response Review – EHSCP Contribution
Appendix 4	Financial Breakdown

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 *(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. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The Preparing for Emergencies Guidance sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☐ ☐		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. 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. 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. 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. 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

				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. 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. 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.	☐ ☐ ☐		EHSCP Tactical Plan considers every essential service within the Partnership and covers various risk-assessed scenarios, including seasonal flu and COVID. 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. Severe Weather Group - members from Council, NHS Lothian and EHSCP to further strengthen resilience response and share resources during weather related incidents.

3	The NHS Board and HSCPs have appropriate policies in place should winter risks arise. These cover: • what staff should do in the event of severe weather or other issues hindering access to work, and • how the appropriate travel and other advice will be communicated to staff and patients • 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. *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 *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/ Comments
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity. *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		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. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.* *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*	☐		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

	All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.			about capacity in private care homes is also utilised to match service users to places dependant on price and funding available. Should exceptional pressures develop these will be escalated to EMT. 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 *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *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.*	☐		Not applicable – NHS Lothian to complete

	Plans in place for the delivery of safe and segregated COVID care at all times. *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter 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. *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.* *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.* *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

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. *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. *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. 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.

3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*	☐		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. **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. Referrals to the flow centre will come from: • NHS 24 • GPs and Primary and community care • SAS • A range of other community healthcare professionals. 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.	☐		Not applicable – NHS Lothian to complete (under the Redesign of Urgent Care workstream)

	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.			

	Professional to professional advice and onward referral services should be optimised where required 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. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☐		Proactive MATT meetings daily to support hospital flow and onsite presence of Home First navigators on acute sites Home First Flow Navigators in the WGH site to support early pull working with front door and with wards Home First Navigators working with discharge hub in WGH to manage people on acute medical wards. Discharge to Assess to create an alternative pathway to admission 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	☐		The MDTs will be focussed on 7 day discharges and that all

	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. *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.*			discharges take place as early in 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. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*	☐		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 *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.
5	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			
5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions. Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☐		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. *Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.* *All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible*	☐		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. 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

				Home First Prevention Care will support people at home as an alternative to hospital for up to 72 hours. Reablement will run over the festive period and will prepare for surge actions for the post Festive Surge. 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. *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. Covid-19 ACP guidance and resources have been developed for healthcare professionals, GP practice teams and care homes. • *ACPs in Care Homes 7 Steps to ACP*

				• COVID-19: Effective communication for professionals (RED-MAP resources) • *ACP and Coronavirus: for GP practices (Update)* 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. 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. *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.

				260 third sector and health and social care staff have been trained to improve ACP during this period. Long Term Conditions Programme are currently supporting VOCAL, Edinburgh Carer Support Team, 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.	☐		EHSCP Communications Plan is being developed and will include this

	Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach. *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*			
6.2	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *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.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*	☐		This will be included within EHSCP's Communications Plan. NHS Lothian will lead on external communications for messaging to avoid hospital admissions and reduce impact on acute sites. 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). Both partner organisations will be heavily involved in resilience communications.

3	**Out of Hours Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays. *This should include an agreed escalation process.* *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 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. *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.

				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. 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 *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. *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. *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 to Assess team hours of operation will be expanded to cver 7-

	discharge planning, along with examples of innovation involving the use of ambulance services.			day working, facilitating weekend discharges 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, 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 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. *This should confirm agreement about the call demand analysis being used.*	☐		Not applicable – NHS Lothian to complete
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☐		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. *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. *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 *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☐		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. 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. *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. 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. *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.

				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.
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. *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. *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. *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. *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
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. 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** *(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 *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. *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 with NHS Boards fully support vaccine delivery and uptake.* *Vaccine uptake will be monitored weekly by performance & delivery division.*	☐		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 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 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: • 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. • Is Covid-safe, preventing the spread of Covid-19 as far as possible with social distancing and hygiene measures. • Have been assessed in terms of equality and accessibility impacts *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: ○ 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 ○ 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 ○ 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 ○ In addition, vaccinations are also available through pharmacies but clinics are the preferred route in most cases ○ The vaccination programme is being supported by Volunteer Edinburgh.
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. *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. *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: • Adults aged over 65 • Those under 65 at risk • Healthcare workers	☐		Not applicable – NHS Lothian to complete

	• Unpaid and young carers • Pregnant women (no additional risk factors) • Pregnant women (additional risk factors) • Children aged 2-5 • Primary School aged children • Frontline social care workers • 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household • Eligible shielding households 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. *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. Aerosol Generating Procedures (AGPs) 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-date. ***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***	☐		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.
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: • Adherence to the updated extended of use of face mask guidance issued on 18 September and available here. • Testing during an incident or outbreak investigation at ward level when unexpected cases are identified (see point 9). • Routine weekly testing of certain groups of healthcare workers in line with national healthcare worker testing guidance available here (see point 9). • 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. • Implementation of COVID-19 pathways (high, medium and low risk) in line with national IPC guidance. • Additional cleaning of areas of high volume of patients or areas that are frequently touched. • Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September.	☐		All requirements and measures are in place throughout the Partnership

	• Consideration given to staff movement and rostering to minimise staff to staff transmission and staff to patient transmission. • 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.			
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 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. *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. 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/ 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 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. 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** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☐		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. 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. 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. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*	☐		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. 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. Patients issued with self management ACP and 'Think COPD Think CRT' fridge magnet to prompt them to **'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 pulmonary rehab team to manage their condition using this app.

1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☐		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. *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. 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.

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. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* *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. 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.

4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			
4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☐ ☐ ☐ ☐		Patients with COPD should aim to have oxygen saturations on air of 88% or above at rest if doesn't have LTOT at home. If a patient is acutely unwell with lower oxygen saturations they should be referred to hospital for treatment which may include acute oxygen therapy 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. 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. *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
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. 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					
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. Discharge home/care facility: 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					

Winter Planning Proposals - Performance Report (19/04/2021)

Context

As part of winter planning for the Edinburgh Health and Social Care Partnership (EHSCP), a number of winter projects to support the Home First (HF) pathway were undertaken. These projects included:

- Additional D2A capacity (Occupational Therapists and Healthcare Support Workers).
- Embedding HF therapists in acute sites (WGH and RIE) to support effective discharge planning in secondary care.
- A Social Worker enhancement initiative aimed at reducing delayed discharges by processing referrals and completing assessments within target timescales to reduce the length of stay (LOS) for individuals.
- An enhanced service to complement the Community Respiratory Team, CRT+, to support patients with acute chest infections to remain in the community and prevent hospital admission.
- Reablement Coordinators to enable 7-day discharge.
- A Single Point of Access (SPOA) for post-COVID rehabilitation was established to provide access to support using existing Allied Health Profession (AHP) services which provide rehabilitation to people recovering from COVID 19.

1. Additional Discharge to Assess Occupational Therapists

Project/Service	D2A Enhancement
Reporting Period	1/12/20 to 31/03/2021
Project Improvement Aims	Increased Hospital Discharge

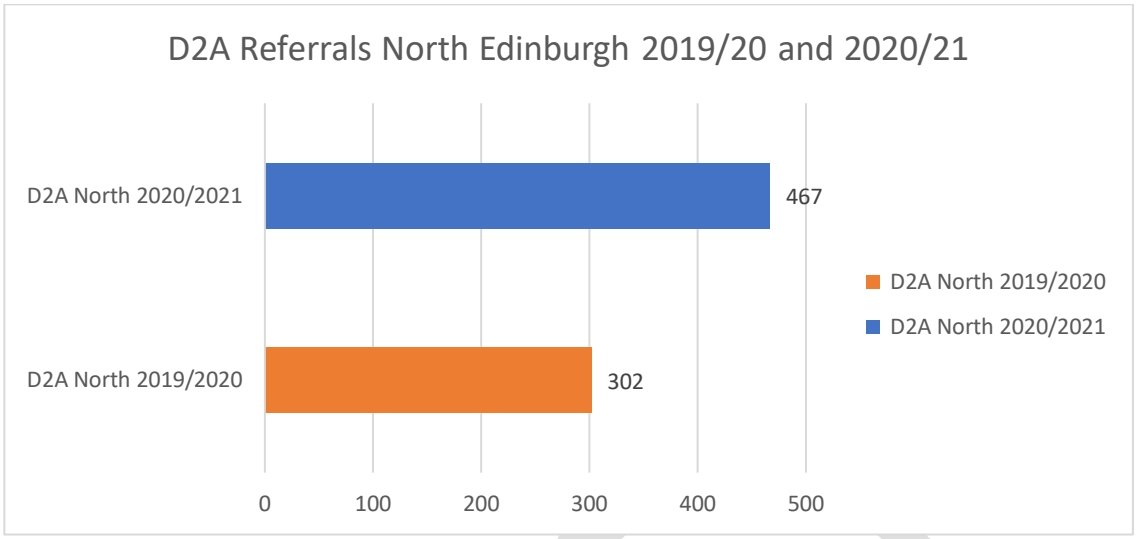
The Discharge to Assess (D2A) service within EHSCP was augmented. The service aimed to facilitate discharge with ongoing rehabilitation in the person's own home as an alternative to bed-based rehabilitation, which potentially could result in a longer stay in hospital and increased risk of hospital acquired infection. The D2A service within EHSCP consisted of a South and a North team that, prior to 1 December 2020, had 8 Occupational Therapists and 8 Physiotherapists. Through the additional winter capacity, 2 Occupational Therapists to support the North and South D2A team were recruited.

D2A Total number of referrals accepted between December 2020 and March 2021

Team	D2A Referrals 2019/20	D2A Referrals 2020/21	% Increase	Average D2A referrals per month
D2A North	302	467	55%	117
D2A South	N/A*	376	N/A*	94
Total		**843**		

**D2A South started in March 2020; therefore, we are not able to provide a full comparison across both years.*

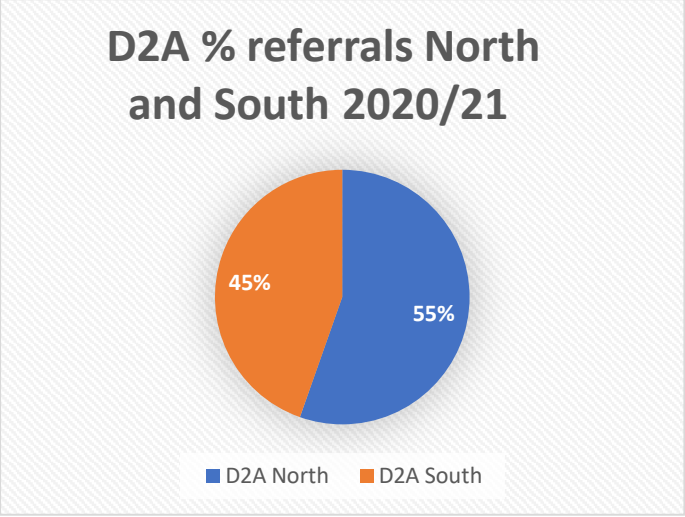
D2A North team number of referrals accepted- A comparison of 2019/20 and 2020/21



(Source: D2A local data)

D2A North has had an increase of **55%** with **165** additional referrals during the winter period November 2020 – March 2021.

Edinburgh D2A % referrals to each team 2020/21

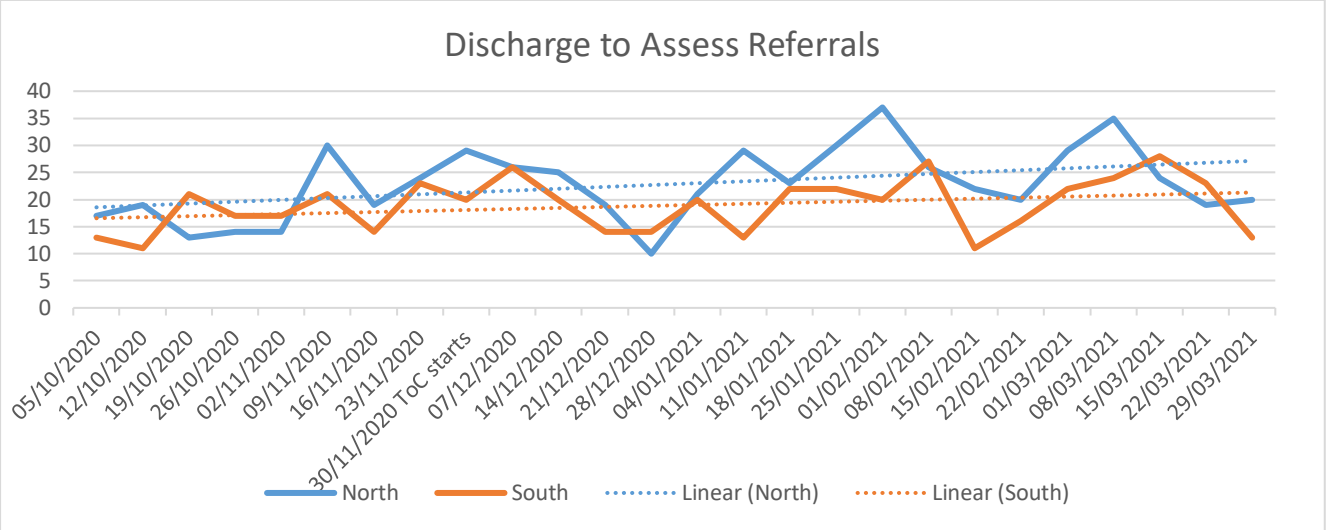


A comparison of D2A South team for March 2020 and 2021

Team	D2A Referrals
D2A South March 2020	56
D2A South March 2021	109

D2A South has seen an increase of **95%** with **53** additional referrals in March 2021 compared to March 2020. (*Note: due to the D2A South team commencing service on 1 March 2020 the data is only available to compare the month of March)*

D2A Performance measures 10/2020 to March 2021



Discharge to Assess Demand

The table below compares D2A demand between the winter period (30/22/20-29/03/21) and the 18-week period prior to November 2020.

D2A Demand			
NORTH	Test of Change 18 weeks	Previous 18 weeks	% Increase
D2A Referrals (N)	444	355	
Weekly Average	25	20	25%
SOUTH	Test of Change 18 weeks	Previous 18 weeks	
D2A Referrals (S)	337	274	
Weekly Average	19	15	21%

The data shows an increase in referrals for both teams of over 20% over the winter period from the previous 18 weeks.

It should also be noted that the Partnership has, since the end of January 2021, supported the addition of 4 x Assistant Practitioners for the D2A service. Early indication shows that this capacity has, as well as contributing to the skill mix within D2A, enabled the therapists

to assess patients in a timelier manner and deliver more intensive rehabilitation. The impact on activity is minimal/negligible at this stage.

2. Home First Therapists - RIE and WGH Sites

Project/Service	Home First Therapists
Reporting Period	1/12/20 to 31/03/2021
Project Improvement Aims	Enhance the adoption of the Home First Principles within acute therapy teams at RIE and WGH. Increase number of people supported by D2A and other community teams

2 WTE therapists (1 PT and 1 OT) working within RIE Wards 104 and 202 and WGH (throughout site).

The aim was to support acute hospital staff planning a patient discharge. The therapists provided specialist advice on community therapy/resource options to support timely discharge. They promoted knowledge and confidence in positive risk taking with planning discharges and, together with the wider Home First team and acute staff, worked to enhance the Home First ethos within the acute setting. They also took a lead role in the triage of the Intermediate Care (bed based) list (Test of Change 3).

Direct Performance Measures for Home First therapists

Site	Number of patients supported	Predicted impact on LOS	Number of supported home visits	Time spent gathering collateral information (on AIS) that supports discharge planning
WGH	74	For 16 patients: 10 < 4 days 6 > 4 days	13	Not collecting
RIE*	98	15 patients 10 < 4days 5 > 4 days	6	Average = 47 min per patients. Range 20mins – 110mins

**stopped data collection on this Feb 28th as they moved to test of change 2*

The data shows for both sites, for the 172 patients supported, 18% had an adjustment to their LOS and 6% had a reduction in LOS greater than 4 days. By the nature of supporting acute staff to support discharge planning it was an intended consequence that D2A referral activity would increase. Evidence of this can be seen in D2A activity data shown in section 1. Please also refer to D2A performance measures.

2.1 Home First Therapist supporting Boarders Ward Round RIE

2 WTE therapists (1 PT and 1 OT) were integrated into the Boarders Ward Round for a period of 4 weeks.

The aim was to reduce unnecessary hospital bed days by improving patient access to the best discharge pathway available, encouraging improved patient flow whilst embedding HF principles within the MDT.

HF Performance Measures

HF Boarders WR Test of Change 01/03/21 to 26/03/21 (4 weeks)

Total referrals	Week 1	Week 2	Week 3	Week 4
17	6	6	3	2

Bed days saved		
9	>4 days	90%
1	<4 days	10%

Readmission		
At 7 days	0/17	0%
At 14 days	0/17	0%

Source		
16	Boarders WR	92%
1	AMU WR	8%

Presentation		
14	Falls	92%
3	Frailty	8%

HF Input		
40hrs	**Direct**: Involved in PT/OT Ax and intervention	49%
42hrs	**Indirect**: Facilitating discharge planning with Ward PT/OT	51%

In the 4-week Test of Change, 10 patients that were case managed by HF therapists went home. The data shows all patients had an estimated reduced LOS with 90% estimated at >4 days and 10% < 4 bed days saved. The data also shows that no patients had been readmitted at 7 or 14 days.

2.2 Intermediate Care Facility Triage list (Test of Change 3)

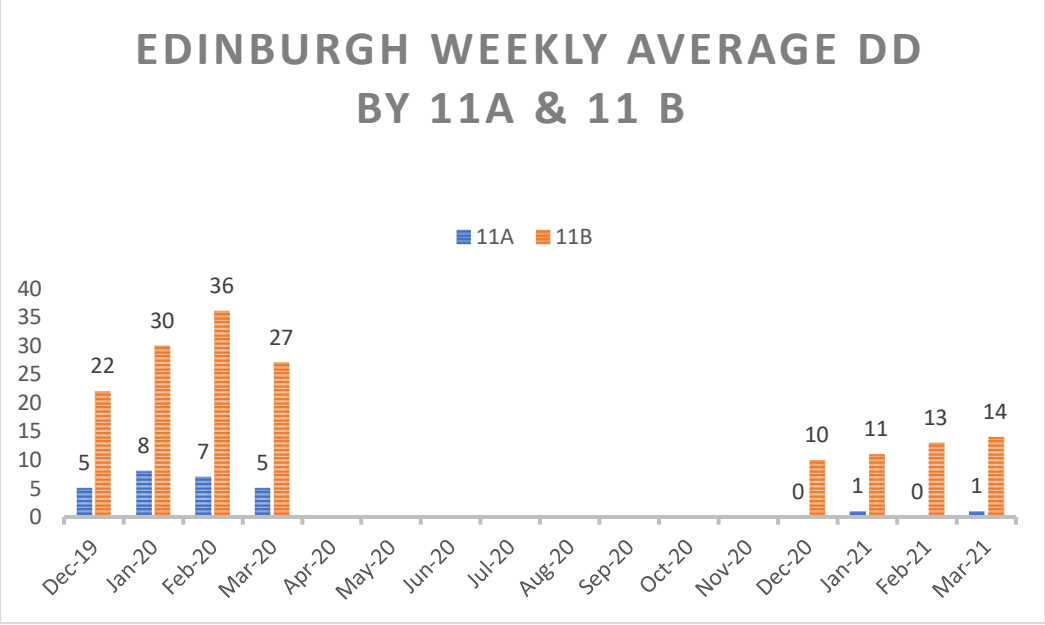
The HF therapist led this process for the 4 months of the project and in this time worked with the AAH Discharge Hub to make a robust and effective process. Our early data shows that, as this staff group gain competency, they can take on non-complex new patient assessments, in addition to following up with rehabilitation sessions. This allowed for an increase in collective capacity for D2A. A full 4-month evaluation report will be available in May 2021.

3. Social Worker Enhancement

Project/Service	Hub Social Worker Enhancement
Reporting Period	1/12/20 to 31/03/2021
Project Improvement Aims	Hospital Discharge and community admission prevention

Additional Social Workers were based across the Community Hub/Cluster and Acute Hospital Social Work Teams to prevent hospital admissions and to reduce delayed discharges. The hospital-based Social Work team have a duty service, which is a responsive service to any Adult Support and Protection concern being raised by colleagues in acute care. The aim was to reduce delayed discharges by processing referrals and completing assessment within target timescales to reduce length of stay for individuals. The Social Workers also facilitated discharge to the person's own home with a package of care or to interim or permanent placement in a Care Home.

Weekly average Delayed Discharge by 11a and 11b in Edinburgh during Winter 2019/20 – 2020/21

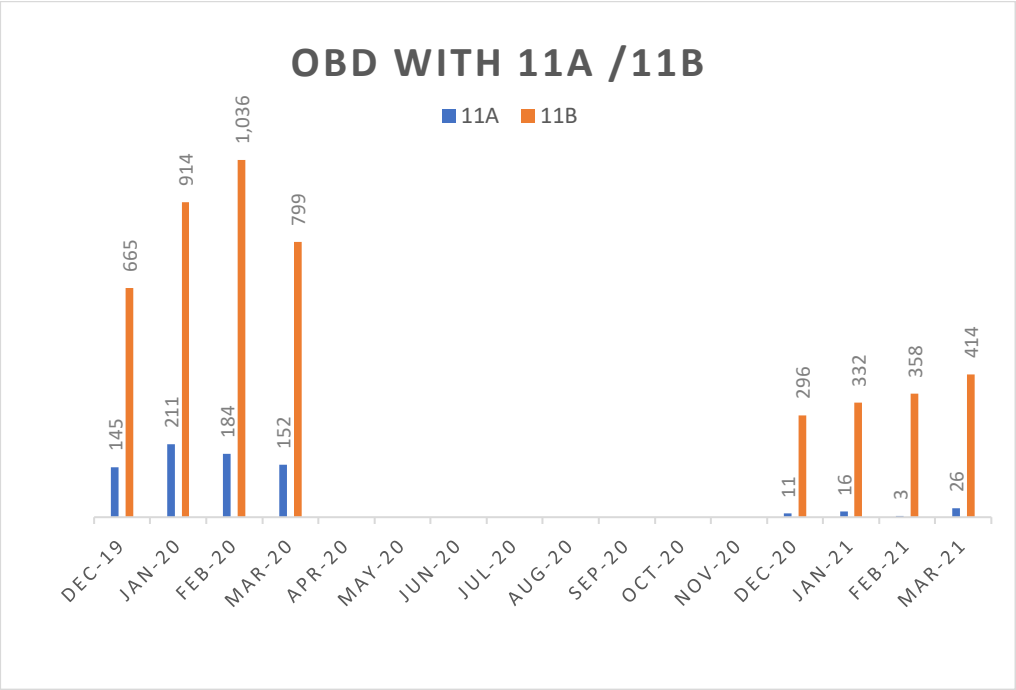


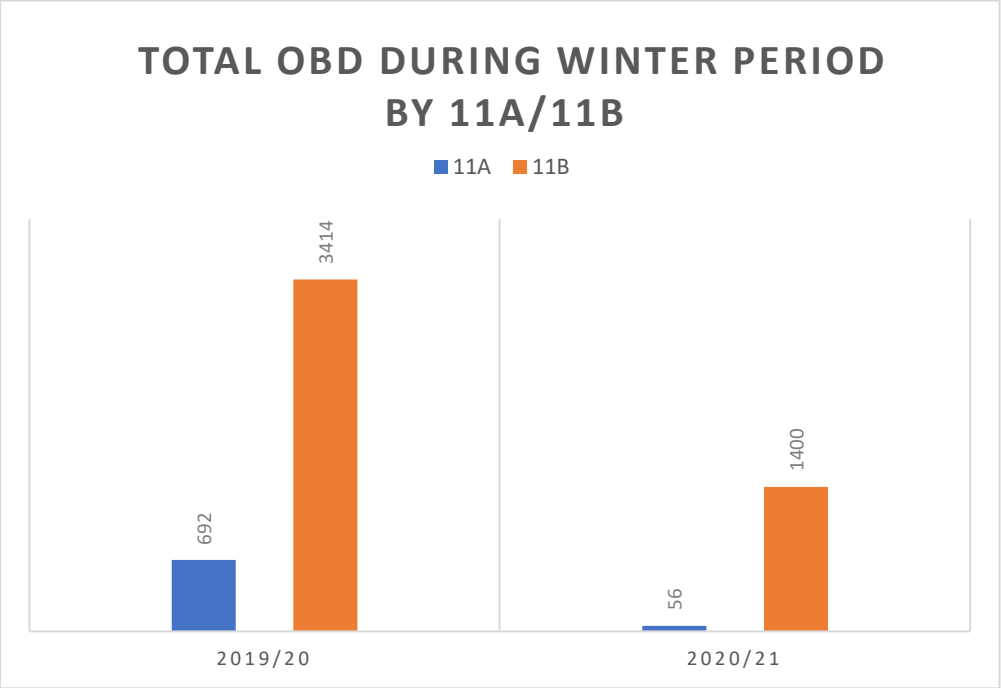
(Source: Tableau DD dashboards data)

The data shows a reduction in 11a codes compared to 2019/20. This may be, in part, due to the implementation of the Discharge Hub team in 2020, with a dedicated team that ensures all referrals are validated and coded correctly. The 11a codes show a reduced number of patients waiting for a community worker to be allocated to them, resulting in reduced LOS.

In addition, the data shows a reduction of weekly average of delays by 11b codes. This may be due to the COVID- 19 pandemic impact.

Comparison by Occupied Bed Days

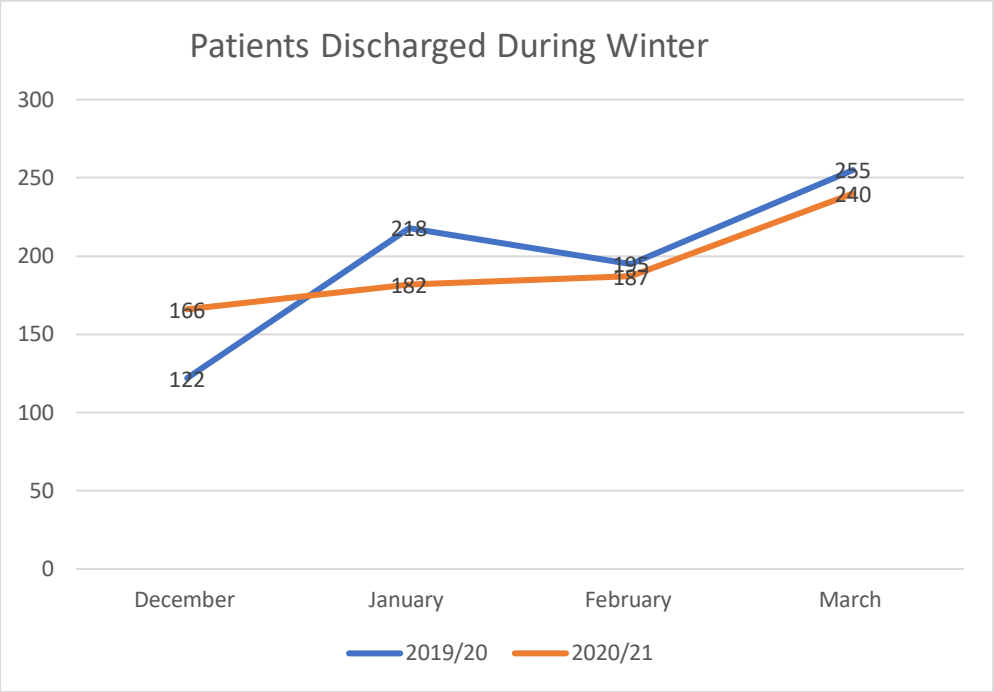




The graphs above show that the number of Occupied Bed Days (OBD) due to 11a and 11b, were significantly lower for 2020/21 than winter 2019/20.

Patients discharged from 01/12/2019 to 31/03/2021 across the four Edinburgh localities (SE/SW/NE/NW)

Month	Total	Month	Total
Dec 2019	**122**	Dec 20	**166**
Jan 20	**218**	Jan 21	**182**
Feb 20	**195**	Feb 21	**187**
Mar 20	**255**	Mar 21	**240**



(Source: CEC discharges data)

The data shows performance during both winters was similar, with slightly better performance at the start of the winter 2021.

The Social Worker enhancement in winter 20/21 was 20% higher, thus, if all things could be considered equal, the Partnership performance has been enhanced this winter.

3.1 The Intermediate Care Facility Service (ICF)

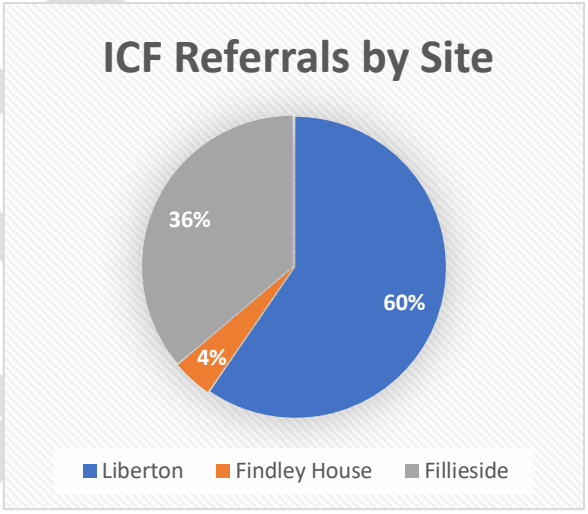
(Reporting period from 05 January 2021 to 30 March 2021)

Part of the additional Social Work staffing resource was used to provide support for rehabilitation needs in intermediate care facilities situated in 5 wards across two sites: Liberton Hospital and Findlay House – Fillieside.

There were 24 funded beds within Fillieside and 40 funded beds in Liberton Hospital. Winter funding provided 1 WTE Home First Navigator to support earlier discharge planning. This post was filled from 05/01/2021 – 30/03/2021. The data range provided is for the full 12 weeks.

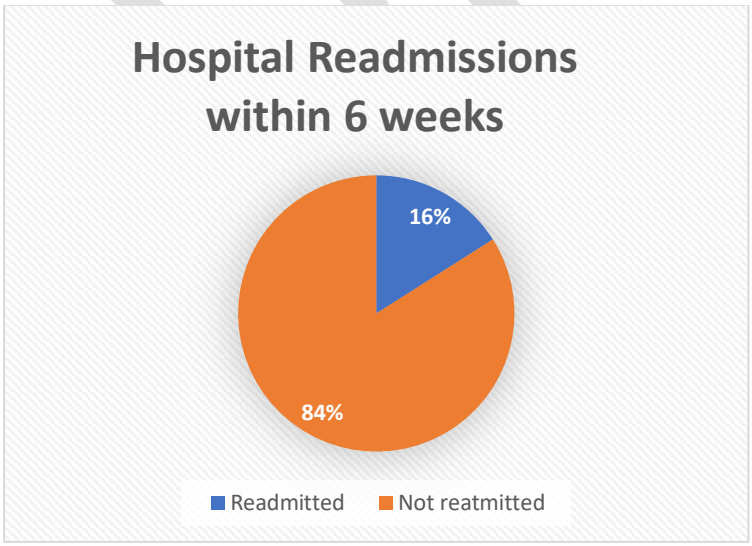
ICF Referrals by site

Site	Referrals
Liberton Hospital	28
Findley House	2
Fillieside	17
Total patients supported	**47**



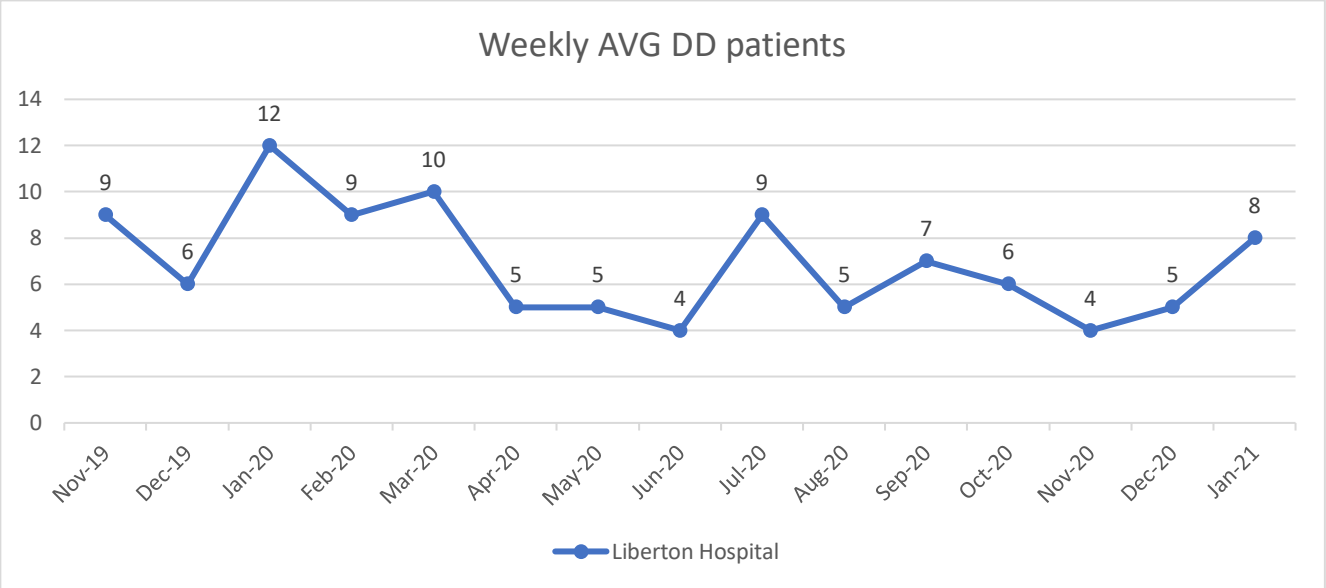
The data shows that most referrals were to the ICF in Liberton Hospital.

Readmissions to Hospital within 6 weeks

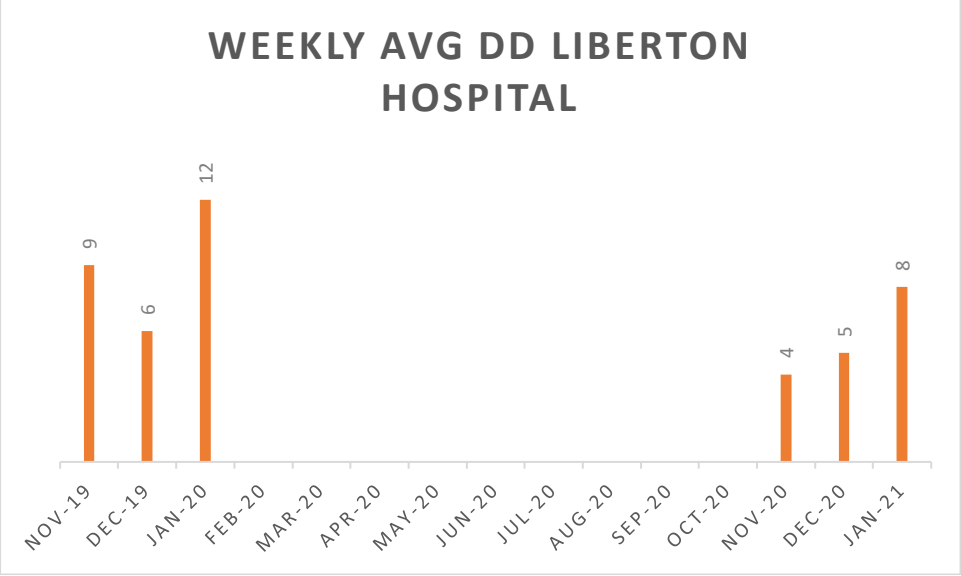


Of the total 47 patients supported, the data shows 16% were readmitted into hospital within 6 weeks, with the majority (84%) remaining in their usual home.

Average Delayed Discharged patients in Liberton Hospital

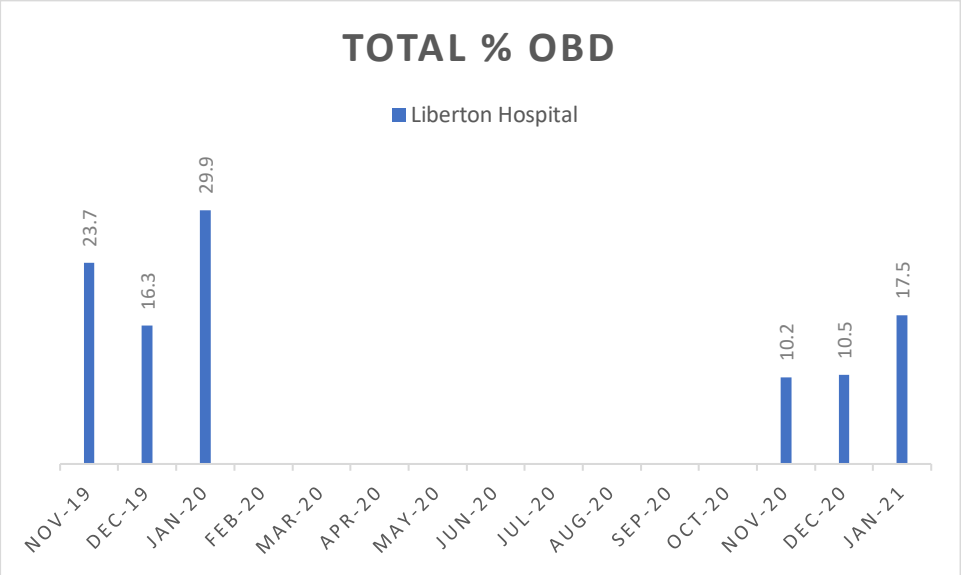


(Source: Tableau dashboard)



The data shows a 37% reduction of delayed discharge patients in Liberton Hospital during the months of the test of change (November to January).

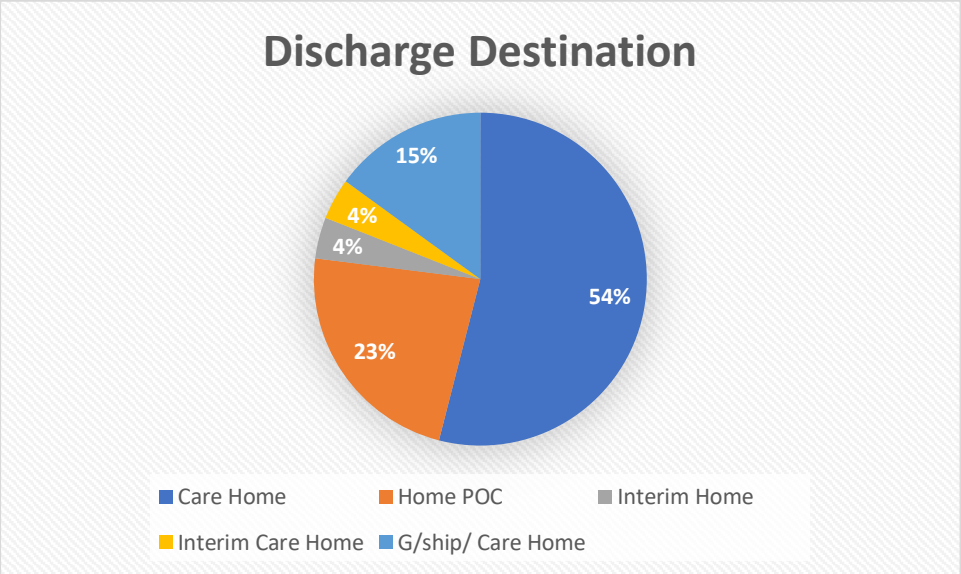
Total Occupied Bed Days Liberton Hospital



(Source: Tableau dashboards)

According to the data, for the period of the test of change, there has been a reduction of OBD of 32%.

Discharge destination from ICF



The data shows that most patients seen by the team (54%) were discharged to a Care Home. The evaluation of the full impact of this post is still underway. The reduction in OBD would indicate success in supporting earlier discharge, despite the wider challenges of COVID-19, in relation to flow into and out of intermediate care beds, closure of wards due to infection,

testing requirements for destination to care home and the fact that an average of 60% of our City wide care home capacity was unavailable in any given week.

4. Reablement Coordinators

Project/Service	Reablement Coordinators
Reporting Period	28/11/ 2020 to 31/01/2021
Project Improvement Aims	7- day discharge

(Reporting period from 28/11/ 2020 to 31/01/2021)

A decision was made to end the service due to its limited impact.

Reduced delayed discharge numbers: 15 weekend discharges over 10 weekends across WGH/RIE for patients across North and South. On average this was only reducing delay numbers by 1-2 a week across the whole of the city. There was no significant increase in weekend discharges with additional staff.

LOS for the people discharged was a mixture of long delays to short delays, with LOS varying: 73 days, 10 days, and 144 days.

LOS (days)
73
10
144

5. Enhanced Community Respiratory Team (CRT+) Service and Single Point of Access (SPOA)

Project/Service	Community Respiratory Team Enhancement CRT+ Single Point of Access (SPOA) for Post COVID rehabilitation
Reporting Period	1/12/20 to 31/03/2021
Project Improvement Aims	CRT + An enhanced CRT service to support patients with acute chest infections to remain in the community and prevent hospital admission. SPOA provided support and rehabilitation through existing AHP services to provide rehabilitation to people recovering from COVID 19.

Our proposal was to enhance staffing within Edinburgh Community Respiratory Team to deliver CRT+ (within CRT) and a single point of access to provide support through existing AHP services and provide rehabilitation to people recovering from COVID 19. CRT+ has been successfully delivered for 3 winters. The service enables GPs and secondary care to refer patients who have acute chest infections to be supported and managed by the team. Our aim was to reduce the demand on GPs by CRT+ taking a lead role in in the management of these patients and aiming to prevent admission to secondary care. CRT+ has also supported patients being discharged from hospital if admission has been required.

This year we have also proposed to support patients with respiratory conditions beyond COPD and supported patients with post-COVID 19 infection, with access to AHP rehabilitation services. Our staffing proposal for CRT+ allowed for clinical leadership (Band 7) and specialist skills (Band 6).

CRT+ Referrals by year

Year	Referrals
2018/2019	48
2019/2020	58
2020/2021	23

CRT+ referrals have been down this year compared to the previous 3 winters. Some possible causes of reduced referrals may include the second lockdown, shielding, and GPs doing remote consultations with more confidence therefore not referring as much. The lower CRT+ numbers mirrors the reduced respiratory presentations throughout health systems this winter.

CRT+ Source of referrals

Acute Chest infection referrals to CRT+						
Source	Nov'20	Dec'20	Jan'21	Feb'21	March'21	**Total**
GP	3	4	2	6	4	19
Hospital	1	0	0	0	2	3
Other	1	0	0	0	0	1
Total						**23**

The table above shows most referrals for CRT+ are from GPs, suggesting engagement of primary care with the CRT+ service.

CRT+ Activity

Indicator	Number	Comments
Average time to contact	0.8	Most patients contacted on the day of referral
Average number of home visits per patient	1	
Average number of telephone consultations per patient	4.4	

Number of patients at risk of admission	16 of 23	70% of all referred
Patients remaining at home at 48hrs	100%	
Patients remaining at home at one week	83%	
Number of supported discharge patients	3	

COVID -19 Referrals to CRT+

COVID – 19 Referrals to CRT+						
Source	Nov'20	Dec'20	Jan'21	Feb'21	March'21	Total
SPOA	7	4	9	5	4	**29**

Indicator	Number
Average time to contact	2.9 days
Average number of HV per patient	0.5
Average number of telephone consultations per patient	3.3

The tables above show 52 referrals were made to the CRT+ service between November 2020 and March 2021, suggesting a level of awareness of this additional capacity in the CRT.

5.1 Single Point of Access for Post COVID AHP (Rehabilitation) (SPOA)

(Reporting period from November 2020/ to March 2021)

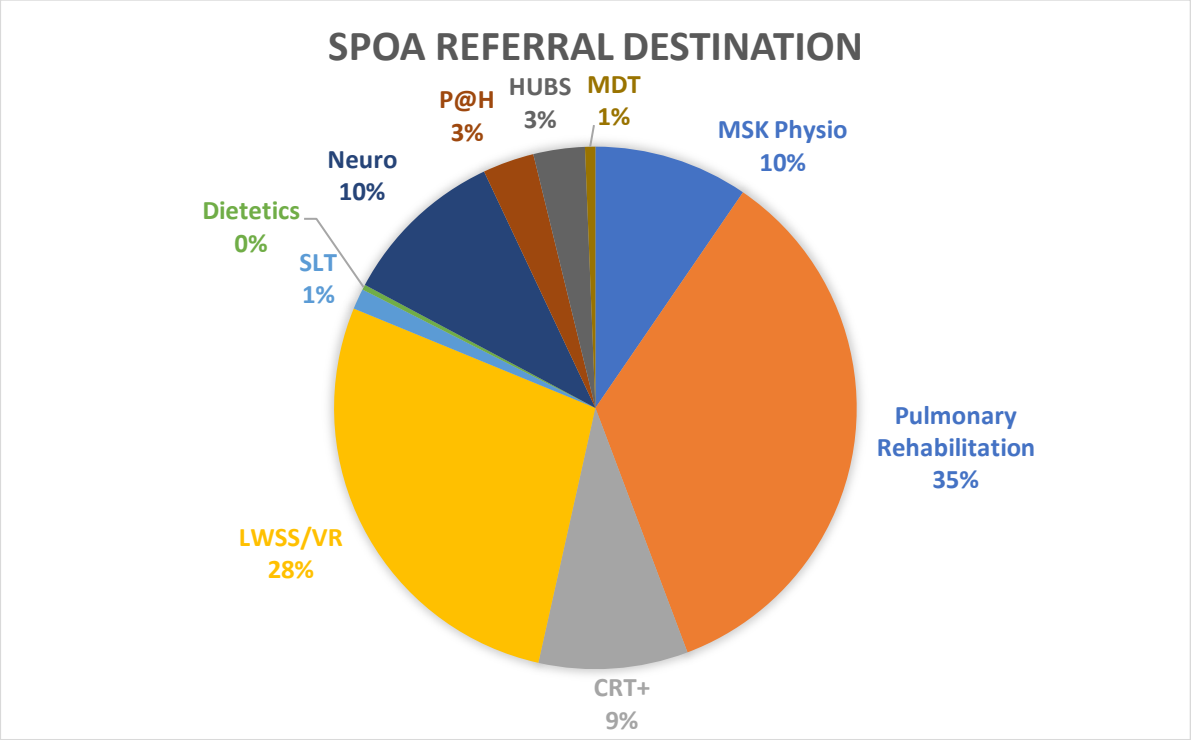
SPOA Referrals

SPOA	Referrals
Referrals into SPOA	290
Referrals from SPOA to appropriate teams (some referrals require 2 services)	314

Onward referrals from SPOA by destination

Ref. Destination	Nov20	Dec'20	Jan'21	Feb'21	Mar'21*	Total
MSK Physiotherapy	10	9	5	4	2	**30**
Pulmonary Rehab	33	15	22	25	14	**109**
CRT+	7	3	9	5	5	**29**
Lothian Workers Support Services WSS/VR	19	12	15	22	19	**87**
Speech and Language Therapy	1	1	0	1	1	**4**
Dietetics	0	0	0	0	1	**1**
Neuro OT/PT	1	0	0	5	26	**32**
Physio at Home	3	3	1	3	0	**10**

HUBS	9	1	0	0	0	**10**
Multi-Disciplinary Team	0	1	0	1	0	**2**
TOTAL	**83**	**45**	**52**	**66**	**68**	**314**



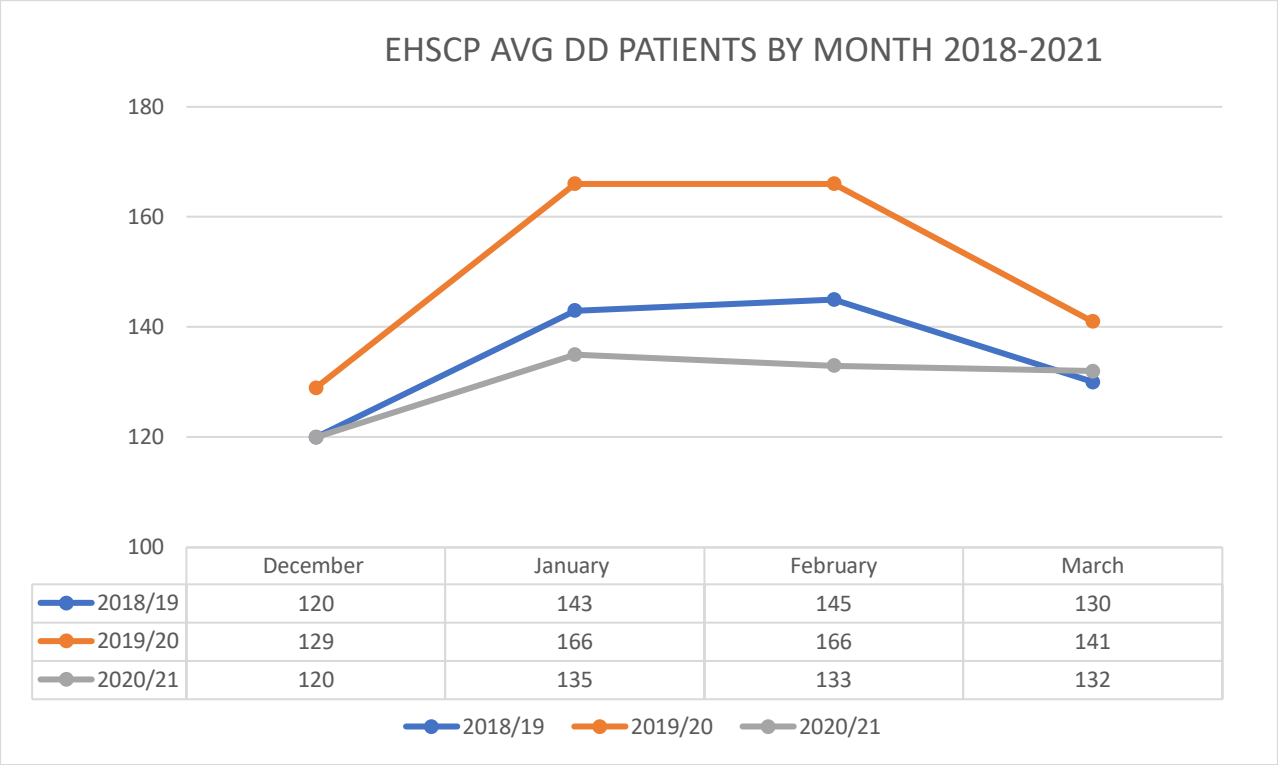
The chart above shows the majority of onward referrals (35%) were for pulmonary rehabilitation (plus an additional 9% to CRT+) with a smaller but similar number (28%) going to the Lothian Workers Support Services, meaning 63% of onward referrals were to two specific services.

The SPOA demonstrated the success of utilising a single pathway to access existing AHP rehabilitation services for patient suffering ongoing symptoms 'Post-COVID'. It is recognised, however, that these AHP services are experiencing a significant increase in referrals as a consequence, making the remobilisation of services challenging. The SPOA does not provide a comprehensive multidisciplinary model of patient centred care.

Collaboration and discussions are underway with key stakeholders across Lothian to explore feedback funding for a dedicated 'Long Covid' Service. Engagement with service users is also underway.

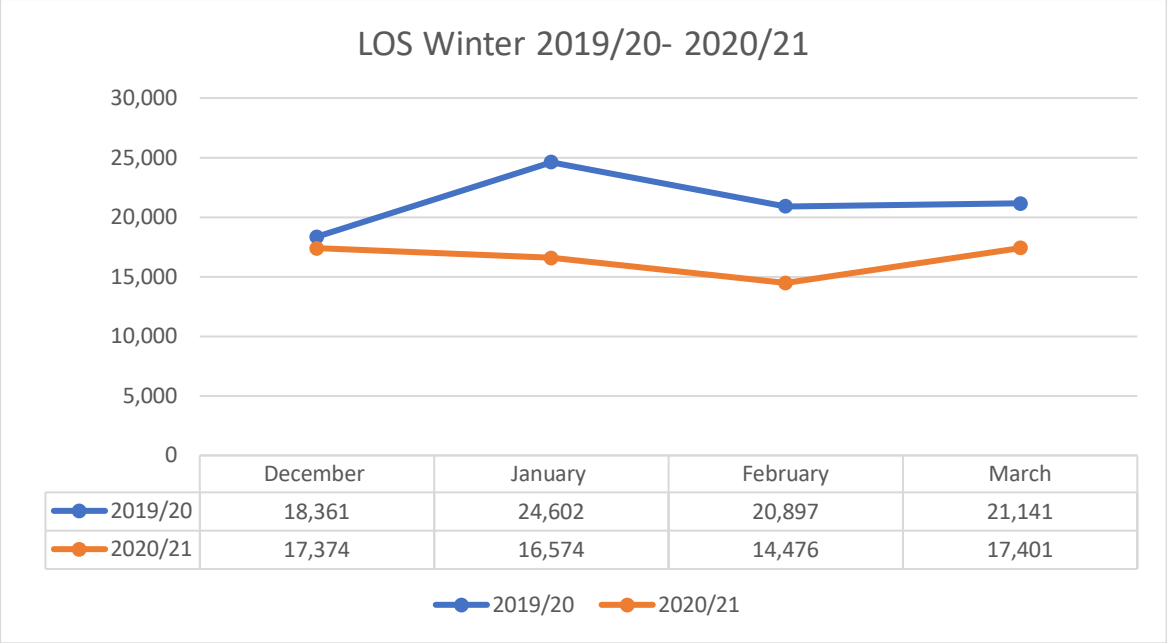
6. Overall Key Performance Indicators

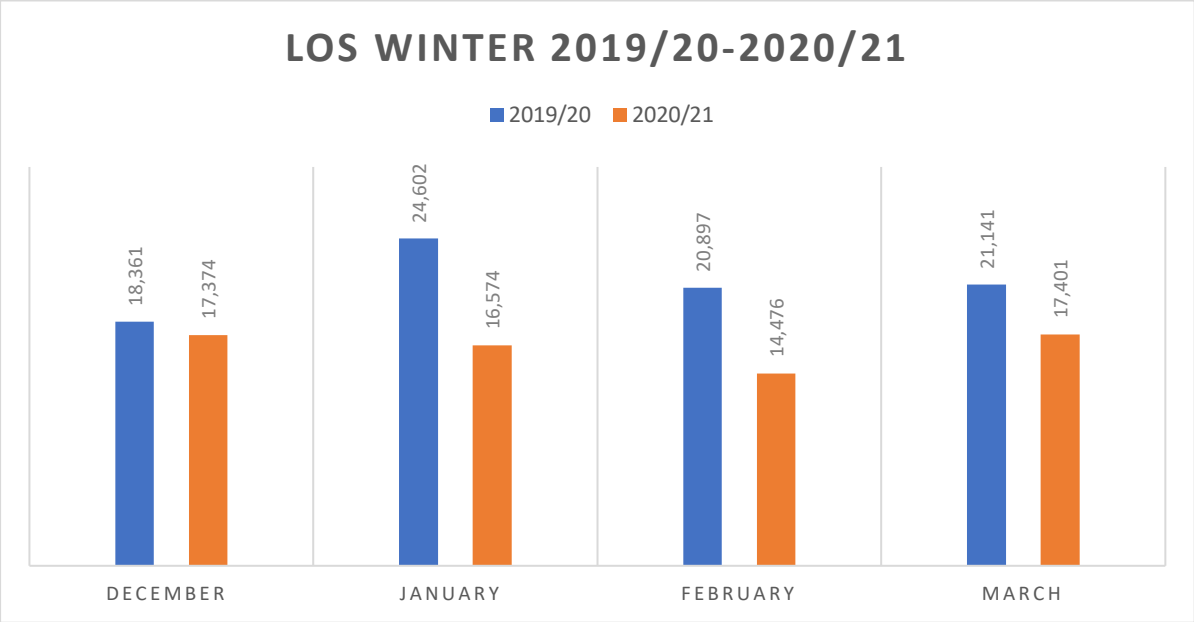
A comparison of delayed discharges by month across Edinburgh hospitals (RIE and WGH) December-March for 2018/19, 2019/20, 2020/21 is shown in the table below:



	December	January	February	March
2018/19	120	143	145	130
2019/20	129	166	166	141
2020/21	120	135	133	132

The two tables below show the LOS during winter months December to March - 2019/20-2020/21 across Edinburgh hospitals (RIE and WGH).


LOS Winter 2019/20- 2020/21
30,000
25,000
20,000
15,000
10,000
5,000
0
December January February March
2019/20 18,361 24,602 20,897 21,141
2020/21 17,374 16,574 14,476 17,401
2019/20
2020/21


LOS WINTER 2019/20-2020/21
2019/20
2020/21
18,361
17,374
24,602
16,574
20,897
14,476
21,141
17,401
DECEMBER
JANUARY
FEBRUARY
MARCH

2020/21 Winter Planning & Response Review (Local System)

Introduction

The 2020/21 Winter Planning and Response review aims to capture lessons identified through an assessment and evaluation of the following elements:

1. Local Health and Social Care winter planning and response arrangements at NHS Board / HSCP level.
2. Scottish Government, Health and Social Care Directorate, support, governance and assurance arrangements.
3. Role of the Winter Planning and Response Group (WPRG)

This short survey is focused on the first element and provides local systems at NHS Board / HSCP level with an opportunity to evaluate the effectiveness of their winter planning and response arrangements and to identify key areas for improvement ahead of next winter.

Local systems are asked to complete and lodge a copy of their local winter review using this template as a guide to inform that process. Local reviews should have senior joint sign-off reflecting local governance arrangements across NHS Boards and their associated Health and Social Care Partnerships. We expect that your Chairs and Chief Executives will be fully engaged in this year's review which should include:

- the named executive leading on winter across the local system who will coordinate and produce the local plan for 2021/22
- key learning points and planned actions which should be linked to the winter component of Board Remobilisation Plan's where appropriate
- top 5 local priorities that you intend to address through the 2021/22 winter planning process

Completed reviews should be sent to **Winter_Planning_Team_Mailbox@gov.scot** by no later than close of play on **Friday 21 May 2021.**

Thank you for your continuing support.

Winter Programme Team
Directorate for Performance & Delivery
Scottish Government

NHS Board:	NHS Lothian
Linked HSCP/s:	Edinburgh, West Lothian, East Lothian and Midlothian
Winter Executive Lead:	Alison MacDonald, Chief Officer, East Lothian Health and Social Care Partnership

1	**Risk Assessment and Business Continuity Planning (BCP)**
	Consider rigour of risk assessments, BCP testing and implementation, communication protocols across NHS Board and HSCP/s

1.1	**What went well?**
	•

1.2	**What could have gone better?**
	•

1.3	**Did you implement any learning points from the Health Board Support event around EU Exit and Concurrency Planning held in Sept 2020?**
	•

1.4	**Key lessons / Actions planned**
	•

2	**Alignment of services across the sector**
	Consider alignment and support between Acute Hospital, Primary and Social Care services, contribution to avoidance of unnecessary admissions, reducing length of stay, reducing attendances and optimising discharge.

2.1	What went well?
	• The CRT+ service ran from December 2020 to the end of March 2021 and offered community patients respiratory assessment, treatment and management from specialist physiotherapists embedded in CRT. The service enables GPs and secondary care to refer patients who have acute chest infections to be supported and managed by the team. The aim was to reduce the demand on GPs by CRT+ taking a lead role in the management of these patients, aiming to prevent admission to secondary care. CRT+ has also supported patients being discharged from hospital if an admission has been required. Sources of referrals were primarily GPs but also Secondary Care. During the service period, **23** referrals were received, **16** of these were deemed at risk of hospital admission **(70%).** The service successfully supported a prevention of admission of **100%** at 48 hours and **83%** at 7 days. • Phase 2 of the national Redesign of Urgent Care programmes aims to develop pathways that provide the right care in the right place at the right time, improving patient and professional experience and providing care closer to home to reduce hospital admissions. In Edinburgh HSCP, we developed new and strengthened existing pathways to provide a 4-hour response through the Flow Centre's single point of access. This response is for Home First (Urgent Therapy and Social Care), Hospital at Home and Respiratory pathways. In order to support the Home First Pathway and develop a prof to prof option for referrers, we are testing a Home First Navigator (OT) role in the Flow Centre. This allows for people most in need to be one the most appropriate pathway as quick as possible. • 4 WTE Therapists (2WTE Physiotherapists and 2WTE Occupational Therapists) were embedded within acute therapy teams in the RIE (Wards 104 and 202) and WGH (whole site) to enhance the adoption of the Home First principles and increase the number of people supported by D2A and other community teams. The aim was to support acute hospital staff planning a patient discharge. The therapists provided specialist advice on community therapy/resource options to support timely discharge. They promoted knowledge and confidence in positive risk taking with planning discharges and, together with the wider Home First team and acute staff, worked to enhance the Home First ethos within the acute setting. A total of **74** patients were supported on the WGH site, along with **13** supported home visits. **98** patients were supported on the RIE site, and the team undertook **6** supported home visits. The data shows, for both sites, for the **172** patients supported, **18%** had an adjustment to their LOS and **6%** had a reduction in LOS greater than 4 days. By the nature of supporting acute staff to support discharge planning it was an intended consequence that D2A referral activity would increase. • Promoting and supporting D2A teams resulted in a total of **843** referrals across Edinburgh during winter. The D2A north team had a **55%** increase in referrals compared to the previous winter. There was an increase in referrals for both teams of over **20%** during winter from the previous 18 weeks. • Part of the additional Social Work staffing resource funded by winter monies was used to provide support for rehabilitation needs in intermediate care facilities situated in 5 wards across two sites: Liberton Hospital and Findlay House (Fillieside). There were 24 funded beds within Fillieside and 40 funded beds in Liberton Hospital. Winter funding provided 1 WTE Home First Navigator to support earlier discharge planning. This post was filled for 12 weeks from 05/01/2021. A total of **47** patients were supported (28 at Liberton, 2 at Findlay House and 17 at Fillieside). Only **16%** of patients were readmitted to hospital within 6 weeks. There has been a **32%** reduction in occupied bed days.

2.2	What could have gone better?
	• A Hospital at Home (H@H) pilot pathway for the frail elderly was developed in conjunction with Scottish Ambulance Service and Medicine of the Elderly. The aim was to help avoid admission in a group that may have a poor experience within an acute care setting in addition to the risk of infection, deconditioning, loss of independence and high mortality. The pilot started in November 2020 for people in particular Edinburgh postcodes, however, the test saw limited success with only a small number of referrals generated.

2.3	Key lessons / Actions planned
	• The learning from the H@H pilot pathway allowed the H@H Team to focus on developing a prof to prof pathway from ED to H@H thereby increasing referrals to H@H and reducing the number of ED attendances converted to admissions

3	Demand and Capacity Planning
	Consider accuracy and limitations of demand and capacity projections used to inform planning assumptions around Elective, Unscheduled and Covid-19 activity, including the development of surge capacity

3.1	What went well?
	•

3.2	What could have gone better?
	•

3.3	Key lessons / Actions planned
	•

4	Testing Escalation and Surge Plans
	Consider effectiveness of testing escalation and surge plans based on anticipated Unscheduled and Covid-19, stakeholders involved in scenario testing, responsiveness of plans under actual pressure

4.1	What went well?
	•

4.2	What could have gone better?
	•

4.3	Did you implement any learning points from the Health Board Support event around Escalation and Surge Planning held in Oct 2020?
	•

4.4	Key lessons / Actions planned
	•

5	Staffing Levels
	Consider staffing levels across all partners to facilitate optimal and consistent discharge rates, particularly across weekends and holiday periods, wider resilience of staffing across departments, impact of critical gaps in Medical / Clinical / Nursing / AHP / Social Care / Support staff capacity.

5.1	What went well?
	• For the third year, a spreadsheet was developed mapping the annual leave arrangements during the 2-week festive period for all managers and team leads in the 4 localities, hospital and hosted services, and the Executive Management Team. This provided a quick reference tool for cover arrangements and points of contact in each service. Managers and Team Leads were also asked to provide assurance about the level of staffing in place throughout this period, particularly on the weekends and public holidays. • Local arrangements for managed annual leave plans ensured bank/agency staff were not being used to provide cover. • Social Work presence on both RIE and WGH sites to facilitate discharge planning, particularly with regards to the interim bed base, over the New Year public holidays and festive period weekends. Hub Managers were also available on-call. • The NE Locality Manager was on-call on 03/01/2021, providing an additional point of contact during the New Year weekend. • Chief Officer and Head of Operations attended Gold Command meetings • The Command Centre function was available for the escalation of any risks/issues • Staff sickness was lower this year due to the reduction in the usual winter illnesses, likely as a result of social distancing

5.2	What could have gone better?

	• Reablement Coordinators were funded to support 7-day discharge by providing cover at weekends. A decision was made to end the service due to its limited impact. Reduced delayed discharge numbers: 15 weekend discharges over 10 weekends across WGH/RIE for patients across the North and South of the city. On average this only reduced delay numbers by 1-2 a week across the whole of the city. There was no significant increase in weekend discharges with the additional staff in place. • There was a request to open 12 additional beds in Intermediate Care at Liberton Hospital earlier in the year in response to unscheduled care pressure in winter. 6 additional beds in the existing 3 wards were opened but to open the full 12 beds another ward had to be opened, giving a total of 10 additional beds in 4 wards. The only extra staffing was nursing – there were no additional AHP or medical staff. 4 substantive staff from Liberton and HBCCC were rostered to the additional ward and regular bank staff that worked within Liberton were allocated to Ward 3. Due to competing demands for staff from other partnerships and services it was deemed unsafe to continue to keep ward open. With the Chief Officer's approval, we reduced to the 6 again in the existing 3 wards.

5.3	Key lessons / Actions planned
	• It has been recognised that weekend discharges are a priority area for development in NHS Lothian. There will be a greater focus on weekend discharge as part of the Planned Date of Discharge (PDD) workstream this year.

6	Elective Activity
	Consider steps taken to maximise elective activity over winter (including protection of same day surgery capacity) in line with Remobilisation Plans and challenges experienced

6.1	What went well?
	•

6.2	What could have gone better?
	•

6.3	Key lessons / Actions planned
	•

7	Infection Prevention & Control (IPC)

	Consider IPC measures relating to Covid-19, Norovirus and Seasonal Influenza within acute, primary and community care settings, including any challenges around Personal Protective Equipment (PPE).

7.1	**What went well?**
	•

7.2	**What could have gone better?**
	•

7.3	**Did you implement any learning points from the Health Board Support event around PPE held in Sept 2020?**
	•

7.4	**Key lessons / Actions planned**
	•

8	**Vaccination Programmes**
	Consider logistical and clinical aspects of delivering Covid-19 and Seasonal Flu Vaccination Programmes to public and staff across Acute, Primary and Social Care settings over the winter period

8.1	**What went well?**
	•

8.2	**What could have gone better?**
	•

8.3	**Key lessons / Actions planned**
	•

9	**Test and Protect –** Wendy MacMillan
	Consider logistical and clinical aspects of delivering the Test and Protect Programme to public and staff across Acute, Primary and Social Care settings over the winter period

9.1	**What went well?**
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9.2	**What could have gone better?**
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9.3	**Key lessons / Actions planned**
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10	**Top Five Local Priorities for Winter Planning 2021/22**

10.1	**1. Enhance hospital based social work capacity to deliver on Planned Date of Discharge ambitions and eliminate Code 11 breaches.** **2. Enhance the Home Care Prevention Team realigned to localities to prevent hospital admissions where intermediate social care support is required** **3. Proactive identification of frequent attendees in each locality (via MATTs or equivalent) to offer assessment and support to frequent fallers, develop social care anticipatory care plans and identify any other opportunities to prevent ED presentations** **4. CRT+ if the business case for all year funding is unsuccessful** **5. Provision of Long-COVID Single Point of Contact and rehabilitation if ongoing funding is not successful**

Edinburgh Health Social Care Partnership
Winter Planning Submissions 2019/20

Title	Lead	Amount Requested	Amount Awarded	Amount Spent		NHS Spend	CEC Spend	Slippage
Home First Acute Site Therapy	Orla Prowse	£60,379.00	£60,379	£38,049		£25,962	£12,087	£22,330
Discharge to Assess Occupational Therapy	Gail James	£61,179.00	£61,179	£16,111			£16,111	£45,068
Hub Social Work	Steph Craig	£88,965.00	£88,965	£86,029			£86,029	£2,936
Reablement Coordinators	Vicki Murray	£29,211.00	£29,211	£9,248			£9,248	£19,963
CRT+ and Long-COVID SPOA	Laura Groom	£50,188.00	£50,188	£48,604		£48,604		£1,584
TOTAL		**£289,922.00**	£289,922	£198,041		£74,566	£123,475	£91,881
							Available	**£91,881.00**