Edinburgh Integration Joint Board

REPORT

Preparations for Winter 2021/22

Edinburgh Integration Joint Board

26 October 2021

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board with an update on preparations that are being made for Winter 2021/22. 1. Preparations for Winter 2021/22 are well underway and are aligned to wider Partnership planning around remobilisation and capacity planning in response to system pressures. Plans were presented and approved at a meeting of the NHS Lothian Performance Overview Board. 2. The methodology for allocating Scottish Government funding for winter pressures changed this year with the Partnership allocation being based on average percentage of funding received in the previous three years. EHSCP received an allocation of £171,000 for Winter 2021/22 which, along with slippage from previous years, is being used to enhance service capacity in key areas as outlined in paragraph 10 below. 3. Edinburgh HSCP allocated an additional £20,132 to other initiatives to improve outcomes for people with severe frailty and those who are at risk of falls through proactive anticipatory care planning, and to provide support for unpaid carers over the festive period. 4. John Burns, Chief Operating Officer for NHSScotland, wrote to NHS health boards on 21 July 2021 setting out requirements for the latest iteration of their Remobilisation Plan, known as RMP4. This included planning for Winter 2021/22 and requested that they should take account of the impact of winter and other seasonal factors likely to affect demand. It also indicated their intention to produce a separate Social Care Winter Preparedness Plan, details of which will be issued later in the year.

	5. Edinburgh HSCP (EHSCP) completed the Checklist for Winter Preparedness for 2021/22 for inclusion with the NHS Lothian remobilisation plan and this was submitted on 13 September 2021. 6. The EHSCP community mobilisation programme is proposing to fund the Community Taskforce Volunteer programme for the next three years, providing ad-hoc support and assistance with daily tasks for people who are elderly, may have underlying health conditions and/or are living in poverty/social isolation. Linking in with the Discharge Hubs this would reduce the risk of further deterioration and re-admission to hospital. 7. The annual flu vaccination programme started in September with the aim of having all eligible people vaccinated by 6 December 2021. The JCVI issued guidance on eligibility for COVID-19 booster vaccinations on 14 September 2021 and this programme is also underway with overall capacity to carry out 20,000 vaccinations a week.

Recommendations	It is recommended that the Edinburgh Integration Joint Board: 1. Note progress with the preparations being made for Winter 2021/22. 2. Accept this report as a source of reassurance that the Partnership has developed a robust winter strategy; taking on board learning from our evaluation of the previous winter campaign. 3. Note that the preparations for Winter 2021/22 are interlinked with other aligned workstreams such as the Redesign of Urgent Care, Home First, Partnership remobilisation plans, and capacity planning in response to system pressures.

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 26 October 2021.

Main Report

Background

2. Winter preparedness planning plays a key role in ensuring Health Boards and HSCPs are ready to meet the additional challenges likely to be faced over the winter months, and this has been amplified again this year by the ongoing COVID-19 pandemic. As lockdown ended and society started to open again the impact has been felt across the whole system through increasing demand and workforce pressures.

3. John Burns, Chief Operating Officer for NHSScotland, wrote to NHS health boards on 21 July 2021 setting out requirements for the latest iteration of their Remobilisation Plan, known as RMP4. This included planning for Winter 2021/22 and a self-assessment checklist which was to be completed and returned by 30 September 2021. It requested that their planning should take account of the impact of winter and other seasonal factors likely to affect demand including the need for COVID-19 booster vaccinations alongside the annual flu vaccination programme, and the potential for an upsurge in Respiratory Syncytial Virus (RSV) cases this winter. It also indicated their intention to produce a separate Social Care Winter Preparedness Plan, details of which will be issued later in the year.

4. The Partnership was approached and asked to complete the self-assessment for inclusion in the Lothian return, incorporating:

    - Resilience preparedness
    - Unscheduled/elective care preparedness
    - Out of hours preparedness
    - Norovirus outbreak control measures
    - COVID-19, RSV, seasonal Flu, staff protection and outbreak resourcing
    - Respiratory pathway, and
    - Integration of key partners/services

5. A copy of the completed Edinburgh HSCP Checklist of Winter Preparedness 2021/22 is attached in Appendix 1.

6. At a national level a review is being undertaken of the lessons learned during the previous winter which will inform the route forward over the next few months, building on what has been learned during the pandemic to shape the delivery of services during winter and beyond.

7. EHSCP Winter Planning Group leads on the planning, monitoring and evaluation of preparations for winter. It has multi-agency and pan-system representation, including acute sites, Social Care Direct, and leads for winter vaccination, carers, third sector, resilience, and communications with monthly meetings scheduled to run throughout the winter period.

Financial support for winter pressures

8. Over recent years, a number of different approaches have been used by NHS Lothian Unscheduled Care Committee to ensure best use of Scottish Government funding for winter pressures. This has generally involved submission of proposals from across the system with schemes being scored against criteria including:

    - Supports joint working between acute/HSCPs
    - Supports a Home First approach

- Facilitates 7-day working and discharging
- Site and community resilience/flow
- Admissions avoidance
- Supports a non bed-based model

9. This year however it was agreed that winter funding would be allocated to each area based on average percentage of funding received in the previous three years. This would give local areas autonomy to build more sustainable solutions to winter pressures. The outcome of this was that EHSCP received a total allocation of £171,000 for Winter 2021/22.

10. Allocation of this funding, along with slippage from previous years, has been based on previously identified priorities arising from the evaluation of Winter 2020/21, taking into account funding already set aside through Gold Command and the resultant gaps. An outline of the selected areas of work is given below:

Title	**Outline of proposal**	**Total funding (£)**
Hospital Social Worker Enhancement	4 Social Worker and 2 Senior Social Worker posts to ensure early intervention and responsiveness to the Home First model with assessments taking place earlier in the hospital patient pathway. To ensure early conversations with the person and carers/families to assist and influence the ready for discharge date (or PDD) or support discharge without delay. There will be social work cover for Saturdays and also public holidays over the festive period.	£129,373.00
Edinburgh Community Respiratory Hub CRT+	1 Advanced Physiotherapy Practitioner (APP) Physiotherapist and 2 Specialist Physiotherapist to support patients with respiratory conditions beyond COPD with assessment, treatment, and self-management of acute chest infections with a focus on prevention of hospital admissions.	£44,706.01

Facilitate early supported discharge for people with COVID-19 – a test of change	0.5 WTE APP Physiotherapist to allow early supported discharge of patients with COVID-19, monitoring respiratory symptoms and facilitating oxygen weaning (as appropriate) and discharge. Collaboration with secondary care clinicians where appropriate regarding the deteriorating patient.	£9,473.73
Assistant Practitioners Discharge to Assess teams	4 Assistant Practitioners will enhance D2A skill mix and increase capacity of the service to facilitate early hospital discharge as an alternative to bed-based rehabilitation/ provision of rehabilitation at home.	£46,664.00
Total		**£230,216.74**

11. Recruitment for each of these funded posts is underway. There have been significant recruitment challenges in previous years and efforts are being made to minimise the risks for Winter 2021/22:

- Discharge to Assess – It has been agreed that the four Assistant Practitioner posts will be recruited on a permanent basis, with Home First taking over funding from the end of March 2022. It's recognised that they add considerable value to the flow out of hospital and reducing length of stay. Making them permanent will also make them more attractive to prospective applicants.
- Acute hospital social work capacity - Recruitment to additional posts is underway. These posts will be recruited to on a permanent basis with ongoing funding being made available through the Partnership from the end of March 2022. Recruitment of experienced social work staff has proven exceptionally challenging in recent times and this will be a major risk for winter.
- Community Respiratory Team – Recruitment is underway. Should posts remain unfilled then internal secondments from Physio@Home and associated services will be considered, with posts being backfilled through

the Staffbank.

12. Additional funding has also been made available through the Partnership to improve outcomes for people with severe frailty and those who are at risk of falls through proactive anticipatory care planning, and to provide support for unpaid carers for whom the festive period can be particularly difficult.

Title	Outline of proposal	Allocation
Improving outcomes for people at risk of falls	Proactive identification of people who have fallen, are at risk of further falls and who have not had a multifactorial falls assessment in the previous six months. Offer a multifactorial falls assessment and share key information through ACP to inform shared decision making and reduce emergency department presentation/admission.	£12,000
Improving outcomes for people with severe frailty through ACP	Proactive identification through the development of a NE frailty register of people with no to mild cognitive impairment, provide an Anticipatory Care Plan-Key Information Summary (ACP-KIS) with core quality criteria including information on power of attorney.	£5,332
Surviving Christmas – providing support for unpaid carers	Support for approximately 70 unpaid carers through a series of emotional support groups, drop-in sessions, short-break visits to local attractions, and recreational activities. It can also be a busy time for calls to the office and VOCAL will contribute to the cost of staffing during this time including a SMART recovery group meeting, activities, support and refreshments.	£2,800
Total		**£20,132**

13. In August 2021, NHS Lothian Unscheduled Care Committee requested an update on how allocated funds were being used and how the investment would increase winter capacity (Appendix 2). Partnership plans were subsequently

presented and approved at a meeting of the NHS Lothian Performance Oversight Board. Additional funding may be available to support surplus bids contingent on the outcome of discussions at the Unscheduled Care Committee meeting on 1 October 2021.

Reducing delayed discharges

14. Much has been done in EHSCP in recent years to improve patient flow and increase capacity for home care with delayed discharges falling below the national average for the first time in November 2020. The success of the COVID-19 vaccination programme has resulted in a weaker link between infection and severe illness or hospital admission; however the easing of lockdown means we are experiencing an increase in demand across the entire health and social care system. This is making it difficult to maintain that improved delayed discharge position and is complicated further by workforce pressure caused by staff absence as a result of COVID-19 infection and the need to self-isolate, and difficulties in recruiting to key areas such as Care at Home. How to best balance these demands while continuing to provide the required level of care is being considered at a Partnership level and preparations for Winter 2021/22 are being aligned to support that effort.

15. The Home First model continues to ensure assessment for longer-term care and support is undertaken in the most appropriate setting and at the right time for the individual:

- The onsite presence of Home First Navigators at the RIE and WGH, working as part of the multi-disciplinary team with the Emergency Department, Medical Assessment Unit and wards to support point of access, reduce unnecessary hospital admissions and delays.
- Additional social work (SW) capacity has also allocated for RIE and WGH as well as Intermediate Care to support moves from these facilities and create flow from acute beds by utilising community assets.
- Tests of change are currently underway at the WGH and in intermediate care to begin the rollout of Planned Date of Discharge (PDD) or support

discharge without delay, and a further plan for the RIE. Key benefits of setting a PDD are:

I. for improvement work to identify blockages and improve flow
II. provide a useful target for the MDT to work towards
III. improve working relationships between team members
IV. help keep patient and their family or carers fully informed and improve patient satisfaction

16. A test of change is currently under development within the NW locality in partnership with the WGH. This is primarily aimed at collectively ensuring that packages of care are appropriately prescribed given the current system pressures so that care can be prioritised for those who need it the most. It is anticipated that collaborative, informed and measured risk taking and early conversations with patients, families and carers will manage expectations at an early stage. The MDT planning will also involve members of the ATEC24/tech team who will provide support to consider digital options to enhance or reduce care requirements to support early discharge and reduce length of stay. This test of change is at the planning stage, anticipated to begin in early October.

17. The Partnership has been invited to participate in a nationally-funded Pathfinder Programme – Discharge without Delay – which will augment the PDD work and enable us to develop integrated discharge hubs to facilitate this.

18. Acute hospital SW capacity will be enhanced with the creation of four social worker and two senior social worker posts to support the Home First model of care, deliver on PDD or support discharge without delay ambitions and reduce Code 11 breaches.

- The aim for Winter 2021/22 will be to reduce Code 11B delayed discharges by 90%, an improvement on the 58% reduction achieved during 2020/21, and reduce length of stay.
- The increased capacity will enable the team to handle an additional 80 cases per month, provide cover for bank holidays and Saturdays over the winter period, and build better relationships with acute hospital staff.

19. There will be a prompt allocation of all social work assessments and completion within 72 hours, engaging with the individual, carers and/or families to assist and influence the ready for discharge date (or PDD) or support discharge without delay. It is anticipated that this early intervention will also reduce the numbers being discharged to a care home setting.

20. The Discharge to Assess pathway and service are being fully utilised to create an alternative pathway to admission. We are increasing capacity for home-based rehabilitation which will impact on whole system flow and increase the number of discharges by an estimated 56 to 72 cases per month. Therapy capacity will be increased at a time of peak demand with the addition of four Assistant Practitioner posts aligned to each locality. This will enhance the skill mix within the service, enabling therapists to delegate key tasks, achieve a greater focus on complexity and intensity of rehabilitation, and facilitate early discharge from hospital.

21. Early supported discharge of people with COVID-19 from wards 203/204 at the RIE will be facilitated by the Community Respiratory Team (CRT) with monitoring of respiratory symptoms and oxygen weaning, if appropriate, at home. Collaboration with secondary care clinicians when appropriate regarding the deteriorating patient. This test of change is running from July to December 2021 with current data indicating a reduction in length of stay with two bed days saved per case. Potential expansion of this pathway is being considered for the WGH site as a whole.

22. The District Nurse In-reach Team is being expanded to include Hospital to Home, with the recruitment of 20 community clinical support workers and a team leader. The focus will be on facilitating the early supported discharge of people requiring care at home with previous evaluation suggesting occupied bed days could be reduced by 150 to 200 a month.

23. Hub therapy weekend working will be re-established in November 2021 and SW on Saturdays which will increase the number of end of working week discharges from acute sites. There will also be SW cover on public holidays

over the festive period. There is a low level of system wide discharge at the weekends but the Lothian-wide PDD workstream will drive improvements in performance as it rolls out.

24. Provision of care packages remains an ongoing challenge as the sector continues to struggle with the impact of COVID-19 and the EU Exit on recruitment and retention of staff. To mitigate some of the challenges and pressures EHSCP is working in close partnership with providers and other wider groups of stakeholders to support, at a minimum, stability in the market and the existing capacity that they deliver.

- A campaign to promote employment opportunities in Edinburgh across the health and social care sector will run through to January/February 2022 at a minimum, providing an understanding of the rewards of the career, skills, values and attributes required and linking to current vacancies.
- Additional community care assistants, one WTE each for SE, SW and NW localities, replicating the successful “unmet needs officer” role piloted in NE Edinburgh. This role delivered a significant reduction in unmet need and hospital delays through a single point of contact, and pro-active approach to building of relationships with providers, assessors, other health professionals and people waiting for support. The aim being to come to practical solutions to enable support to be put in place rapidly where previously there were barriers indicated.
- Tracking hospital admissions where care arrangements exist and ensuring that these are re-started at earliest point of fitness to discharge, or where no discharge planning is in place to free up the capacity to match to another individual to support discharge home or prevention of admission.

25. A Care at Home Action Plan is currently being finalised that outlines how the Partnership will prioritise resources, release capacity from existing resource and optimise performance. This includes a new process implemented to increase collaborative working between all organisations delivering support. This will maximise efficiencies that can be delivered through more joined up

approaches to use of existing workforce, increasing the number of individuals who can be supported to remain at home through provision of appropriate support arrangements.

Reducing avoidable admissions and re-admissions

26. Work is ongoing under Phase 2 of the Redesign of Urgent Care (RUC) to redirect appropriate community pathways through the Flow Centre. There has been refinement to pathways to support prevention of admission through Home First, Hospital at Home and the CRT. Pathways have also been established for SAS direct to Hospital at Home, ED direct to Hospital at Home, and the SAS Falls Pathway to direct people not conveyed to hospital to locality hubs for an urgent falls assessment within 24- hours.

27. Hospital at Home takes referrals from SAS crews to prevent the need to transport to hospital, avoiding unnecessary admissions. They have also enhanced weekend referrals to the service by taking GP referrals from care homes.

28. These pathways and services are bedding in and demonstrating increasing success and it is anticipated that they will help avoid admissions for the aging patient with underlying frailty, and co-morbidity, in addition to those with a risk of infection, deconditioning and loss of independence.

29. Resource has been obtained from Health Improvement Scotland and RUC for additional posts in Hospital at Home, the Flow Centre, Home First Team and the Community Respiratory Team which will provide increased capacity and support.

30. An enhanced Community Respiratory Team will again lead on the community-based management of individuals with COPD or acute respiratory illness with the aim of preventing unnecessary admissions to hospital and easing pressure on general practice. The Community Respiratory Team operates an on-call weekend service, including public holidays. This includes the 90-minute response pathway in place for individuals with COPD exacerbations referred

from the SAS and the Flow Centre. The additional service capacity being put in place will enable management of between 40 and 50 new cases over the winter period.

31. The Long Term Conditions Programme has worked with health & social care professionals and third sector organisations to improve anticipatory care planning (ACP) conversations and models for sharing/accessing information across the integrated system. There are now 259,301 active Key Information Summaries in place for people in Edinburgh, which is a 287% increase since March 2020.

32. COVID-19 ACP bundles with educational guidance, information for citizens, and resources for sharing/accessing ACP quality criteria have been developed for health and social care professionals, GP practice teams, care homes and third sector partners. The care home ACP toolkit has been shared nationally and supports open and honest discussions with residents and their families about their health and wellbeing and wishes for the future, putting the resident at the centre of decisions about their health.

33. During winter 2021-22 a model will be tested to proactively identify people at risk of falls using locality Boxi reports and develop an ACP bundle with falls prevention and management information; and with social workers to improve the quality of social care information shared for people with severe frailty, including Power of Attorney arrangements. Both tests of change aim to decrease avoidable admissions and delayed discharges from hospital through ACP.

34. A Lothian-wide short life working group has been established to focus on person-centred care planning that reduces presentations of people to emergency departments at point of crisis. The top ten ‘Frequent Attenders’ have been identified in Edinburgh with analysis undertaken to profile of these individuals and plan care and support to reduce emergency attendances. A mental health focused workstream within the Home First programme is being established to take this work forward.

Supporting people to remain at home

35. The first phase of a bed-based review for residential care in Edinburgh was recently approved by the IJB including plans to increase intermediate care capacity, the phased reduction of hospital-based complex clinical care capacity and investing in nursing provision within care homes. This modernisation will further allow people to be cared for in the most appropriate setting for the needs they have, helping them stay independent at home or in a homely setting for as long as possible.

36. The festive period can be a trying time for many unpaid carers so VOCAL is being funded to provide support for approximately 70 unpaid carers this year. It will offer a range of emotional support group and drop-in sessions, recreational events and short-break respite visits to local attractions. Although the 'open days' at VOCAL carers hub between Christmas and New Year are generally not well attended (VOCAL usually closes to the public during this period), for those who do attend, it can provide a lifeline. It can also be a busy time for calls to the office and VOCAL will contribute to the cost of staffing during this time including a SMART recovery group meeting, activities, support and refreshments. The programme will include socially distanced support, allowing carers who wish it an opportunity to have a break outside their home, as well as online support for those who prefer to isolate. It has been designed flexibly and will be delivered in an online format should physical events become unfeasible.

37. EHSCP community mobilisation programme is proposing to fund the Community Taskforce Volunteers (CTV) programme organised by Volunteer Edinburgh for three years. This was set up in April 2020 following the Scottish Government's Ready Scotland volunteers appeal in response to the COVID-19 pandemic but developed with the expectation that the help of volunteers would be needed beyond the immediate lockdown period and could potentially be developed to provide on-going ad-hoc support to some of the most vulnerable people in Edinburgh, particularly those with no familial or neighbour support. Recipients are generally older people, tend to have underlying health conditions

and/or are experiencing poverty and social isolation. A number have been identified as needing more and/or specialist support and have therefore been signposted to appropriate statutory services. The project benefits people who are unknown to services or at risk of falling through gaps in provision. The support needed is very simple and can be temporary, perhaps as a result of illness or hospital discharge, but without these needs being met could lead to further deterioration:

- Referrals for support can come direct from the individual themselves, from family members (often where the family is geographically distant), Social Care Direct, front line healthcare professionals, and other statutory and third sector partners. Links are being made to the discharge hubs to ensure any additional support which might be beneficial can be put in place prior to a person leaving hospital with the aim of reducing the risk of re-admission.
- Volunteers may provide support with dog-walking, collection/delivery of prescriptions, gardening, waste/recycling and a variety of other one-off tasks. Working with NHS Lothian Audiology, they also collected and returned over 500 repaired hearing aids directly to people's homes, reducing waiting times for people with hearing impairment.
- During Winter 2020, volunteers provided essential support to Flu vaccination clinics across the city and later also the COVID-19 vaccination clinics.
- To date only weekday support has been provided but Volunteer Edinburgh is exploring also extending this to weekends in future.

38. We are in conversation with EVOC and will consider any other initiatives with the potential to support EHSCP capacity planning in response to system pressures.

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

Ensuring business continuity

40. Partnership resilience plans are in place for all essential/critical services, and in the process of being reviewed and updated ahead of winter. Plans document the risks and impact of service disruption and consider the resources required to maintain key services in the event of a resilience event. The Partnership is currently looking to create integrated resilience plans as NHS and Council services are documented differently.

41. The Partnership Resilience Team review the severe weather plan annually as part of a formal review, with reviews undertaken as part of any severe weather incidents to ensure any lessons learned are captured in future iterations of the plan. A severe weather group was set up in 2019 focussing specifically on winter weather-related incidents.

42. Both NHS Lothian and City of Edinburgh Council have procedures in place for what staff should do in the event of severe weather or other issues hindering access to work. The Partnership also ensures that any key communications relating to accessing travel are cascaded through the management line or via colleague news.

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

Coping with periods of peak demand across the system

44. Additional capacity has been created in Social Work, Discharge to Assess, and CRT+ to support areas where peak demand is expected over winter.

45. In primary care, Community Treatment and Care (CTAC) staff can be mobilised if required to do home visits, freeing up district nurse and GP capacity. This was used during lockdown and worked well.
46. We receive regular updates from NHS Lothian Public Health and Infection Prevention and Control teams enabling the Partnership to target activity in response to any surge in flu activity or local outbreaks of Norovirus.
47. The Partnership is in the process of reviewing how any excess capacity in internal care homes might be used to best effect over winter. We are working closely with other providers to secure additional interim care beds to support the Intermediate Care pathway and flow from acute hospital beds, with 26 beds sourced through Northcare.

Ongoing management of COVID-19 and implications for Winter 2021/22

48. As the response to COVID-19 is now being managed in a more planned way, the command centre has been stood down. An Operational Oversight Group was stood up in its place in Summer 2021 and was changed to focus on system pressures highlighting the fluid and dynamic nature of the operational response at this time. This arrangement will be kept under review.
49. COVID-19 guidance is updated regularly and will be monitored and implemented through all appropriate operational and planning for a on an ongoing basis.
50. The Partnership has worked closely with all care home managers to ensure visiting plans are robust, thoroughly risk assessed and that support is available from our RRT and Care Home Support Team to ensure effective infection control measures are in place and homes remain open to both visits and admissions.

Winter vaccination programme

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

absence. This is even more important given the experiences of the past 18-months and imperative that we continue to reduce the risk of flu and COVID-19 on those who are most vulnerable in our communities.

52. The Chief Medical Officer issued a letter to NHS Boards, Integration Authorities and Local Authorities on 26 March 2021 (Appendix 3) outlining arrangements for the 2021/22 adult seasonal flu programme and the childhood and school programme on 3 June 2021 (Appendix 4).

53. In addition to existing eligible groups this has been extended to offer vaccination to:

- Independent contractors such as GP, dental and optometry practices, and community pharmacies
- Teachers and pupil-facing support staff
- Prison population and prison officers delivering direct detention services
- All secondary school pupils, and
- All those between 50 and 64 years of age.

54. The vaccination transformation programme in Scotland means that responsibility for delivering vaccines has moved from GPs and now sits with health and social care partnerships. Edinburgh HSCP took responsibility for the 2020/21 programme but most other health and social care partnerships are taking responsibility for the first time this year.

55. The programme started in September 2021 with the aim of having all eligible people vaccinated by 6 December 2021 although there will still be opportunities into early 2022. To maximise flexibility, 11 vaccination sites have been set up across the city along with two drive-through sites at Edinburgh Bioquarter and the Scottish Government building at Victoria Quay. The main mass site will be at Ingliston Lowland Hall. There is capacity within the city clinics to vaccinate 200,000 people. This averages 20,000 appointments being available each week. The Partnership has had to adopt the national service appointment system this year but will flex as much as possible to ensure access for

vulnerable groups who cannot make the appointment site they have been scheduled to attend.

- Over 75s and those who are immunocompromised will receive a letter with appointment details.
- Frontline health and social care staff will be able to self-register and book online, providing flexibility around work commitments. There are also a number of peer vaccinators (nursing staff) who are able to administer the vaccination to any staff, regardless of whether they are employed by the NHS or City of Edinburgh Council, within their teams.
- Teachers and children of school age will be vaccinated through the community vaccination team. Home-schooled pupils will be contacted and invited to make an appointment with the team.
- Children's Services across Lothian will start to vaccinate children aged between six months and two years old who are identified as 'at risk'. All two to five year olds will be offered vaccination.
  The rest of the adult population over 50 years of age will be contacted by letter inviting them to self-register and book online.
- Pregnant women may also receive their vaccination through maternity services
- Vaccinations for the housebound and care home residents are being carried out by the Primary Care Treatment and Care Nurses (CTAC) supplemented by bank Home Visit team and district nursing teams in the city.

56. Delivery of the remainder of the COVID-19 first and second dose vaccination programme is being continued through existing walk-in clinics. Additional mobile clinics visited Napier University and Edinburgh College sites in September.

57. 12 to 15 year olds are now also eligible for vaccination and able to attend one of the walk-in clinics, and there was also a mobile clinic at Fort Kinnaird in September for this group.

58. The Joint Committee on Vaccination and Immunisation (JCVI) issued guidance on booster doses of the COVID-19 vaccination for specific groups on 14 September 2021. This includes:
    - Those living in residential care homes for older adults
    - All adults aged 50 years or over
    - Frontline health and social care workers
    - All those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe COVID-19 and adult carers, and
    - Adult household contacts (aged 16 or over) of immunosuppressed individuals
59. Those who are aged 70 or over or were previously on the shielding list will receive a vaccination invitation by letter. Frontline health and social care workers will be able to book online. These groups may be able to have both flu and booster vaccinations at the same appointment to make best use of clinic time and minimise disruption. Other eligible groups will be able to book through the online portal. COVID-19 boosters can only be given if six months have elapsed since the second vaccination was received.

Communications

60. As a Partnership, we will promote preventative or operational messages around seven key topics; winter resilience messages and arrangements, winter vaccination programme, falls prevention, hospital avoidance/signposting, anticipatory care planning, keeping safe and healthy over winter, and support and advice for carers.

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

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

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

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

65. We will work closely with the City of Edinburgh Council communications team on resilience messaging around severe weather etc to ensure we more effectively reach people in Edinburgh with time critical messages.

66. Responsibility for communications around the flu vaccination programme now also rests with the Partnership although there will be Scottish Government campaign promoting them. Public Health Scotland has also prepared a range of materials explaining the benefits aimed at the different audiences and in a wide variety of languages. We will amplify the Scottish Government campaign on our social media channels and support GPs in their messaging on their websites and social media in addition to making staff aware of the local programme.

Implications for Edinburgh Integration Joint Board

Financial

67. EHSCP has received an allocation of £171,000 of Scottish Government funding for winter pressures and this was combined with slippage from previous winter campaigns.

68. A total of £230,216.74 was allocated to the four priority areas as outlined earlier in this report. An additional £20,132 has been made available by the

Partnership to support unpaid carers over the festive period and proactive anticipatory care planning for people with severe frailty and those who are at risk of falls

Legal / risk implications

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

70. Ability to recruit to social work posts as a result of competitive packages being offered by neighbouring organisations.

71. Delays across the Partnership in the procurement of laptops for new staff as a result of global shortages computer chips may influence their ability to carry out duties.

Equality and integrated impact assessment

72. 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.

73. Local residents will continue to benefit from the provision of person-centred care, with improved access to services in a timely manner and providing care closer to home. Admission to hospital will be avoided wherever possible and the quality of discharge and home care support will be enhanced. Additional support being put in place through VOCAL will reduce social isolation and increase the resilience of unpaid carers at what can be a difficult time of year.

74. Communication with groups for whom English is not their first language was highlighted as some communities are disproportionately affected by COVID-19. We are taking this on board and looking at how to strengthen communication plans. Public Health Scotland has also prepared a range of materials explaining the benefits aimed at the different audiences and in a wide variety of languages.

Environment and sustainability impacts

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

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

77. Improving infection control through care management at home.

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

79. There is the potential for the impact of severe weather and service disruption to be minimised with priority road clearance and gritting, access to emergency food supplies as required.

Quality of care

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

81. Experience from previous years leads us to anticipate enhanced challenges to flow due to staff absence, influenza and norovirus. Failure to achieve the delayed discharge trajectories will impact on system wide flow but will be rigorously monitored.

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

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

Consultation

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

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

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

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Background Reports

None.

Appendices

Appendix 1	Preparing for Winter 2021/22: Supplementary Checklist of Winter Preparedness Self-Assessment
Appendix 2	Edinburgh HSCP Allocation of Winter Funding 2021/22
Appendix 3	SGHD/CMO(2021)7 Adult Flu Immunisation Programme 2021/22
Appendix 4	SGHD/CMO(2021)14 Scottish Childhood and School Flu Programme 2021/22

Preparing for Winter 2021/22: Supplementary Checklist of Winter Preparedness: Self-Assessment

Priorities

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

These checklists supplement the narrative and deliverables identified in your RMP4 and support the strategic priorities for improvement identified by local systems from their review of last winter's pressures and performance and experiences of managing Covid -19.

Your winter preparedness assessment should cover systems, processes and plans which take into account the potential impacts of COVID-19, Respiratory Syncytial Virus (RSV), seasonal flu, other respiratory conditions and severe weather impacts. Plans should recognise that some of these events may occur concurrently and should take into account system wide impacts. Plans should also reflect a strategic as well as operational approach to maintain service resilience and business continuity.

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 National 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	NHS Board and Health and Social Care Partnerships (HSCPs) have clearly identified all potential disruptive risks to service delivery and have developed robust Business Continuity (BC) plans to mitigate these risks. Specific risks include the impact of Respiratory Infections (e.g. Covid, RSV, Seasonal Flu) on service capacity, severe weather and staff absence. Business continuity arrangements have built on lessons identified 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 preparedness to ensure that business continuity management principles are embedded in Remobilisation / Annual Operating Plans as part of all-year-round capacity and service continuity planning *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.* This guidance Preparing for Emergencies Guidance*sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☐ ☐		The Partnership has a designed Resilience Lead and Co-ordinator who regularly link with both Council and NHSL resilience teams in a resilience event. The Partnership Resilience Team review the severe weather plan annually as part of a formal review, with reviews undertaken as part of any severe weather incidents to ensure any lessons learned are captured in future iterations of the plan (eg this year the resilience teams will work with CEC Transport and Roads colleagues to ensure optimal use of existing resources. In addition, additional seasonal resources such as hired 4x4s will be brought in at an earlier stage). There are several groups that manage/co-ordinate resilience activity included the Resilience Steering Group, Resilience Committee which includes a cross-section of the Partnership and focus on resilience events. Alongside this, a severe weather group was set up in 2019, and

				include a range of key stakeholders. This group specifically focuses on winter weather-related incidents. As the response to COVID19 is now being managed in a more planned way, the command centre has been stood down, however an Operational Oversight Group was stood up in its place in Summer 2021 and was changed to focus on system pressures highlighting the fluid and dynamic nature of the operational response at this time. This arrangement will be kept under review. The Partnership are currently in the process of updating their resilience plans and Business Impact Assessments and aim to be completed by early October. The plans cover the arrangements for services to maintain their service in the event of a resilience event (eg loss of building, loss of IT etc). The Partnership are currently looking to create integrated resilience plans as currently the Council and NHSL have difference ways of documenting their approach to a resilience event.

				The Resilience Steering Group also discuss a range of potential resilience related activity that could affect service deliver (eg EU Exit, COP26) and agree / discuss mitigation strategies
2	BC plans take into account all critical activities across the NHS Board / HSCPs spectrum of activity and include analysis of the risks of disruption and their actual effects and demonstrate that planning has been based upon the likelihood and impact of worst case scenarios. Risk assessments take into account staff absences including those likely to be caused by a range of scenarios and are linked to a business impact analysis to ensure that essential staff are in place to maintain key services. All critical activities and actions required to maintain them are included on the corporate risk register and are actively monitored by the risk owner. The Health Board and HSC partnership have robust arrangements in place to support mutual aid between local / regional partners in respect of the risks and impacts identified	☐ ☐ ☐		Partnership Resilience Plans cover all essential / critical services and document the risks and impact of service disruption and considers the resources needed to maintain key services in an emergency and appropriate risk assessment have been undertaken. The Partnership have also tested their call trees in terms of how long it would take key staff to arrive on site to allow planning to determine minimum number of staff that could be available in a resilience situation. The Partnership resilience lead / co-ordinator is linked into the relevant Council and NHS Lothian resilience groups.
3	The NHS Board and HSCPs have appropriate policies in place to cover issues such as : • what staff should do in the event of severe weather or other issues hindering	☐		Both CEC and NHS Lothian have appropriate procedures in place which are held on the orb /intranet. The procedures are

	access to work, and • arrangements to effectively communicate information on appropriate travel and other advice 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.*			regularly communicated with staff about what they should do in the event of adverse weather/ access to work. The Partnership also ensures that any key communications relating to accessing travel arrangements are cascaded through the management line (eg bus strike) or via colleague news.
4	NHS Board/HSCPs websites will be used to advise patients on any changes to service access arrangements or cancellations of clinics / outpatient services due to severe weather, reduced staffing levels etc,	☐		There are communication plans in place and in the event of severe weather impacting on service delivery, access to services, the Partnership website as well as NHS Lothian and CEC would be updated accordingly. The Partnership would also utilise relevant twitter accounts to communicate any issues.
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.

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 and visibility of other key performance indicators *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 and communication processes are in place within EHSCP including regular Executive Management Team meetings and Senior Operational Team meetings.
1.2	Effective communication protocols are in place between clinical departments and senior managers across the whole system, 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 with key actions and timescales assigned to individuals.	☐		Daily tele- or video conferences will be scheduled if there are significant pressures across the system. Individual services have systems in place for daily communication and escalation of pressures or issues, for example via daily huddles. From these actions are identified and followed up.
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.	☐		Not applicable – NHS Lothian to complete

	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, with PDDs (planned dates of discharge) visible and worked towards, to ensure patients are discharged without delay.*			
1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☐		Care Home admissions are managed centrally matched to available capacity and information 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. Senior Mgt is in regular contact with the AAH Discharge Hub throughout the day especially over winter and has knowledge/early sight of any specific issues in community hospitals which could impact on flow and assist the team in finding solutions. There are no plans to increase the capacity in Liberton Hospital over winter. Any escalations will be via Head of Operations to the EMT/Chief Officer. The Partnership is in the process

				of reviewing how any excess capacity in internal care homes might be utilised to the best effect over winter, and working closely with other providers to secure additional interim care placements should the need arise
2	**Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID-19 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.* *Plans in place for the delivery of safe and segregated COVID-19 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-19 surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*	☐		Not applicable – NHS Lothian to complete

2.2	Pre-planning created pathways which provide an alternative to admission, and optimised the use of inpatient capacity for the delivery of emergency and elective treatment, including identification of winter / COVID-19 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*	☐		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

	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.			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.
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 hospital 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 viable appointments / timeslots at A&E services. The impact on health-inequalities and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.			Not applicable – NHS Lothian to complete (under the Redesign of Urgent Care workstream)
	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 continuing and ongoing as part of the Redesign of Urgent Care Phase 2 workstream to redirect appropriate community pathways through the Flow Centre . There has been refinement to Urgent Care pathways via the Flow Centre to support Prevention of Admission (Home First, Hospital at Home and the Community Respiratory Team).

				There have been additional pathways established including that from SAS direct to Hospital and Home, ED direct to Hospital at Home, and the SAS Falls Pathway. Hospital at Home takes referrals from SAS crews to prevent transporting to hospital and therefore avoiding admission. They have also enhanced weekend referrals to the service by taking GP referrals from care homes. Additional resource has been sourced and obtained from HIS and RUC for additional posts in Hospital at Home, the Flow Centre Home First Team and the Community Respiratory Team which will provide increased capacity and support. Development of a frailty nurse post in the Flow Centre to redirect admissions to hospital at home and rapid assessment.
4	**Optimise patient flow by proactively managing Discharge Process utilising PDD (Planned Date of Discharge) and associated discharge planning tools such as – Daily Dynamic Discharge, to shift the discharge curve to the left and optimise in day capacity, 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.*	☐		Onsite presence of Home First Navigators on both RIE and WGH acute sites with ED/MAU and wards working as part of the MDT to support POA. Home First Navigator working within discharge hub in WGH to manage people on acute medical wards. Discharge to Assess pathway and service fully utilised to create an alternative pathway to admission. Tests of change currently underway to begin the roll out of PDD in WGH (Wd 51) and ICF (Fillieside) with a further plan for the RIE site. PDD approach is heavily invested in the involvement of the patient and family/carer. Additional SW resource allocated for WGH and RIE sites as well as ICF to promote the Home First approach and early supported discharged maximising community assets.
4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over	☐		Hub therapy weekend working will re-convene in November (Sat and Sun) and Social Work (SW) on

	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.*			Saturdays. There will also be public holiday SW cover over the festive period for acute sites. SWs will work closely with the D/C hubs. There is a low level of system wide discharge at weekends. The Lothian wide PDD work stream will drive improvements in performance as it rolls out. CRT operates a 7 day service as routine
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.*	☐		Provision of care packages in Edinburgh is an ongoing challenge, in keeping with the trends across much of the Health and Social Care sector. The sector as a whole continues to struggle with the impact of COVID and Brexit on the available workforce and this is evidenced by the increasing levels of unmet need in the community and hospital delays. To mitigate some of the challenges and pressures EHSCP are working in close partnership with providers of these support services, and other wider groups of stakeholders to support at a minimum stability in the market and the existing capacity that they deliver. Measures currently being implemented to support and hopefully improve the situation are: • EHSCP funded and led campaign to promote employment opportunities in Edinburgh across the Health

				and Social Care sector targeted to start end Sept/early Oct and run through to Jan/Feb at a minimum. A landing page on EHSCP website will provide an understanding of what working in Health and Social Care means, rewards of the career, skills, values and attributes required and linking to roles organisations advertise through My Job Scotland. . • Additional CCA resources in post - 1WTE each for SE/SW/NW localities to start in Oct. This will replicate the successful “unmet need officer” role piloted in NE Locality which delivered a significant reduction in unmet need and hospital delays through a single point of contact and pro-active approach to building of relationships with providers, assessors, other health professionals and people waiting for support. The aim being to come to practical solutions to enable support to be put in place rapidly where previously there were barriers indicated. Also tracking

				hospital admissions where care arrangements exist and ensuring that these are re-started at earliest point of fitness to discharge, or where no discharge planning is in place to free up the capacity to match to another individual to support discharge home or prevention of admission. • Mapping exercise of existing care capacity both internally and externally, and new process implemented to increase collaborative working between all organisations delivering support. Maximise efficiencies that can be delivered through more joined up approaches to use of existing workforce to increase the number of individuals who can be supported to remain at home through provision of appropriate support arrangements.
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*	☐		Additional Assistant Practitioner posts have been agreed and are currently being implemented to increase therapy capacity to support Discharge to Assess. The additional skills mix will ensure that the therapists are made available to provide additional

	assess where possible			rehabilitation, supporting better outcomes in a shorter duration. Patients considered through a variety and increasing range of pathways and services, including Discharge to Assess, Hospital at Home, Intermediate Care, and the Community Respiratory Team to reduce the length of hospital stay and to prevent a delayed discharge.
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 has worked with health & social care professionals and third sector organisations to improve ACP conversations and models for sharing/accessing information across the integrated system. COVID19 ACP bundles with educational guidance, information for citizens, and resources for sharing/accessing ACP quality criteria across the integrated system have been developed for health and social care professionals, GP practice teams, care homes and third sector partners. The care home ACP model has been shared nationally and recently updated with

				learning and improvements gained during the pandemic, available on the NHS Lothian care home website: 7 steps to ACP: Creating Covid-19 relevant ACPs in Care Homes - Implementation Guide and Resources All other ACP bundles are available on the NHS Lothian intranet and will be soon be available on the HIS
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 259,301 active Key Information Summaries (KIS) in place for people in Edinburgh, a 287% increase since March 2020. Guidance has been shared with GP practices on how to review and update the volume of KISs in place, including when to obtain consent to prevent KISs for high risk individuals created under the COVID19 protocol being deleted. The Long Term Conditions Programme is facilitating the scale and spread of ACP across community, primary, acute, and 3rd sector services. Providing improvement and implementation support to utilise the ACP bundles (see 5.3), working with teams to test and embed ACP across the patient journey (eg Medicine of the Elderly, Old Age Psychiatry,

				Emergency Medicine, Clinical Genetics Service, Community Nursing, Lanfine Service (neurological conditions), District Nursing, Home Care, Carer Support Services, Adults with Complex and Exceptional Needs Service, Care Homes, and Home First teams, Dementia Link Workers, Admiral Nurses, and Improving the Cancer Journey Link Workers). The Edinburgh ACP Stakeholder Group meets quarterly to drive ACP improvements in practice and during the pandemic has focused on improving information sharing at the interface between acute and primary care. During winter 2021-22 an ACP model will be tested with: falls practitioners to improve information shared through ACP on falls prevention and management; and with social workers to improve the quality of social care information shared for people with severe frailty, including Power of Attorney arrangements. Both tests of change aim to decrease avoidable admissions and delayed discharges from hospital through ACP.

				800 KIS magnets and wallet cards have been given to people who are at risk of hospital admission to display in their home, prompting SAS, OOH, ED to check KISs for quality criteria that will improve shared decision-making on providing quality care at home or as close to home as possible.
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. *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.*	☐		Managed at a corporate level across the whole system through Gold Command and at a partnership level though the winter command centre group. .
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.	☐		EHSCP will amplify the Scottish Government campaign promoting flu vaccination and promote Public Health Scotland's range of

	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*			promotional materials aimed at the different audiences. As well as that, EHSCP will promote preventative or operational messages around seven key topics; winter resilience messages and arrangements, winter vaccination programme, falls prevention, hospital avoidance/signposting, anticipatory care planning, keeping safe and healthy over winter, and support and advice for carers. We will target communications to some of our most vulnerable residents, who are among the largest users of health and social care resources. This includes vulnerable older people, people who receive a care at home service, those who receive technology-enabled care and equipment from us, people with long-term health conditions or who are at higher risk of falls. The most effective route to such a wide audience is through the health and social care workers, their unpaid carers and organisations that support them to live their daily lives. For that

				reason, we plan to communicate with our primary audiences through general practice, social work, occupational and physical therapists, pharmacies, care at home agencies, care home staff and ATEC24. We will also support GPs in their messaging on websites and social media. In addition we will link with the Carer Support Team to ensure that carer organisations are kept informed to allow them to support unpaid carers who often struggle at this time of year. We will keep the EHSCP workforce informed through regular internal communications and briefings to staff on winter arrangements, including the winter vaccination programme. And we will work closely with the City of Edinburgh Council communications team on resilience messaging around severe weather etc to ensure we more effectively reach people in Edinburgh with time critical messages.

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 seven-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. EHSCP 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 ensure availability of robust management information and this will be monitored by senior management on an on-going basis.

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 the Mental Health Assessment Centre at REH. Referral is via GP or phone call; and includes self-referral. Due to COVID19 MHAS is not at present offering a 24-hour walk in service but individuals needing a face-to-face assessment will be offered a specific time slot which will be as soon as possible within hours. 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.*	☐		EHSCP will map annual leave arrangements for all teams to ensure there is adequate cover in place. Operational managers will ensure that there is sufficient capacity to provide front-line services over the festive period.
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 planning, along with examples of innovation involving the use of ambulance services.	☐		The Home First navigator posts are well established within the RIE and WGH (4) alongside the In-Reach Nurses (4) in a Home First Team providing a link between acute and community services. Additional SW resource has been allocated for WGH and RIE sites as well as ICF to promote the

				Home First approach and early supported discharged maximising community assets. Additional capacity has also been obtained to support the Flow Centre Home First Navigator not only support POA, also to support the flow out of hospital, a reduced length of hospital stay and prevention of delayed discharge by utilising community assets. The Hospital at Home team has been successful in obtaining funding for resource to increase its capacity for an ANP and APP/AHP. There have been additional pathways established for Hospital at Home and other EHSCP services including that from SAS direct to Hospital and Home, ED direct to Hospital at Home, and the SAS Falls Pathway. These pathways and services are bedding in and demonstrating increasing success and it is anticipated that they will help avoid admissions for the aging patient with underlying frailty, and co-morbidity, in addition to those with

				a risk of infection, deconditioning and loss of independence.
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.*	☐		All Partnership services have resilience plans/business impact assessments in place, and are in the process of reviewing and updated through September / and October. All resilience plans are held by the Resilience Lead in a

				confidential shared space and can be accessed in an emergency situation.

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 system's e.g. Huddles, care inspectorate reporting. Bed based areas - Escalation to local infection control teams Care Homes – Escalation to Public health
2	IPCTs and HPTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their IPCTs and Health Protection Teams (HPTs) are supported to undertake the advance planning to ensure that Norovirus outbreaks in hospitals and care homes are identified and acted upon swiftly. Boards should ensure that there are sufficient resources to 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	☐		All EHSCP staff have access to appropriate guidance. 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 through the course

				of the outbreak. In other settings paper copies may be held for ease of access. Local outbreaks are discussed and recorded at daily safety huddles.
4	How are NHS Board communications regarding bed pressures, ward closures, 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 sit rep reports are in place detailing capacity and any pressures. Staff also have access to NHS Lothian infection control sit rep which is circulated at least twice a day or more frequently if necessary. This advises on ward closures.
5	Debriefs will be provided following significant outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☐		Outbreak management systems are in place for all settings • Problem assessment groups (PAG) • Incident management teams (IMT) These are led by IPCT and include local clinical management teams.
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	Are there systems in place that would ensure appropriate patient placement, patient admission and environmental decontamination post discharge in ED and assessment areas	☐		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 the 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.	☐		Not applicable – NHS Lothian to complete
11	Are there systems in place to deploy norovirus publicity materials information internally and locally as appropriate,	☐		Materials are available on NHS internet and CEC Orb for staff to access. Any communications are cascaded through 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, RSV, Seasonal Flu, Staff Protection & Outbreak Resourcing *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
	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 CMOs seasonal flu vaccination letter published on Adult flu immunisation programme 2021/22 (scot.nhs.uk) and Scottish childhood and school flu immunisation programme 2021/22 . Further CMO letters will be issued before the flu season begins to provide further details on aspects of the programme, including the marketing campaign and details of education resources for staff administering vaccinations.	☐		EHSCP is working closely with colleagues from NHS Lothian and nationally to implement the winter vaccination programme, starting in September and aiming to have all eligible people vaccinated by 6 December 2021. This will include existing eligible groups, NHS Lothian staff and social care staff delivering direct personal care, and additional groups added this year such as independent contractors, teachers and prison officers. The winter vaccination programme will be offered acute sites, through peer vaccination and by self-registering to attend one of 11 vaccination sites/2 drive-through sites being made available across Edinburgh.

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*	☐		Online booking for self-registration will go live on 13 September with vaccinations offered on acute sites, through peer vaccination and by self-registering to attend one of 11 vaccination sites/2 drive-through sites being made available across Edinburgh. The aim is to ensure the programme is as accessible as possible and provide flexibility around work commitments. The Community Vaccination Team will lead on the school programme covering both staff and pupils in primary and secondary schools. Full guidance is still awaited from the JCVI and centrally, including whether there will be a need for COVID booster doses, so there may still be alterations to these plans as that position becomes clearer.

3	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. SG procures additional stocks of flu vaccine which is added to the stocks that Health Boards receive throughout the season, which they can draw down, 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 co-ordinated and issued by the Vaccinations Strategy Division.)*	☐		EHSCP has sufficient capacity to meet the demands of the winter vaccination programme and is ensuring that appropriate training is in place to facilitate it.
4	PHS weekly updates, showing the current epidemiological picture on COVID-19, RSV and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Public Health Scotland and the Vaccinations Strategy Division 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.
5	Adequate resources are in place to manage potential outbreaks of COVID-19, RSV 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.*	☐		Partnership resilience plans are now in place (subject to review / updating) and detail the required resourcing / response to dealing with concurrent events which may include prioritisation to essential services only.

6	Ensure that sufficient numbers of staff from high risk areas where aerosol generating procedures 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, FFP3 fit-tested and trained in the use of PPE for the safe management of suspected COVID-19, RSV 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.
7	Staff in specialist cancer & treatment wards, long stay care of the elderly and mental health (long stay) will also will be required to continue to undertake asymptomatic weekly testing for COVID-19 throughout this period. We are actively reviewing the current asymptomatic Healthcare Worker testing Operational Definitions to ensure they are still fit for purpose.	☐		Weekly PCRs continue to be undertaken in HBCCC -frail elderly and old age psychiatry areas. This is supplemented by LFT testing
8	Ensure continued support for care home staff asymptomatic LFD and PCR testing and wider social services 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. *Enhanced care home staff testing introduced from 23 December 2020 . This involves twice weekly LFD in addition to weekly PCR testing review of enhanced staff testing underway. PCR testing - transition to NHS lab complete. Good level of staff participation in PCR testing.* *Testing has been rolled out to a wide range of other social care services including care at home, sheltered housing services.*	☐		Weekly PCR testing of care home staff has now transferred from NHS Lighthouse to the NHS Lothian Lauriston Hub.

9	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 • 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 day 1 of the programme utilising automated data collection methods for performance monitoring. Public Health Scotland will report weekly.	☐		Not applicable – NHS Lothian to complete EHSCP are operationally responsible for the Vaccination Programme and will monitor uptake with NHS colleagues and adjust any delivery arrangements to ensure performance trajectory is on target ie use of bus for 'pop up', opening up more appointments
10	**Low risk** – Any care facility where: a) triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact who have isolated/shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the test date OR b) Individuals who have recovered from COVID-19 and have had at least 3 consecutive days without fever or respiratory symptoms and a negative COVID-19 test OR c) patients or individuals are regularly tested (remain negative)	☐		EHSCP follows NHS Lothian guidance on classification of wards with all areas classed as Amber (medium) risk. We follow COVID pathways for those in, admitted to or transferred into our service using both local and national infection control standards and risk assessments.

	Medium risk Any care facility where: a) triaged/clinically assessed individuals are asymptomatic and are waiting a SARSCoV-2 (COVID-19) test result with no known recent COVID-19 contact OR b) testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR c) asymptomatic individuals decline testing **High risk** Any care facility where: a) untriaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals who decline testing So all emergency admissions where COVID-19 status is unknown/awaited will fall into the medium risk pathways until testing can be undertaken to allow them to transition into green.			http://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-infection-prevention-and-control-addendum-for-acute-settings/#a2732
11	All NHS Scotland Health Boards have provided assurance that all emergency and all elective patients are offered testing prior to admission. *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.*	☐		Not applicable – NHS Lothian to complete
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 mid-February 2021, the scope of the LFD testing pathway was expanded further to include patient facing primary care staff (general practice, pharmacy, dentistry, optometry), hospice staff, and NHS24 and SAS call handlers. Some hospice staff had been included in the original scope where staff worked between hospitals and hospices, so this addition brought all patient facing hospice staff into the testing programme.*	☐		These decisions are made at IMTs in conjunction with IPCT and partnership (union) representatives

	On the 17 March Scottish Government announced that the scope of the HCW testing pathway would be further expanded to include all NHS workers. The roll out is currently underway and we expect that all Boards across Scotland will have fully implemented the roll-out of twice weekly lateral flow testing to eligible staff by the end of June 2021. This will include staff who may have been shielding or working from home and is in line with national guidance. *Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-COVID-19-healthcare-worker-testing/*			

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 to prompt clinicians to access this highly effective community service. Fortnightly MDT meeting held at RIE to discuss COPD patients at risk and strengthen links between RIE and community services. Between April 2020 and March 2021 414 people who were at immediate high risk of hospital admission were assessed by the Community Respiratory Team within the hub. 84% 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 0830am-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 all those with acute respiratory illness over the winter period, including at the weekend. This may include supporting appropriate hospital discharge of COVID-19 patients, with an existing respiratory condition. 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 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.
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.
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.*	☐		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.

	SPARRA Online: Monthly release of SPARRA data, *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*			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. 918 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 918 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

COVID-19 Surge Bed Capacity Template **Annex A**

		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						

PART B: CPAP	Please set out the maximum number of COVID-19 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-19 patients (share of 3,000 nationally), should it be required		

Annex B

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/)

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-19 within the same area within 14 days where cross transmission has been identified.** **Confirmed case: anyone testing positive for COVID-19** **Suspected case: anyone experiencing symptoms indicative of COVID (not yet confirmed by virology)** **This tool can be used within a COVID-19 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-19 (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)					

1. PPE requirements: PPE should be worn in accordance with the **COVID 19 IPC addendum** for the relevant sector: • **Acute settings** • **Care home** • **Community health and care settings** 2. All staff should wear a FRSM in accordance with the updated guidance on face coverings, which can be found **here**.					
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 Plans Edinburgh Health and Social Care Partnership (EHSCP)

DD codes (impact on any of the DD codes?)	DD position	Service	Service Description	Resource	Capacity (this is the activity that the resource will generate e.g. the number of cases per month, hours of care etc)	Effect on flow	Risk (any current service risks or issues)	Comments	Cost
11a/11b-Social Care Assessment PDD/all codes	DD position in the month of July 2021 on 11b delays is: **58**	**Hospital Social Worker Enhancement** Monday - Saturday (6 days/week)	Prompt allocation of all hospital social care assessments and completion within 72 hours. Proactive early intervention, responsiveness to the home first model with assessments taking place earlier in the hospital patient pathway. To ensure early conversations with the person and carers/families to assist and	4x WTE SW 2x WTE SSW	Estimated additional capacity of 20 cases /month / SW which will yield estimated: **80 cases/ month.** Saturday cover by Social Worker and Bank Holiday cover will be provided	For this Winter 21/22 the target is a **90% reduction of 11Bs (20/21 achieved a 58% reduction)** Reduction in LOS	Recruitment	No system-wide agreed data set for PDD yet and that will be derived from test of change in ward 51 WGH.	**£129,373**

Winter Plans Edinburgh Health and Social Care Partnership (EHSCP)

DD codes (impact on any of the DD codes?)	DD position	Service	Service Description	Resource	Capacity (this is the activity that the resource will generate e.g. the number of cases per month, hours of care etc)	Effect on flow	Risk (any current service risks or issues)	Comments	Cost
			influence the ready for discharge date (or PDD).						
This is a prevention service	N/A	**Edinburgh Community Respiratory Hub CRT+**	To support patients with respiratory conditions beyond COPD with assessment, treatment, and self-management of acute chest infections with a focus on prevention of hospital admissions.	1 x WTE APP Physiotherapist 2 x WTE Specialist PT	Estimated **additional of 10 NP referred/ month** (capacity using baseline data) Total of **40 to a maximum of 50 NP** over the 4 month winter period (Dec-Mar)	Prevention of hospital admissions for patients with chest infection last winter we achieved: Reduced readmissions Reduced demand in primary care	Recruitment	Substantive caseload for CRT has increased, by 10% since March 2019 and activity increased by 17%. Higher activity and caseloads suggest more complex patients which requires a skilled	**£44,706.01**

Winter Plans Edinburgh Health and Social Care Partnership (EHSCP)

DD codes (impact on any of the DD codes?)	DD position	Service	Service Description	Resource	Capacity (this is the activity that the resource will generate e.g. the number of cases per month, hours of care etc)	Effect on flow	Risk (any current service risks or issues)	Comments	Cost
								workforce with appropriate capacity, especially over the winter period.	
N/A	N/A	**Facilitate early supported discharge for people with COVID-19**	Early supported discharge of patients with COVID-19, monitoring respiratory symptoms and facilitating oxygen weaning (as appropriate) and discharge. Collaboration with secondary care clinicians where appropriate regarding the	0.5 x FTE WTE APP Physiotherapist	Estimate of 2 NP per week (based on test of change period July – Dec 2021)	Early supported discharge of people on this pathway LOS reduction (2 bed days saved per case)	Recruitment	Expansion of this pathway would be subject to evaluation of this test of change.	**£9,473.73**

DD codes (impact on any of the DD codes?)	DD position	Service	Service Description	Resource	Capacity (this is the activity that the resource will generate e.g. the number of cases per month, hours of care etc)	Effect on flow	Risk (any current service risks or issues)	Comments	Cost
			deteriorating patient.						
Healthcare Delay	N/A	**Assistant Practitioners Discharge to Assess teams**	Enhance D2A skill mix and increase capacity of the service to facilitate early hospital discharge as an alternative to bed based rehabilitation/ provision of rehabilitation at home. This skill mix will increase capacity, enable therapists to delegate key tasks and achieve a greater focus	4 x WTE Assistant Practitioners, one per locality.	Estimated 14-18 cases per month per AP. It is estimated that AP resource will allow for an additional capacity of 56 - 72 cases per month.	Increase of D2A referrals (**over 20% increase in demand winter 2020/21**) Reduction on LOS in acute care settings Reduction of bed days lost Reduction on DD	Recruitment		**£46,664**

Winter Plans Edinburgh Health and Social Care Partnership (EHSCP)

DD codes (impact on any of the DD codes?)	DD position	Service	Service Description	Resource	Capacity (this is the activity that the resource will generate e.g. the number of cases per month, hours of care etc)	Effect on flow	Risk (any current service risks or issues)	Comments	Cost
			on complexity and intensity of rehabilitation.						
This is a prevention/ early intervention service	N/A	**Improving outcomes for people at risk of falls**	Proactive identification of people who have fallen, are at risk of further falls and have not had a multifactorial falls assessment in the previous 6 months. A focus on prevention of future falls and unnecessary ED presentations. Share key information through ACP to inform shared decision making	1 x WTE Assistant Practitioners	SAS Number of Falls Attended in 2020: **2186** Number of falls conveyed: **1612** **26% non-conveyed** Total falls Assessment Referrals to Hubs 2020: **1019 referrals** Further data will be gathered at the start of the test of change.	Reduced presentations to ED Prevention of falls Increase in falls assessments and ACP completions	Recruitment	Now funded through Long-Term Conditions Programme (Original proposal was for 2 x WTE AP posts)	**£12,000**

DD codes (impact on any of the DD codes?)	DD position	Service	Service Description	Resource	Capacity (this is the activity that the resource will generate e.g. the number of cases per month, hours of care etc)	Effect on flow	Risk (any current service risks or issues)	Comments	Cost
			and reduce ED presentation and admissions. NW locality has the highest number of ED presentations due to falls and is intended to focus in this area.						
This is a prevention/ early intervention service	N/A	**Improving outcomes for people with severe frailty through ACP**	Proactive identification through the developing NE frailty register of people with no to mild cognitive impairment, provide an Anticipatory Care Plan-Key Information Summary (ACP-	0.2 WTE SW		Reduced presentations in ED Prevention of falls Multifactorial falls assessment increase ACP completions		Now funded through Long Term Conditions programme	**£5,332**

Winter Plans Edinburgh Health and Social Care Partnership (EHSCP)

DD codes (impact on any of the DD codes?)	DD position	Service	Service Description	Resource	Capacity (this is the activity that the resource will generate e.g. the number of cases per month, hours of care etc)	Effect on flow	Risk (any current service risks or issues)	Comments	Cost
			KIS) with core quality criteria including information on Power of Attorney (POA).						

Funding Breakdown:

Title	**Amount Requested**
Edinburgh Community Respiratory Hub CRT+	£44,706.01
Hospital Social Worker Enhancement	£129,932.00
Assistant Practitioners D2A	£46,664.00
Early support discharge of people with COVID-19	£9,473.73
TOTAL	**£230,216.74**
Proposals received but now being funded by LTC Programme	
Improving outcomes for people at risk of falling	12,000
Improving outcomes for people with severe frailty through ACP	5,332
TOTAL	**£17,332**

Chief Medical Officer Directorate

E: SeasonalFluProgramme@gov.scot

The Scottish Government

Dear Colleagues

ADULT FLU IMMUNISATION PROGRAMME 2021/22

1. We are writing to provide you with information about the adult seasonal flu immunisation programme 2021/22.

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

3. Given the impact of Covid-19 on the most vulnerable in society, it is imperative that we continue to do all that we can to reduce the impact of seasonal flu and Covid-19 on those most at risk. It is therefore essential that we build on the success from last year's seasonal flu programme to prevent ill health in the population and minimise further impact on the NHS and social care services.

Planning

4. We recognise that delivering the flu programme this year will be a greater challenge than ever before because of the impact of Covid-19 on our health and social care sector. We would expect us all to draw on learning from our experience with Covid-19 and be mindful on how best to deliver a vaccination programme that is prioritised towards protecting the most vulnerable.

5. We will continue to work with the Scottish Immunisation Programme Group to develop vaccination service delivery to ensure that all who will benefit most from the flu vaccine will have the opportunity to receive it in a timely manner while maintaining good Infection Prevention & Control practices and appropriate physical distancing. The provision of appropriate Personal Protective Equipment (PPE) to those involved in the delivery of the flu vaccination programme will remain an important part of the programme planning. Please refer to the Covid-19 guidance available at: HPS Website - Infection prevention and control (IPC) guidance in healthcare settings.

From Chief Medical Officer
Chief Nursing Officer
Interim Chief Pharmaceutical Officer
Dr Gregor Smith
Professor Amanda Croft
Professor Alison Strath

26 March 2021

SGHD/CMO(2021)7

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

For information
Chairs, NHS Boards
Infectious Disease Consultants
Consultant Physicians
Public Health Scotland
Chief Executive, Public Health Scotland
NHS 24

Further Enquiries
Policy Issues
Vaccination Policy Team
seasonalfluprogramme@gov.scot

Medical Issues
Dr Syed Ahmed
St Andrew's House
syed.ahmed@gov.scot

Pharmaceutical and Vaccine Supply Issues
William Malcolm
Public Health Scotland
nss.fluvaccineenquiries@nhs.scot

Key Objectives

6. The flu programme is a strategic and Ministerial priority. The key objectives of the 2021/22 adult flu programme are summarised below:

- To protect those most at risk from flu in the coming season and to ensure that the impact of potential co-circulation of flu and Covid-19 is kept to an absolute minimum.

- To plan to deliver the programme building on lessons learnt from previous years and our experience of Covid-19, recognising that arrangements may need to be adapted with vital resources correctly positioned to deliver the programme at scale.

- To further increase flu vaccine uptake across all eligible groups with particular focus on those who are aged 65 years and over; those aged 18-64 years in clinical risk groups, as well as pregnant women (at all stages of pregnancy). Full details of eligibility for flu immunisation this season is set out in Annex A.

- To extend the national programme again to offer vaccination to social care staff who deliver direct personal care, unpaid and young carers, Independent Contractors (GP, dental and optometry practices, community pharmacists), laboratory staff (working on Covid-19 testing) including support staff, Teachers, Nursery Teachers and support staff working in close contact with pupils in both a Local Authority and Independent setting, prison population and prison officers and support staff in close contact with prison population delivering direct detention services, secondary school pupils and all those aged 50-64 years old. Some of those aged 50-64 are otherwise eligible due to underlying health conditions or their employment.

- To encourage greater uptake amongst frontline health and social care workers, including Independent Contractors (GP, dental and optometry practices, community pharmacists, laboratory staff (working on Covid-19 testing) including support staff, who are delivering patient front facing services. An innovative timely approach is required and is critical to safeguard staff, whilst also protecting those in their care.

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

8. Throughout the programme life cycle, uptake rates and vaccine supply will be reviewed to ensure that those at greatest clinical risk receive their vaccination.

9. A separate letter for the childhood flu immunisation programme was circulated on 6 June 2020 and is available here: https://www.sehd.scot.nhs.uk/cmo/CMO(2021)14.pdf.

10. A further CMO letter will be issued later in the season providing additional information.

11. More information on the flu vaccines for the forthcoming season, as well as vaccine composition is provided in Annex B.

Extension of the programme

12. Scottish Ministers have indicated that they wish to extend the eligibility of the flu immunisation programme to:

- Independent Contractors (GP, dental and optometry practices, community pharmacists), laboratory staff (working on Covid-19 testing) including support staff,
- Teachers, Nursery Teachers and support staff working in close contact with pupils in both a Local Authority and Independent setting,
- Prison population and prison officers and support staff in close contact with prison population delivering direct detention services,
- Secondary school pupils and,
- all those aged 50-64 years old.

13. Some of the groups may be eligible due to being part of one or more other cohorts e.g. those aged 50-64 years may be otherwise eligible due to underlying health conditions or their employment.

14. The rationale for expanding to:

- Independent Contractors, teachers, prison population, prison officers who deliver direct detention services is to maintain the resilience of services during the Scottish Government's response to the global Covid 19 pandemic and to reduce the risk of infection and transmission of the virus.

- Secondary School pupils is that it will both provide direct protection, lowering the impact of influenza on children and indirect protection, lowering influenza transmission from children to other children, adults and those in the clinical risk groups of any age.

- All 50-64 year olds, beyond those who are already eligible through underlying health conditions or their employment, is that it will help to protect an age group who are more vulnerable to both Covid-19 and seasonal flu viruses than those in younger age groups; and will lower the risk to this age group, of suffering concurrent infection with both viruses. The vaccination of those aged 50-64 years who would not be otherwise eligible should commence from the start of the programme.

15. The Covid-19 pandemic has had an effect on every aspect of public health, including vaccine supply at a global level. With that in mind, the Joint Committee on Vaccination Immunisations' view was sought for the coming season and this informed our decision to expand eligibility for this season. The pandemic has shown us that situations can change rapidly, and we will adapt our approach to any changes that occur throughout flu season, continuing to prioritise those most at risk from seasonal flu, and seeking to protect the NHS and social care as far as possible.

16. To allow us to be responsive to the changing context, we will review the availability of vaccine after uptake levels become clear within existing and expanded cohorts. The Scottish Government will remain in regular dialogue with delivery partners through the Scottish Immunisation Programme Group and will update on any significant developments.

Health and Social Care Workers

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

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

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

Communication materials

20. The national media campaign (TV, radio, press, digital and social media) will be developed and further details will be circulated in due course.

21. The Scottish Government will work with Public Health Scotland colleagues to develop a toolkit to encourage the promotion of the flu vaccine that will support NHS and Social Care colleagues.

22. Public Health Scotland will produce and make available a range of national accessible information materials to support informed consent for all eligible cohorts.

23. The public should be signposted to Flu vaccination - Immunisations in Scotland | NHS inform for up to date information on the programme.

Workforce Education

24. NHS Education for Scotland and Public Health Scotland will work closely with stakeholders to develop and thereafter make available a range workforce education resources/opportunities. These will be available on the NHS Education for Scotland TURAS Learn website https://learn.nes.nhs.scot/14743/immunisation/seasonal-flu.

Resources

25. NHS Boards are asked to ensure that immunisation teams are properly resourced to develop and deliver the extended programme, and we are working with the Scottish Immunisation Programme Group to ensure this work is supported.

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

27. A template was issued by Scottish Government Finance to NHS Board Finance leads and returns should be fed back to your Finance Teams. Please ensure that costs are not double counted for services already delivered. NHS Boards are asked to ensure that immunisation teams are appraised of this information.

Action

28. NHS Boards and those GP practices which may participate and are operationalising the programme, are asked to note and implement the arrangements outlined in this letter for the 2021/22 adult seasonal flu immunisation programme. It is important that every effort is made this year to maximise uptake as this winter, more than ever, the flu vaccine is going to be a key intervention to reduce pressure on the NHS and social care services and protect the most vulnerable in our population.

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

30. We would ask that action is taken to ensure as many people as possible are vaccinated early in the season, and before flu viruses begin to circulate. The benefits of flu vaccination should be communicated and vaccination made as easily accessible as possible.

31. Integration Authority Chief Officers and Local Authorities are asked to work closely to communicate and promote the flu vaccination programme to social care workers providing direct personal care, and to ensure that they are fully supported to access the service. A separate letter will be issued to social care membership organisations to communicate the need to support higher uptake in this discipline to social care providers.

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

Yours sincerely,

Gregor Smith	*Amanda Croft*	*Alison Strath*
Dr Gregor Smith **Chief Medical Officer**	Professor Amanda Croft **Chief Nursing Officer**	Professor Alison Strath **Interim Chief Pharmaceutical Officer**

Annex A

FLU VACCINE: PRIORITISING UPTAKE AND ELIGIBILITY

Prioritising flu vaccine uptake

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

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

3. We should also prioritise the vaccination of eligible health, social care workers and Independent Contractors, to protect them and minimise the likelihood of them spreading Covid-19 and flu to those they care for.

4. All those eligible should be offered the flu vaccination as soon as possible so that individuals are protected when flu begins to circulate. This is the case for all high-risk cohorts.

5. For those aged 50-64 years, not otherwise eligible through underlying health conditions or employment, this will mean starting to vaccinate from the beginning of the programme to provide Health Boards with the maximum flexibility to deliver the programme efficiently and before the end of the calendar year.

6. To provide NHS Boards and GP Practices participating in the programme the maximum flexibility to deliver the programme efficiently before the end of the calendar year, all cohorts may be called from the start of the programme, if possible: beginning in late September/early October.

Pregnant Women

7. Most NHS Boards and Health and Social Care Partnerships (HSCPs) will be delivering flu vaccine to pregnant women through their local maternity services this season and should keep local GP practices informed about their plans, including how to refer women to the services as appropriate or whether they will need GP practices to vaccinate this cohort directly.

Existing Eligible Groups (those eligible in previous flu seasons)

8. In 2021/22, the seasonal flu vaccine should be offered, from the commencement of the programme, to the existing cohorts set out in the table below:

Eligible Groups	Additional Information
Pre-school children aged 2-5 years; All primary school children in P 1-7.	The childhood flu CMO letter for the 21/22 programme was circulated on 6 June 2020 and is available here: https://www.sehd.scot.nhs.uk/cmo/CMO(2021)14.pdf
All patients aged 65 years and over.	"Sixty-five and over" is defined as those aged 65 years and over by 31 March 2022.
Chronic respiratory disease aged six months or older.	Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children who have previously been admitted to hospital for lower respiratory tract disease.
Chronic heart disease aged six months or older.	Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease.
Chronic kidney disease aged six months or older.	Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephritic syndrome, kidney transplantation.
Chronic liver disease aged six months or older.	Cirrhosis, biliary atresia, chronic hepatitis from any cause such as Hepatitis B and C infections and other non-infective causes.
Chronic neurological disease aged six months or older.	Stroke, transient ischaemic attack (TIA). Conditions in which respiratory function may be compromised, due to neurological disease (e.g. polio syndrome sufferers). Clinicians should offer immunisation, based on individual assessment, to clinically vulnerable individuals including those with cerebral palsy, learning disabilities, multiple sclerosis and related or similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological or severe learning disability.
Diabetes aged six months or older.	Type 1 diabetes, type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet controlled diabetes.
	Immunosuppression due to disease or treatment, including patients undergoing chemotherapy leading to immunosuppression, bone marrow transplant. HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4,

Immunosuppression aged six months or older.	NEMO, complement disorder). Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day (any age) or for children under 20kg a dose of 1mg or more per kg per day. It is difficult to define at what level of immunosuppression a patient could be considered to be at a greater risk of the serious consequences of flu and should be offered flu vaccination. This decision is best made on an individual basis and left to the patient's clinician. Some immunocompromised patients may have a suboptimal immunological response to the vaccine. Consideration should also be given to the vaccination of household contacts of immunocompromised individuals, i.e. individuals who expect to share living accommodation on most days over the winter and therefore for whom continuing close contact is unavoidable. This may include carers (see below).
Asplenia or dysfunction of the spleen.	This also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Pregnant women.	Pregnant women at any stage of pregnancy (first, second or third trimesters).
People in long-stay residential care or homes.	Vaccination is recommended for people in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow the introduction of infection, and cause high morbidity and mortality. This does not include, for instance, university halls of residence etc.
Unpaid Carers and young carers.	Someone who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability. A young carer is a child or young person under the age of 18 carrying out significant caring tasks and assuming a level of responsibility for another person, which would normally be taken by an adult. Vaccination can also be given on an individual basis at the GP's discretion following a risk assessment after discussion with the carer.
Health care workers.	Health care workers who are in direct contact with patients/service users should be vaccinated.
Morbid obesity (class III obesity).	Adults with a Body Mass Index ≥ 40 kg/m².

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

Call and recall of patients aged 65 years and over

10. As in previous years the Scottish Government will arrange for a national call-up letter to be sent to all those who will be aged 65 years and over by 31 March 2022. Further details will be issued in due course.

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

11. National call-up letters for those aged under 65 years at-risk will be reviewed and further information will be provided in due course.

New Eligible Groups 20/21

12. In 2021/22, the seasonal flu vaccine should be offered to the new cohorts set out in the table below:

Eligible Groups	Additional Information
NHS Independent Contractors.	This is defined as GP, dental, optometry practices, community pharmacists, laboratory staff (working on Covid-19 testing) and support staff.
All secondary school children.	The childhood flu CMO letter for the 21/22 programme has further details.
Nursery, Primary and Secondary school Teachers and support staff.	This is defined as Teachers, Nursery Teachers and support staff working in close contact with pupils in both a Local Authority and Independent setting.
Prison population.	Prison population in the detention estate.
Prison Officers and support staff.	Prison officers and support staff in close contact with prison population delivering direct detention services.

13. Health, social care workers, Independent Contractors, those aged 50-64 years (by the 31 March 2022), Nursery, Primary, Secondary school teachers and support staff should be vaccinated from the commencement of the flu vaccination programme.

Call and recall of patients aged 50-64 years

14. As with last year, the Scottish Government is currently considering the possibility of sending a national call-up letter to patients aged 50-64. Further information on this will be provided in due course.

Health and Social Care Workers

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

16. Uptake of seasonal flu vaccination by health and social care workers continues to be below the CMO target - in 2020/21 the combined uptake was 41.3% in Territorial Boards, compared with a minimum target of 60%.

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

18. Independent Contractors such as GPs, dental and optometry practices, community pharmacists, laboratory staff (working on Covid-19 testing) as well as support staff, should also arrange vaccination of their staff.

Social Care Workers

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

20. For clarity, social care staff delivering direct personal care in the following settings should be covered by this programme:

    - residential care for adults;
    - residential care and secure care for children;
    - and community care for persons at home (including housing support and Personal Assistants).

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

22. The prevalence of Seasonal Flu has been very low this year, however, it is difficult to predict the level of circulation for the coming season. With the possibility of both seasonal flu and Covid-19 circulating next winter, to alleviate NHS pressure, support key services, and reduce the risk of infection and transmission, the following groups have also been included in this year's programme:

    - Independent Contractors (GP, dental, optometry practices, community pharmacists, laboratory staff (working on Covid-19 testing) and support staff,
    - Teachers, Nursery Teachers and support staff working in close contact with pupils in both a Local Authority and Independent setting,
    - Prison population, Prison Officers and support staff in close contact with prison population delivering direct detention services.

This will be reviewed in the coming year to establish if these additional groups will be included in coming years.

Immunisation against Infectious Disease ('The Green Book')

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

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

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

Annex B

RECOMMENDED FLU VACCINES, VACCINE COMPOSITION AND ORDERING INFORMATION

Flu vaccines for 2021/22

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

Eligible Groups	Vaccine – JCVI Recommended
Individuals aged 65 years and over.	aQIV - Adjuvanted Quadrivalent Influenza Vaccine (Seqirus).
Individuals aged 18-64 years with "at-risk" conditions.	QIVc - Cell-based Quadrivalent Influenza Vaccine (Seqirus).
Health, Social Care Workers and NHS Independent Contractors.	QIVc - Cell-based Quadrivalent Influenza Vaccine (Seqirus).
Unpaid/Young carers.	QIVc - Cell-based Quadrivalent Influenza Vaccine (Seqirus).
Individuals aged 50-64 years not otherwise eligible through a qualifying health condition or employment.	QIVc - Cell-based Quadrivalent Influenza Vaccine (Seqirus).
Nursery, Primary and Secondary school Teachers and support staff.	QIVc - Cell-based Quadrivalent Influenza Vaccine (Seqirus).
Prison population, Prison Officers and support staff.	QIVc - Cell-based Quadrivalent Influenza Vaccine (Seqirus).

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

Vaccine composition for 2021/22

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

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

5. For the 2021/22 flu season (northern hemisphere winter) it is recommended that cell or recombinant-based Vaccines contain the following strains:

    - an A/Wisconsin/588/2019 (H1N1)pdm09-like virus;
    - an A/Cambodia/e0826360/2020 (H3N2)-like virus;

- a B/Washington/02/2019 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

6. For the 2021/22 flu season (northern hemisphere winter) it is recommended that egg based vaccines contain the following strains:

   - an A/Victoria/2570/2019 (H1N1)pdm09-like virus;
   - an A/Cambodia/e0826360/2020 (H3N2)-like virus;
   - a B/Washington/02/2019 (B/Victoria lineage)-like virus; and
   - a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

For more information

7. Recommended composition of influenza virus vaccines for use in the 2021-2022 northern hemisphere influenza season – full report' (February 2021) available here: 202102_recommendation.pdf (who.int).

8. Questions and Answers - Recommended composition of influenza virus vaccines for use in the Northern hemisphere 2021-2022 influenza season and development of candidate vaccine viruses for pandemic preparedness' (February 2021) available here: https://www.who.int/influenza/vaccines/virus/recommendations/202102_qanda_recommendation.pdf?ua=1.

9. Candidate vaccine viruses and potency testing reagents for development and production of vaccines for use in the northern hemisphere 2021-22 influenza season (27 February 2021 15:29 CET) available here: https://www.who.int/influenza/vaccines/virus/candidates_reagents/2021_22_north/en/.

Egg-free vaccine

10. For individuals with egg allergy the advice in the most recent influenza chapter of the Green Book should be followed: https://www.gov.uk/government/publications/influenza-the-green-book-chapter-19

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

12. Egg-allergic adults and children over age two years with egg allergy can also be given QIVc - Cell-based Quadrivalent Influenza Vaccine (Seqirus) (i.e. egg-free) vaccine, which is recommended and licensed for use in this age group.

Vaccine ordering and delivery arrangements

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

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

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

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

17. NHS Boards and GP practices participating in the programme must ensure adequate vaccine supplies before organising vaccination clinics.

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

19. To make it simpler for front line staff in the coming season, all NHS Boards will be allocated the same type of vaccine for each cohort e.g. QIVc for most cohorts. Only aQIV should be ordered for individuals aged 65 years and over. Only QIVc should be used for 50-64 year olds, not otherwise eligible due to underlying health condition or employment. Those who are egg-allergic should be offered the QIVc vaccine as detailed above.

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

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

22. A small volume of QIVe (Sanofi) has been procured for children aged 6 months to under 2 years. GPs should request this vaccine from their local Vaccine Holding Centre.

Further information and support

23. As with last year, a Procurement Officer within NHS National Procurement will act as a link between participating GP practices and Movianto to ensure any potential allocation or delivery issues can be minimised and swiftly resolved.

Contact details for the Procurement Officer are as follows: NSS.fluvaccineenquiries@nhs.scot

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

Chief Medical Officer

E: seasonalfluprogramme@gov.scot

The Scottish Government

Dear Colleagues

SCOTTISH CHILDHOOD AND SCHOOL FLU IMMUNISATION PROGRAMME 2021/22

1. We are writing to provide you with information about the childhood and school based seasonal flu immunisation programme 2021/22 (this includes both a Local Authority and Independent school setting).

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

3. Delivery of the flu immunisation programme will protect those at risk, and it is therefore essential that we build on the success from previous year's programmes to prevent ill health and minimise further impact on the NHS.

4. A recommendation to extend influenza vaccination to children and adolescents was made in 2012 by the JCVI, to provide both individual protection to the children themselves and reduce transmission across all age groups. Implementation of the programme began in 2013, with pre-school and primary school children offered vaccination.

5. The expanded influenza vaccination programme that we implemented last

From Chief Medical Officer
Chief Nursing Officer
Interim Chief Pharmaceutical Officer
Dr Gregor Smith
Professor Amanda Croft
Professor Alison Strath

3 June 2021

SGHD/CMO(2021)14

Addresses

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

For information
Chairs, NHS Boards
Infectious Disease Consultants
Consultant Physicians
Public Health Scotland
Chief Executive, Public Health Scotland
NHS 24

Further Enquiries

Policy Issues
Vaccination Policy Team
seasonalfluprogramme@gov.scot

Medical Issues
Dr Syed Ahmed
St Andrew's House
syed.ahmed@gov.scot

Pharmaceutical and Vaccine Supply Issues
William Malcolm
Public Health Scotland
nss.fluvaccineenquiries@nhs.scot

season, will continue in 2021/22 as part of our wider planning for the next winter, with the programme being further extended to include secondary school pupils.

6. Vaccinating children provides direct protection to children but also reduces transmission of influenza among household members and close contact. JCVI have recommended that expanding flu vaccination to secondary school pupils would be cost effective and provide further resilience to the NHS during the winter months, particularly if Covid-19 is still circulating. During the coming winter, it remains a key intervention to reduce pressure on the NHS and will be reviewed going forwards on an on-going basis. This is a school based programme and only pupils attending school at the time of the vaccination programme are eligible (see below about home educated children).

Planning

7. We recognise that delivering the flu programme this year will be a greater challenge than ever before because of the impact of Covid-19 on our health and social care sector. We would expect us all to draw on learning from our experience of Covid-19 and be mindful on how best to deliver a vaccination programme that is prioritised towards protecting the most vulnerable.

8. We will continue to work with the Scottish Immunisation Programme Group to develop vaccination service delivery to ensure that children will have the opportunity to receive the flu vaccination in a timely manner while maintaining good Infection Prevention & Control practices and appropriate physical distancing. The provision of appropriate Personal Protective Equipment (PPE) to those involved in the delivery of the childhood flu vaccination programme will remain an important part of the programme planning. Please refer to the Covid-19 guidance available at: https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/infection-prevention-and-control-ipc-guidance-in-healthcare-settings/#title-container

Eligibility

9. Health Boards should continue to arrange vaccination for any primary and secondary school pupil (outlined below) resident in Scotland at the time of the immunisation programme who was not vaccinated during their local school immunisation session or who requires a second dose of inactivated vaccine to complete their first course of flu vaccine.

Those eligible for the childhood and school flu vaccination programme include:

- All children aged two-five* years (not yet at school) (*children must be aged two years or above on 1 September 2021); and
- All primary school children (primary one to primary seven) at school.
- All secondary school pupils (years one to six) at school

10. A number of Health Boards and Health and Social Care Partnerships (HSCPs) have either transferred, or are in the process of transferring across delivery of the flu vaccine to children in the two-five years age group from GP Practices. A small number of Health Boards and HSCPs have not yet made alternative delivery arrangements. Health Boards and HSCPs will be working closely with local practices to ensure that all eligible children are offered this vaccine timeously to protect them against this infection. GP practices will be responsible for vaccinating this age group where they agree to do so under the forthcoming Influenza and Pneumococcal DES for 2021/22.

Vaccine

11. Fluenz Tetra®, a live attenuated nasal influenza vaccine (LAIV), is the vaccine available for the majority of children and adolescents aged under 18 years this year. A very small number of pupils may be aged 18 years at the time they receive the vaccine and they should also be offered the LAIV off label and this will be included in the national PGD template. Please note that, as a live, attenuated vaccine, Fluenz Tetra® is contraindicated in a very small number of children and pupils. Children who have a contraindication to LAIV should be offered a suitable quadrivalent, inactivated flu vaccine, as appropriate for their age. Cell based quadrivalent influenza vaccine (Seqirus Vaccines) (QIVc), which is now licensed for all children aged two years and above, will be available to order for children in at risk groups who are contraindicated to receive LAIV. Children in clinical risk groups aged 6 months to less than 2 years should be offered egg based quadrivalent influenza vaccine (Sanofi Pasteur Vaccines) (QIVe).

12. Fluenz Tetra® has a shorter shelf life (18 weeks) than other flu vaccines. The expiry date on the nasal spray applicator should always be checked before use.

13. The delivery schedule for Fluenz Tetra® for 2021/22 has not yet been confirmed, as this is subject to manufacturing and ongoing regulatory processes. As Fluenz Tetra® has a shorter shelf life than other vaccines it will be delivered into the national stockpile in a number of

consignments in order to ensure that there are in date supplies available throughout the period vaccine can be offered.

14. To support efficient delivery of the programme, it is anticipated that the delivery schedule will result in most of the vaccine becoming available to order in the initial weeks of the programme.

15. Arrangements should be made to ensure that pupils who missed out on vaccination during the school session are recalled and offered subsequent opportunities to attend. Precise arrangements for achieving this are for local determination. Children who are in eligible age groups and are home educated should also be offered vaccination through local arrangement.

16. Sufficient vaccine has been procured for flu season 2021/22 to ensure adequate vaccine supply is available, and will also allow for an increased uptake in light of Covid-19. NHS Boards and practices must ensure adequate vaccine supplies before organising vaccination clinics. Any issues or queries should be escalated to the Immunisation Co-ordinator within the NHS Board. If you require contact details for your NHS Board Immunisation Coordinator please email seasonalfluprogramme@gov.scot.

17. More information on the vaccines available for the 2021/22 seasonal flu immunisation programme, as well as additional information is set out in **Annex B**.

Communication materials

18. An invitation letter and leaflet will be issued to parents/guardians of all eligible pre-school children aged two to five years inviting them for vaccination. A national media campaign (TV, radio, press, digital and social media) will be timed around parents receiving this communication. Research and insight activity will underpin the campaign in light of Covid-19, and potentially changing attitudes to vaccination.

19. Posters, leaflets and other materials to support the campaign will also be distributed to relevant settings such as nurseries and GP Practices. Some NHS Boards and HSCPs may undertake additional local communication activity as appropriate to complement national communication.

20. For school based programmes, consent packs will be distributed to local schools to be sent home in school bags. These packs will include a

letter and leaflet for parents of primary and secondary school pupils as well as a consent form. The messaging within these is currently being revised and tested in light of Covid-19.

21. To support the programme in schools, Public Health Scotland will ensure all schools have supporting materials on the flu vaccine for staff, parents, children and pupils. These will all be available for schools to download from mid-August 2021.

22. Information for children aged two to five years, primary and secondary school flu leaflets will be available in other languages (including Polish, Mandarin and Arabic) and alternative formats (BSL, audio and Easy Read) at www.nhsinform.scot/childflu (under 'Further Information'). Public Health Scotland is happy to consider requests for other languages and formats. Please contact 0131 314 5300 or email phs.otherformats@phs.scot.

23. The public should be signposted to www.nhsinform.scot/childflu for up to date information on the programme.

Workforce education materials

24. Workforce education materials will be made available before the start of the programme at Seasonal flu | Turas | Learn (nhs.scot).

Resources

25. Health Boards are asked to ensure that immunisation teams, including vaccine holding centres, are properly resourced to develop and deliver the extended programme. Scottish Government Workforce and Chief Nursing Officer Directorates will support Boards through the provision of workforce planning tools and resources to ensure that at all times suitably qualified and competent individuals, from a range of professional disciplines as necessary, are working in numbers appropriate for the health, wellbeing and safety of patients, enabling the provision of safe and high-quality health care and the wellbeing of staff.

26. Any additional costs related to adapting immunisation programmes to meet Covid-19 requirements (e,g. physical distancing, PPE) should be recorded in Health Boards' Local Mobilisation Plans, now called Covid-19 finance returns. This is in the form of a single row figure in the return. Please ensure that costs are not double counted for services already delivered.

ACTION

27. Health Boards, including their Primary Care teams, and GP practices are asked to note and plan appropriately to implement the arrangements outlined in this letter for the 2021/22 childhood and school seasonal flu immunisation programme. It is important that every effort is made this year to ensure high uptake as this winter, more than ever, the flu vaccine is going to be a key intervention to reduce viral transmission and pressure on the NHS and social care services.

28. We have procured additional vaccine to support higher vaccination uptake however, ongoing and effective management at a local level will also be required. Health Boards and Primary Care teams should fully consider the needs of their eligible cohorts and plan appropriately and timeously in order to successfully deliver the programme.

29. We would ask that action is taken to ensure as many children and adolescents as possible are vaccinated early in the season, and before flu viruses begin to circulate. The benefits of flu vaccination should be communicated and vaccination made as easily accessible as possible.

30. We would also ask Health Boards to engage early with education colleagues, including school heads, to ensure that models of vaccine delivery are discussed and agreed particularly in light of physical distancing and the potential for a blended learning model to be in place.

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

Yours sincerely,

Gregor Smith	*Amanda Croft*	*Alison Strath*
Dr Gregor Smith **Chief Medical Officer**	Professor Amanda Croft **Chief Nursing Officer**	Professor Alison Strath **Interim Chief Pharmaceutical Officer**

Annex A

FLU VACCINE: PRIORITISING UPTAKE AND ELIGIBILITY

Prioritising flu vaccine uptake

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

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

Eligible Groups

3. In 2021/22 the seasonal flu vaccine should be offered, from the commencement of the programme, to all pre-school, primary and secondary school children and pupils.

Recommendation

4. The Joint Committee on Vaccination and Immunisation (JCVI) recommends the live attenuated influenza vaccine (LAIV) is offered to children and adolescents, as it is more effective in the programme than the inactivated injectable vaccines. This is because it is easier to administer and considered better at reducing the spread of influenza to others, who may be vulnerable to the complications of influenza.

5. Uptake of seasonal flu vaccination last year for children aged 2-5 years was 59.3% with a national target of 65%. For primary school children, the national target was 75% and the actual uptake was 75.3%.

6. While vaccination uptake for primary school children has risen, we will look to all NHS Boards to do everything they can to further increase uptake to all children in the existing and new cohorts. It is important that parents understand the seriousness of vaccinating their children as this will reduce the potential spread of the virus and pressure on the NHS.

Immunisation against Infectious Disease ('The Green Book')

7. Further guidance on the list of eligible groups can be found in the most recent influenza chapter (chapter 19) of the Green Book available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/931139/Green_book_chapter_19_influenza_V7_OCT_2020.pdf

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

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

Annex B

RECOMMENDED FLU VACCINES, VACCINE COMPOSITION AND ORDERING INFORMATION

Flu vaccines for 2021/22

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

Eligible Groups –	Vaccine – JCVI Recommended
At risk children aged 6 months - 2 years	Offered Egg based Quadrivalent Influenza Vaccine (split virion, inactivated Sanofi Pasteur Vaccines (QIVe),
Children aged 2 –18 years who cannot receive LAIV	Offered, Cell-based Quadrivalent Influenza Vaccine (surface antigen, inactivated), (now licensed from the age of 2 years) Seqirus Vaccine QIVc,.
Pre-school children aged 2-5 years	Offered live attenuated influenza vaccine (LAIV)
Primary school children	Offered live attenuated influenza vaccine (LAIV)
Secondary school pupils	Offered live attenuated influenza vaccine (LAIV)

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

Vaccine composition for 2021/22

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

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

5. For the 2021/22 flu season (northern hemisphere winter) it is recommended that cell or recombinant-based Vaccines contain the following strains:

    - an A/Wisconsin/588/2019 (H1N1)pdm09-like virus;
    - an A/Cambodia/e0826360/2020 (H3N2)-like virus;

- a B/Washington/02/2019 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

6. For the 2021/22 flu season (northern hemisphere winter) it is recommended that egg based vaccines contain the following strains:

    - an A/Victoria/2570/2019 (H1N1)pdm09-like virus;
    - an A/Cambodia/e0826360/2020 (H3N2)-like virus;
    - a B/Washington/02/2019 (B/Victoria lineage)-like virus; and
    - a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

For more information

7. Recommended composition of influenza virus vaccines for use in the 2021- 2022 northern hemisphere influenza season – full report' (February 2021) available here: 202102_recommendation.pdf (who.int)

8. Questions and Answers - Recommended composition of influenza virus vaccines for use in the Northern hemisphere 2021-2022 influenza season and development of candidate vaccine viruses for pandemic preparedness' (February 2021) available here: https://www.who.int/influenza/vaccines/virus/recommendations/202102_qanda_recommendation.pdf?ua=1

9. Candidate vaccine viruses and potency testing reagents for development and production of vaccines for use in the northern hemisphere 2021-22 influenza season (27 February 2021 15:29 CET) available here: https://www.who.int/influenza/vaccines/virus/candidates_reagents/2021_22_north/en/

Egg-free vaccine

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

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

12. Egg-allergic young people and children over age two years with egg allergy can also be given the quadrivalent inactivated cell based (i.e. egg-free) vaccine, Seqirus Vaccines) (QIVc), which is licensed for use in this age group.

Vaccine ordering and delivery arrangements

13. Information on ordering and delivery arrangements for the flu vaccine will be provided within further correspondence.

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

15. If you have any issues with log-in arrangements or if you have new staff who require access to the system please contact Seqirus Customer Services on 01628 641 500 for assistance.

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

17. Health Boards and participating GP practices must ensure adequate vaccine supplies before organising vaccination clinics.

18. When placing orders for the vaccines in Marketplace, practices should search for the type of vaccine required. For example, if vaccines are required for patients aged 2-5 years these can be found in Marketplace by entering the search term "LAIV" or on the 'Orders' screen.

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

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

Further information and support

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

22. For queries linked to ordering and deliveries, please contact the Seqirus Customer Service Team (01628 641 500) and Sanofi Customer Services Team (0845 023 0441). If any delivery service issues cannot be resolved satisfactorily through dialogue, the issue should be escalated to NHS National Procurement (contact details as above) in the first instance and thereafter the Immunisation Co-ordinator within the NHS Board. If you require contact details for your NHS Board Immunisation Coordinator please email immunisationprogrammes@gov.scot