Edinburgh Integration Joint Board

REPORT

Evaluation of Winter 2021/22

Edinburgh Integration Joint Board

9 August 2022

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board with an update on performance over winter 2021/22. As anticipated, winter 2021/22 proved to be challenging, not only in the Partnership but system-wide due to the continuing effects of the Covid-19 pandemic. The easing of lockdown has seen an increased demand for services alongside workforce pressures caused by staff absence and difficulties in recruiting to key service areas including social work, therapy, and care at home, exacerbated in Edinburgh due to the competitiveness of the local recruitment market. This was reflected in a high number of delayed discharges but despite this challenging position, we were able to maintain delays at a relatively similar level throughout December and January, avoiding the increase normally seen at that time of year. Delays decreased through the remainder of winter ending 18% lower in March than November 2021, something not seen in previous years. This has also bucked the national trend, with Edinburgh seeing a 14% drop in delays at census point for those over 18 years of age between the peak in January and March, compared to a 7% rise across the rest of Scotland (minus Edinburgh). There was a similar trend for those over 75 years of age, with a 13% drop in Edinburgh and a 10% rise across Scotland. Also, a 17% drop in monthly bed days occupied for 18+ between the peak in January and March compared to a 5% rise across the rest of Scotland. For 75+ this was a 16% drop in Edinburgh and a 7% rise across Scotland.

Recommendations	It is recommended that the Edinburgh Integration Joint Board: 1. Note the evaluation of winter 2021/22 contained in this paper. 2. Note that a number of winter initiatives are being funded recurringly. 3. Note that planning is underway around identified priorities for winter 2022/23.

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 has not been presented to any other EIJB Committee.

Main Report

2. Winter preparedness planning plays a key role in ensuring National Health Service (NHS) boards and Health and Social Care Partnerships (HSCP) are ready to meet the additional challenges likely to be faced over the winter months as a result of seasonal influenza, norovirus, severe weather, and public holidays. This was again amplified 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 NHS Scotland, 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 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 cases this winter.

4. The Partnership was approached and asked to complete the self-assessment for inclusion in the Lothian return, incorporating:
   a. Resilience preparedness
   b. Unscheduled/elective care preparedness
   c. Out of hours preparedness
   d. Norovirus outbreak control measures
   e. COVID-19, RSV, seasonal Flu, staff protection and outbreak resourcing
   f. Respiratory pathway, and
   g. Integration of key partners/services

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

Allocation and use of additional funding for winter pressures

6. Over recent years, several 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:
   a. Supports joint working between acute/HSCPs
   b. Supports a Home First approach
   c. Facilitates seven-day working and discharging
   d. Site and community resilience/flow
   e. Admissions avoidance
   f. Supports a non-bed-based model

7. This year however it was agreed that winter funding would be allocated to each HSCP 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 the Edinburgh Partnership received a total allocation of £171,000 for winter 2021/22.

8. Allocation of this funding, was based on previously identified priorities arising from the evaluation of winter 2020/21, considering funding already set aside through NHS Lothian's Gold Command and the resultant gaps. An outline of the selected areas of work is given below in table 1, along with an update on outcomes.

Table 1 Winter Funding Allocation

Title	Update
Hospital Social Worker Enhancement	Recruitment of experienced social workers was exceptionally difficult, with posts being re-advertised four times. It was not until January 2022 that the four posts were filled. Following employment checks, three candidates were given a start date of March/April but the fourth accepted an offer from another local authority. These posts will enhance hospital social work capacity but with a focus on a Home First approach. A social worker will be part of a dedicated 'front door' team where the focus is on the patient for the first 72 hours, supporting them and ensuring early conversations with the person and their family/carer to assist and influence discharge. This should reduce the numbers being admitted and enable prompt discharge. Recruitment to the two senior social workers posts was unsuccessful. These and the remaining social worker post will be re-advertised early June 2022.
Edinburgh Community Respiratory Hub CRT+	Additional Advanced Physiotherapy Practitioner (APP) and specialist physiotherapist posts to support patients with respiratory conditions other than COPD remained unfilled. Ongoing support and care of these patients was instead

	delivered through the Physio@Home Service, with a referral pathway on SCI-Gateway and professional-to-professional for this group. There were a total of 13 referrals made, below the seasonal average, likely due to the continuing pandemic. The service was able to manage these additional cases with minimal impact to their routine waiting list or delivery of their normal weekend service. There were a total of 32 interventions (13 face-to-face and 19 by telephone). This provided an improved experience for the patients as it required fewer hand offs, and the service was able to provide follow-up interventions to support other non-respiratory symptoms or needs.
Early supported discharge of people with Covid-19	The Community Respiratory Team (CRT) further built on the success of the test of change done in Wards 203/204 at the Royal Infirmary of Edinburgh in 2021 to support the discharge of patients with Covid-19. Patients continued to have a complex presentation with all of those discharged during November 2021 to January 2022 requiring long-term oxygen. This involved an increased number of interventions, in some cases spanning several months. CRT clinicians supported them in navigating the system, ensuring appropriate follow-up from the wider multi-disciplinary team, and overseeing the oxygen weaning process. There were 20 referrals over the reporting period with the average being 27 days on oxygen (range 0 to 147). The average number of days on the CRT caseload was 41 days (range 5 to 147). No new referrals were received during February and March, indicating a trend towards reducing demand, and all patients have now been discharged from the service. The initiative has highlighted that this can be facilitated in the community by a specialist respiratory team and this can be reinstated in the Community as and when needed in the future.
Assistant Practitioners, Discharge to Assess (D2A) teams	Recruitment to these posts took several months, despite being on a permanent basis. This was due in part to difficulties experienced navigating the NHS recruitment process and employment checks for staff who are new to the NHS. Staff took up post late March 2022 and were going through induction but still awaiting Protecting Vulnerable Group (PVG) certification. They will enhance the service skill mix and capacity to facilitate early discharge as an alternative to bed-based rehabilitation going forward. Winter demands were met by the locality based D2A teams who were and are supported by the wider Hub therapy, team therapists if/when required. This ability to utilise the

	wider team ensured discharges could still be supported however the impact on supporting Prevention of Admission functions were monitored to ensure this was not negatively impacted.

9. Recruitment to key service areas to support reducing admissions/re-admissions and delayed discharges proved to be a significant challenge. This has been a sector-wide issue but exacerbated in Edinburgh due to the competitiveness of the local recruitment market. In addition, the increased demand for staff across the system also made it difficult to source suitably qualified candidates. This was not limited to short-term winter contracts but also experienced for full-time roles the Partnership was recruiting to on a permanent basis. The outcome of this was that planned additional capacity was not available in most service areas, adding significantly to pressures.

10. As set out in table 2 below, additional funding was also made available through the Partnership to support unpaid carers for whom the festive period can be a difficult time, and to improve anticipatory care planning (ACP) for people with severe frailty or were at risk of falls. An update of the outcomes of this work is set out below.

Table 2 Additional Winter funding allocation

Title	Update
VOCAL Surviving Christmas – providing support for unpaid carers	The programme supported 105 unpaid carers (114 people in total as carers could be accompanied) across a range of interventions. This included emotional support groups, drop-in sessions, short break visits to local attractions, and recreational activities such as arts and crafts. Where they responded to the online evaluation, they reported high levels of improvement in areas of mental health (94.2%) and social interaction (94.4%), but also improved relationships (70.6%), financial position (61.2%) and confidence (53%). An outcomes review (involving a practitioner obtaining evaluative information through conversation with carers) reported that it was well received with participants reporting feeling less isolated, having improved well-being and for many, the funding enabled them to access supports there would not otherwise have been able to afford at that time of year. Feedback from participants: “I felt less alone at that point in time – it enabled me to get through” “It was really great to know that someone was thinking of me at that time of year” “It is so important that these opportunities are maintained – this time of year, carers can be very isolated and not supported elsewhere”

	As VOCAL gain more experience of running this programme they are able to ensure maximum uptake. It is not just offering recreational opportunities but an important way to sustain their caring role and improve caring relationships.
Improving outcomes for people with severe frailty through anticipatory care planning	Funded through LTC programme. The social worker who was to progress this initiative unfortunately left and it had to be put on hold due to an inability to recruit. The aim is that it will be picked up again in future as initial work was promising. It has the potential to inform evidence-based decision making to provide the right care, at the right time, in the right setting, reducing unnecessary hospital admissions and delayed discharges.
Improving outcomes for people at risk of falls	Funded through the LTC programme. This initiative was aimed to identify people at risk of falls in the NW locality to offer multifactorial falls assessment, rehabilitation, and intervention. An assistant practitioner was recruited however with considerable upskilling requirements. A three month extension was proposed and declined, which resulted in the project being unable to continue. A total of 14 people were identified in the community for follow up, 10 of which were telephoned for further support. Out of these, 3 accepted further support, with 2 accepting a face to face falls assessment, and 1 being referred to Steady Steps programme. A dedicated project management function to provide support and oversight has been identified as the main lesson learnt. Learning from this will be incorporated into the Home First Programme where the falls pathways continue to be subject to scrutiny and improvement.

11. In January 2022, the NHS Lothian Unscheduled Care Committee requested an update on how allocated funds were being used and how they might contribute to winter pressures (Appendix 2). This was followed by an end-of-winter report in April 2022 (Appendix 3).

Performance from November 2021 to end of March 2022

12. Since October 2021, Edinburgh IJB has received updates describing the significant system pressures being faced by the wider Lothian health and social care system as society opened up and restrictions eased. This is also reflected nationally and many of these pressures are not new although they have been exacerbated by the EU exit and the Covid-19 pandemic.

13. There was both an increase in referrals to Assessment and Care Management teams with requests for service, and an increasing number of cases assessed as requiring a service since March 2021. Other drivers for increasing demand include people being de-conditioned, frailer, and less confident following periods of lockdown, family/unpaid carers who are exhausted having cared for people during the pandemic returning to work following furlough, and a general build-up of demand emerging as messaging about services being ‘open as usual’ have been released. Coupled with this increasing demand, we were also faced with a decrease in care capacity available to support

people, compounding an already challenging position.

14. As a result, we entered winter 2021 in an already difficult position with pressures being felt across the system. This was reflected in the high number of delayed discharges at the start of the winter period. Despite this challenging position, we were able to maintain delays at a relatively similar level throughout December and January, avoiding the increase in the number usually seen in January each year. Since January, delays have been on a decreasing trend through the remainder of winter, with delays in March 18% lower than in November, something not seen in previous years. This has also bucked the national trend, with a 14% drop in delays at census point for those over 18 years of age between the peak in January and March in Edinburgh, compared with a 7% rise across the rest of Scotland (minus Edinburgh). There was a similar trend for those over 75 years of age, with a 13% drop in Edinburgh and a 10% rise across Scotland. Also, a 17% drop in monthly bed days occupied for 18+ between the peak in January and March in Edinburgh compared to a 5% rise across the rest of Scotland. For 75+ this was a 16% drop in Edinburgh and a 7% rise across Scotland. A breakdown of activity of the winter months is included as Appendix 4.

15. Community hospital bed provision continued to deliver rehabilitation, intermediate care and hospital based complex clinical care (HBCCC) over the winter months. There were no additional beds opened over this period although six extra unfunded intermediate care beds remained open at Liberton Hospital; a continuation of additional beds from the end of winter 2020/21. Following direction given by NHS Lothian's Gold Command, options were investigated to open additional capacity in both Liberton Hospital and Astley Ainslie Hospital due to system pressures. Although the wards were prepared, they could not open as it was not possible to achieve safe nursing staff levels despite a pan-Lothian approach taken to secure the required staff. This was due to the ongoing high levels of nurse vacancies across Lothian and unplanned leave particularly during peaks of staff absence due to Covid-19.

16. The Astley Ainslie Discharge Hub supported flow through the hospital beds by retaining accurate waiting lists, ensuring patients were on the right pathway for the type of ongoing inpatient care they required, and proactively arranging admissions as soon as discharges were planned. The ward clinical teams focussed on early discharge planning whenever this was achievable and identified any potential barriers or challenges with discharge planning as early in the patient stay as possible. Home First Navigators or named social workers were allocated to the intermediate care and HBCCC services to reduce the overall number of social workers working with the clinical teams with the aim of improving focus on early discharge planning and health and social care staff working in a more integrated way in inpatient settings. Discussions on discharge planning included seeking consent for a move to an interim bed if timely discharge home directly was not achievable. The clinical teams had realistic conversations with patients and their families regarding this.

17. Fillieside Ward at Finlay House participated in a test of change for Planned Date of Discharge (PDD) and this work continues. This increased the focus of the whole team on aiming for a specific discharge date from the outset with the PDD set within 48 hours of admission. The increased collective working was evident including the invaluable contributions by the allocated Home First Navigator to the team.

18. The Partnership are progressing with the implementation of phase one of the bed-base review which will see a rebalance of intermediate care, HBCCC and care home beds across the city. Adaptations are required to transition the former Drumbrae Care Home to an HBCCC facility. When Drumbrae is operational, the redesign of Intermediate Care can begin. Phase one of the bed base review will see an increase in Intermediate care capacity and a reduction of HBCCC capacity. Further to that, we are in the process of recruiting to our new model of care within our 60 bedded care homes. The introduction of nursing staff into the care homes will enable the Partnership to provide high quality nursing care at affordable local authority rates, an area where Edinburgh has limited provision at present. The nursing staff will be recruited over the next six to nine months with one of three care homes operating the new model in time for winter.

19. The Partnership purchased a number of interim care home beds to support people who are medically fit to leave hospital but need additional time to ensure a package of care is in place to support them at home. These beds were purchased during extreme system pressures however, due to the impact on hospital flow, some of these beds will be considered on a longer-term basis as part of the Partnerships commitment to improve flow through the system. There were 121 people moved into an interim placement by 31 March 2021 (end of the financial year) and 71 of these had already ended their placement, a 59% turnover. In total this initiative saved 6,239 bed days in hospital by the end of the financial year and reduced the number of daily delayed discharges by 61 delays at the peak.

20. Phase 2 of the Redesign of Urgent Care continues, with the expansion of the Home First Navigators (HFN) in the Flow Centre to provide a service for longer hours Monday to Friday. They take calls mainly from GPs across Edinburgh for urgent therapy and/or social care to prevent admission and liaise directly with the patient/family and locality hubs. The HFNs are also working closely with the Frailty Assistant Nurse Practitioner (ANP) in the Flow Centre, which is also strengthening links to Hospital at Home (H@H). Under the banner of Home First, the Prevention of Admission work is being further developed with collaboration of Partnership colleagues to focus on three workstreams – frequent attenders, re-admissions, and prevention of admission from care homes. Data is currently being collected to inform the interventions that may be successful in reducing the number of people presenting or being admitted to an acute hospital.

21. Home First Edinburgh continues to build on the work undertaken to date and will have a number of key areas of focus in the year ahead:
    a. Structure and governance - ensuring the correct management and reporting structure is in place so that colleagues have clear roles and responsibilities, are part of a wider Home First network and are supported in their roles.
    b. Interface Care (prevention of admission and attendance) - building on the prevention work that has taken place already, interface care will identify and target areas of improvement that will support prevention of admission or attendance from acute hospital sites. Building on the work undertaken so far, including a single point of access via the Flow Centre and Home First navigators at the front door of Emergency Department (ED), Interface Care will provide alternatives to hospital attendance and admission, enabling citizens to access the most appropriate care and support through alternative community-based services.
    c. Optimising patient flow (including Discharge without Delay) - optimising patient flow and discharge without delay will be accelerated in the coming year aligned to the

Scottish Government's national initiative. Working collaboratively with all Partnerships across Lothian, system wide priorities have been identified. Edinburgh will consider these locally and establish an action plan on how to achieve the system wide priorities at local level.

d. Pathways - pathways into and out of hospital need to support the initiatives outlined above, they need to be streamlined, consistently applied, and should not cause unnecessary delays. Some of the pathways in Edinburgh could be improved and these will be targeted, driven by data, and based on the experience of those working with them in front line services. Pathways, where possible, should be consistently applied regardless of where they are provided from. Pathway improvements will follow a quality improvement (QI) methodology allowing evaluation and amendments throughout.
e. Performance metrics and data analytics - Home First now has a dedicated data analyst and service improvement manager who will support all the planned activities going forward. Measuring success through data capture and trend analysis and where improvements are identified, working to a defined QI methodology to ensure consistency of practice and continuous improvement processes. Local support will be supplemented regionally and nationally through collaborative working and shared objectives.

22. The Discharge without Delay (DwD) programme continues to progress, with five areas identified for action this quarter, to facilitate working towards Planned Date of Discharge (PDD) in Lothian. This three-month action plan has been shared with the Partnership and will include:
    a. Focus on first 72 hours of the acute patient journey - developing a whole system approach aligned to the 'front door' to facilitate the very earliest date of discharge. A test of change is being planned for the Western General Hospital.
    b. Home First Patient Flow and Discharge Tracker - to categorise and prioritise patients for whom Edinburgh HSCP interventions are expected to prevent admission to downstream wards or facilitate a sooner discharge. In time this will allow automatic updating of the PDD, keeping community services informed of changes.
    c. Request for Service (RFS) – improve the RFS process by reducing the number of steps required between the ward team deciding they need social care input and the partnerships actions.
    d. Roll out the PDD initiative to other two wards in Liberton Hospital- implementing the new model of PDD.
    e. Discharge and transfer policy review - the new policy is now a pan-Lothian policy, incorporating Scottish Government's DwD guidance. A self-assessment tool has been developed and baseline assessment done to identify areas for improvement.

23. The development of the H@H service continues with ongoing review of progress following recommendations arising from a Lothian-wide review against Healthcare Improvement Scotland (HIS) guiding principles for service development. A number of different referral routes have been introduced including from Scottish Ambulance Service (SAS) as well as ED. Virtual clinics have been introduced to accept ED referrals out-of-hours for visits the following day, and there are GP out-of-hour referrals for care home residents. There is ongoing work with acute medical unit colleagues to increase referrals from "front door" areas.

24. The H@H service is working to increase virtual capacity, having been set a target increase of 50% by HIS to be achieved by March 2022 and doubling capacity by March 2023. Using funding provided for one-off costs to support short-term increases in bed capacity to help relieve pressure, enabled the service to exceed this first target with an increase of nearly 61%. Work is now underway to better understand what will be needed to meet the 2023 target.

Ensuring Business Continuity

25. Throughout 2021/22, the Partnership continued to deal with COVID-19 alongside undertaking resilience planning for COP26, the climate change conference being hosted in Glasgow, and care for people. The Partnership Severe Weather Resilience Plan was formally reviewed in the summer 2021 and will be continuously reviewed on an annual basis with the addition of any lessons learnt from the impacts of Severe Weather.

26. Resilience plans are in place for all services across the Partnership and are in the process of being reviewed and updated. Work is also ongoing to develop tabletop exercises to test the Partnership resilience plans over the 2022/23 cycle.

27. The Partnership as part of its Severe Weather had arrangements in place to access 4 x 4 vehicles if required. There were no significant severe weather incidents that arose during winter 2021/22.

Winter Vaccination Programme

28. The Partnership winter vaccination programme for adults was planned to have all eligible people vaccinated by early December 2021, with a concentration on flu vaccination delivery. Changes were however required due to the changing guidance and the programme was extended at full capacity to accommodate the additional groups.

29. From September 2021, the lead responsibility for the delivery of the Covid vaccination programme transferred from NHS Lothian to Edinburgh HSCP. The approach to delivery remains highly collaborative between all Lothian HSCPs and NHS Lothian.

30. The programme started in September with an emphasis on delivering flu vaccinations, but this emphasis changed due to the emergence of the Omicron variant of Covid-19.

31. The scale of this delivery was unprecedented. In 2019, medical practices and community pharmacists delivered approximately 70,000 flu vaccinations to 70,000 adults. By Christmas 2021 for comparison, more than 300,000 vaccinations in total were given.

32. The vaccination programme became multifaceted and complex as more groups were added:
    a. The NHS Lothian children's Community Vaccination Team carried out the school programme for Flu (including home-schooled pupils). In Edinburgh, the additional Covid 12 to 15 and 16 to 17 year-old cohorts were fitted into the adult programme from 4 October 2021 and first doses were delivered to all those willing to come

forward. Opportunity to 'drop-in' to all local clinics for first doses in these cohorts has been maintained.

b. Vaccination of those in care homes and the housebound started from 27 September 2021. Care Homes were completed by 5 November 2012 and all housebound were to be visited or brought to clinics by early December (both vaccinations offered, and staff and any carers eligible also offered vaccination).
c. Health and social care staff were vaccinated through a mixture of peer vaccination, staff clinics and self-appointment to adult clinics.
d. From November 2021, those aged 50-59 and unpaid carers were able to self-appoint (totalling approximately 100,000 people in Edinburgh).
e. Community Pharmacists have played an important role again this year, offering booked appointments for flu (only) to patients unable to get to clinics.

33. In total, 145,352 flu vaccinations were delivered to all eligible groups by end of December 2021.

34. Covid-19 booster vaccinations were prioritised at beginning of December and a 'Booster by the Bells' campaign began with the ask of boosters to be delivered to as many people aged 18 years and over by the end of December 2021. From the beginning of October 2021 to the end of December 2021, 258,491 third and booster doses were given.

35. Spring Covid-19 booster vaccinations are currently being offered to everyone aged over 75 and those at highest risk of severe Covid-19 disease including residents in care homes for older adults, and individuals aged 12 years and over who are immunosuppressed. The decision came following the latest Joint Committee on Vaccinations and Immunisation advice that a second booster jab was required to provide as much protection as possible and to reduce the risk of waning immunity. Latest guidance is that a further autumn booster should be offered to over-65s, health and care staff and clinically vulnerable adults aged 16 to 64.

36. Lowland Hall at Ingliston Showground in Edinburgh was an essential and very effective clinic to offer vaccinations to large numbers however it is recognised that it was not a convenient or popular venue. Early in 2022 Lowland Hall was decommissioned as a venue and the vaccination programme has been delivered in two 'mini-mass' sites in the Gyle shopping centre and Ocean Terminal which will offer year-round vaccinations. There is also a venue in Waverley Mall which is anticipated to remain in use to provide accommodation for any surge vaccinations required during the 2022/23 programme as well as offering an accessible city centre venue. The delivery of the programme should gradually be more evenly distributed across the whole year, making possible the use of smaller venues in combination with our established network of local clinics.

Communications

37. The communications for winter 2021/22 followed a similar format to previous years, focusing on the most vulnerable with preventative messaging. This winter, there was the added complexity of changing messaging around winter vaccinations (for flu and Covid-19) for those who were eligible.
    a. Frontline adult social care workers were encouraged to get their winter vaccinations.

b. Key information was created and shared with frontline teams to help them support vulnerable audiences over winter.
c. The Edinburgh Carer Support team worked with the communications team to provide customised information for carers online, and on carer information boards in hospitals.
d. Shared public messaging from NHS Lothian, Public Health Scotland, and Scottish Government.
e. Supported vulnerable audiences mainly through Partnership care workers and backed that up with social media and information on the Edinburgh Health and Social Care website. Also, internally through colleague news, colleague hub, briefings to frontline teams and services, and through News Beat, the Council's e-magazine.

38. An evaluation of communications undertaken is available on request.

Forward Planning for 2022/23

39. Planning in already underway around priority actions which will need to be in place for winter 2022/23. These include:
    a. Progressing work around Home First including a 12-month plan aligning with Urgent and Unscheduled Care, and more specifically the DwD programme.
    b. Enhancing hospital-based social work capacity to deliver on DwD ambitions. This would include development of dedicated, site-based hospital teams focussing on early identification, assessment and pull, arranging timely community support and enable PDD, with designated teams allocated to individual wards. A proposal has been submitted from the Partnership following the release of recurring funding from Scottish Government to provide additional social work capacity within local authorities, but this is highly unlikely to be met in full so winter funding can be used to augment this resource.
    c. Supporting community-based services within the Partnership to provide care in the community and avoid emergency admissions. Learning from the Home First Prevention of Admission and Frequent Attenders workplan will inform this work.
    d. Explore the CRT+ model for future winters including the skill mix in CRT and Physio@Home. This is being explored through the Interface Care Group.
    e. Work more closely with third sector organisations to relieve pressure on health and social care services and provide community-based care and support for local residents. This will include working with the Cyrenians, the Defence Medical Welfare Service (DMWS) and other third sector organisations via our expanding Community Resilience (community navigators) team to support discharge for veterans, those experiencing homelessness and the elderly. Locality-based workers will support clients holistically and link with colleagues to provide tailored advice on local community resources which could be used before or instead of statutory services.

Implications for Edinburgh Integration Joint Board

Financial

40. NHS Lothian was allocated a total of £1.451M to support the costs of ensuring health and social care services were prepared for winter 2021/22.

41. A total of £171,000 was allocated to Edinburgh HSCP based on the average percentage of funding received in the previous three years.

42. An additional £8,132 was made available by the Partnership to other initiatives to support unpaid carers over the festive period and for anticipatory care planning to improve outcomes for people with several frailty.

43. The Partnership is now in receipt of the £171,000 allocation for winter 2022/23 and planning has started to address priority areas.

Legal / risk implications

44. Ability to recruit, not only to short-term posts required for surge capacity, but permanent posts will continue to be challenging due to system-wide pressures and the competitiveness of the local recruitment market. In future there will be a need to weigh up the recruitment timescale and training costs involved against the potential benefits accrued by some of these posts.

Equality and integrated impact assessment

45. An integrated impact assessment was undertaken in November to consider potential impacts on people with protected characteristics and other groups of winter plans. It was not deemed necessary to repeat that this year as the key areas of focus remained the same.

Environment and sustainability impacts

46. Improvements to public safety through identification of vulnerable people living in the community and ensuring appropriate support is in place, for example through ATEC24 or Technology Enabled Care; protecting their vital interests during periods of severe weather or where there are concerns for their safety.

47. Improved infection control through care management at home.

48. Reduced need to travel, and potential for accidental injury, by providing care closer to home.

49. Potential impact of severe weather and disruption of services minimised; priority locations for road clearance and gritting; access to emergency food supplies to those assessed as requiring them.

Quality of care

50. Winter planning continues to be providing safe and effective care for people using services and ensuring there is sufficient capacity to meet the expected surge in demand. It focuses on providing care close to home, avoiding unnecessary admissions and re-admissions where possible, and facilitating the early supported discharge where admission is needed. This supports service delivery across the wider system of health and social care over the winter months and during festive public holidays.

Consultation

51. Preparing for winter is done in close consultation with key stakeholders through the Winter Planning Group, which includes multidisciplinary representation not only from the Partnership but also acute services and the third sector.

52. The Partnership is also represented on the NHS Lothian Unscheduled Care Tactical Committee which has oversight of Lothian-wide planning for winter.

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Background Reports

Not applicable

Appendices

Appendix 1	Supplementary Checklist of Winter Preparedness Checklist
Appendix 2	Update on Winter 2021/22 for NHS Lothian Unscheduled Care Committee
Appendix 3	Evaluation of Winter 2021/22 for NHS Lothian Unscheduled Care Committee
Appendix 4	Evaluation of Edinburgh HSCP Performance for Winter 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					

Business Unit	Proposal	Option	Description	Impact / Effect on Flow	Overall Workforce	WTE	Funding £k	Period to cover	Likelihood to Achieve by December	Comments added	Implementation Status
Edinburgh	Winter	Edinburgh Community Respiratory Hub	Enhance CRT capacity 1 WTE APP physio, 2 WTE specialist PT	Prevent attendance / admission	AHP	3	45	4 months	Medium	Agreed for Winter Funding - Recruitment underway	Recruitment has been difficult due to lack of interest and available candidates. Despite this, there has been a steady flow of non-COPD respiratory patients that are still able to access physiotherapy through referral to Physio@Home and there have been six referrals to date. This service have been meeting the needs of these patients Mon-Fri and saw a slight increase in activity over the festive weekend and public holidays. This is having a small impact on the Physio@Home routine waiting list and we are in the process of exploring a couple of locum candidates, through the StaffBank to enhance staffing within Physio@Home. Slippage has occurred due to the above mentioned recruitment challenges.
Edinburgh	Winter	Hub Social Worker Enhancement	Enhance hospital social care assessments and completion within 72 hours , 4 WTE SW, 2 WTE SSW	Support Flow from RIE/ WGH - target is 90% of 11B's (20/21 achieved a 58% reduction)	Social Workers	6	130	4 months	Medium	Agreed for Winter Funding - Recruitment underway however few/no appropriate candidates at first atttempt	Despite three attempts to recruit to 4 WTE social worker and 2 WTE senior social worker posts we have been unable to find suitable candidates. A fourth round of recruitment has now taken place with more success. Interviews were held on 14/1/22 for three full-time Home First social workers, the intention being that these posts will be made permanent. Slippage has occurred due to the above mentioned recruitment challenges.
Edinburgh	Winter	Discharge to Assess	Enhance D2A skill mis and enhance capacity - 4 WTE assistant practitioners, one per locality	Support Flow from acture sites and reduce delays	AHP	4	47	4 months	High	Not agreed through Winter Funding previously - EHSCP agreed to find resourcs and recruitment underway on a permanent basis as per agreement with Tom Cowan - Additional Winter Funding now requested	Recruitment to these posts has been delayed as a result of challenges in advertising the vacancies. Despite this, interviews were held on 17/1/22 with a strong field of candidates and we are confident that posts will be filled. These posts are being made permanent and will be based within the Home First service, improving patient flow and reducing length of stay. Slippage has occurred due to the above mentioned recruitment challenges.
Edinburgh	Winter	Early supported discharge C19	Supported discharge of patients with C19, monitoring respiratory symptoms and facilitating oxygen weaning.	Support flow from RIE	AHP	0.5	9	4 months	Medium	Previously agreed for Winter Funding - Recruitment underway	Plans have been put in place, although we were unable to recruit 0.2 WTE Band 7 Advanced Physiotherapist. Patients discharged via this pathway continue to have a complex presentation with all patients discharged in November and December being on oxygen. CRT clinicians have supported 20 patients so far, and it is estimated that from these patients, there has been a total of 140 bed days saved. Slippage has occurred due to the above mentioned recruitment challenges.

Evaluation of Winter 2021/22

NHS Board: **Health & Social Care Partnerships:**	NHS Lothian West Lothian **Edinburgh** East Lothian Midlothian	**Winter Planning Executive Lead:**	Alison MacDonald, Chief Officer, East Lothian Health & Social Care Partnership

Introduction

To continue to improve winter planning across NHS Lothian and the four Health and Social Care Partnerships (HSCP's) we are asking colleagues to complete this winter evaluation for 2021/22. This is a beneficial exercise which helps to identify lessons learned and key priorities areas for Winter 2022/23.

Completed evaluations should be sent to Louise.Baillie@nhslothian.scot.nhs.uk no later than close of play on Thursday 21st April 2022.

Thank you for your continuing support.

Iain Gorman
Head of Operations, East Lothian HSCP
Unscheduled Care Tactical Committee Chair

Jill Gillies
Director
Unscheduled Care Programme

1.0	**Overall process to support Winter Planning and Funding 2021/22** *(Please consider how the new process worked for you and your teams. No longer bidding for funding, the release of funding earlier/set amount, recruitment processes etc.)*
1.1	**What went well?**
	• The new process for allocating funds was positive. The Partnership was made aware of available funding early in the winter planning process and was free to allocate them as desired based on previously identified local priorities which were also aligned with other programmes of work. • It removed the need for service managers to take time out to prepare proposals for consideration by the USC with no guarantee of success. • Availability of funding earlier in the year enabled recruitment to start ahead of Winter however ultimately this remained a challenge for reasons outlined below.
1.2	**What could have gone better?**

	• Recruitment to key service areas to support reducing admissions/re-admissions and delayed discharges proved to be a significant challenge. This was a sector-wide issue but worsened in Edinburgh due to the competitiveness of the local recruitment market. The increased demand for staff from across the system also made it difficult to source suitably qualified candidates.
	• Navigating the NHS recruitment systems is further complicated where services are managed by a local authority employee as may be the case for a HSCP
	  ○ the authorisation process for going to advert can be delayed with no direct link or support available, and
	  ○ a post was approved but then deleted in error resulting in the process needing to start again and taking six weeks in total.
	• Where successful candidates are new to the NHS, completing the necessary checks prior to taking up post can be lengthy.
	• The induction period for new staff can be significant, with some staff required to achieve the desired band competency during that time. In certain cases, this took up to 12 weeks and impacted on their ability to support winter pressures.
	• These issues were not limited to short-term contracts but also experienced for roles the Partnership was recruiting to on a permanent basis and would be funding after the end of winter.

1.3	**Key Lessons / Actions**
	• Attracting the required number of potential candidates for short-term contracts has historically been difficult. In future there will be a need to weigh up the recruitment timescale and training costs involved against the potential benefits accrued.

2.0	**Impact of Winter Interventions** *(Please consider how effective your interventions have been and include any evidence you may have on impact. Anything you would do differently going forward?)*
2.1	**What went well?**
	• Although unable to recruit to additional CRT+ posts as planned, the Physio@Home service supported non-COPD respiratory patients in Edinburgh with a referral pathway on SCI-Gateway and professional lines for this group. There were a total of 13 referrals to the service during the winter period with minimal impact to their routine waiting list or delivery of their normal weekend service. There were a total of 32 interventions (13 face-to-face and 19 telephone calls). Physio@Home involvement provided an improved experience for the patients as there were fewer hand offs, with the service able to provide follow-up intervention to support other non-respiratory symptoms or needs. • CRT further built on the success of the test of change done in Wards 203/204 at the RIE earlier in 2021 to support the discharge of COVID19 patients. Patients continued to have a complex presentation with all patients discharged during November 2021 to January 2022 requiring long-term oxygen. This also involved an increased number of interventions, in some cases spanning several months. CRT clinicians supported them in navigating the system, ensuring appropriate follow-up from the wider MDT and overseeing the oxygen weaning process. There were 20 referrals over the reporting period with average number of days on oxygen being 27 days (range 0-147). The average number of days on the CRT caseload was 41 days (range 5-147). No new referrals were received during February and March indicating a trend towards reducing demand, and all patients have now been discharged from the service. • The locality-based Discharge to Assess teams took on meeting the additional demands of winter and were supported in this by the wider Hub therapy team therapists as required. This ensured discharges were still supported but ability to support prevention of admission functions had to be monitored to ensure they were not being negatively affected. The additional permanent posts which were planned are now filled and in the post learning and development stage, meaning they will support the wider teams going forward. • The VOCAL Surviving Christmas programme supported 105 unpaid carers (114 in total as carers could be accompanied) across a range of interventions. An evaluation has shown high levels of improvement in areas of mental health and social interaction, but also improved relationships, financial situation and confidence. It was well received with participants reporting feeling less isolated, having improved wellbeing and for many, the funding enabled them to access supports they would not otherwise have been able to afford at that time of year.
2.2	**What could have gone better?**
	• Recruitment of experienced social work staff was exceptionally challenging despite being advertised on a permanent basis. The 4 WTE social worker (SW) and 2 WTE senior social worker (SSW) posts were re-advertised four times however it was not until January 2022 that recruitment to the 4 SW posts was successful. Following employment checks, three of these candidates were offered a start date between March and April. The fourth unfortunately took up an offer from another local authority. Recruitment to the SSW

	posts has been unsuccessful to date but will be re-advertised this month. These posts will enhance acute hospital social work capacity but with a focus on a Home First approach. A SW will be part of a dedicated team at the 'front door' where the focus is on the patient for the first 72 hours, supporting them and ensuring early conversations with the person and their family/carer to assist and influence discharge. It is anticipated that this will reduce the numbers being admitted and enabling prompt discharges from the 'front door'. • We were unable to recruit to additional Band 6 physiotherapy posts to support CRT+ due to lack of interest and suitable candidates. • Recruitment to the Discharge to Assess assistant practitioner posts took several months to complete, with start dates only commencing the week of 21st and 28th March. • Level of weekend activity and discharges across the system remains a concern.
2.3	**Key Lessons / Actions**
	• The challenge of recruiting Band 6 CRT roles on a temporary basis and the 'pool' of internal staff from Physio@Home/associated services that have previously shown interest has now been exhausted. • The COVID19 pathway time for oxygen weaning was longer than expected due to their complexity of the patient group but the project highlighted that this can be facilitated in the community by a specialist respiratory team. • Carers should continue to be supported as a means of sustaining their caring role, improving their resilience, and relieving some potential pressure on health and social care services.

3.0	**Top Five Priorities for Winter 2022/3**
	1. Progress work around Home First including a 12-month plan aligning with Urgent and Unscheduled Care, and more specifically the Discharge without Delay (DwD) programme. 2. Enhance hospital based social work capacity to deliver on DwD ambitions. This would include development of dedicated, site-based hospital teams focussing on early identification, assessment and pull, arranging timely community support and enable PDD, with designated teams allocated to individual wards. A proposal has been submitted from Edinburgh HSCP for additional funding following the release of recurring funding from Scottish Government to provide additional social work capacity within local authorities, but this is highly unlikely to be met in full, so winter funding can be used to augment. 3. Supporting community-based services within the Partnership to provide care in the community and avoid emergency admissions. Learning from the Home First Prevention of Admission / Frequent Attenders workplan will inform. 4. Explore the CRT+ model for future winters including the skill mix in CRT and Physio@Home. This is being explored through the Interface Care Group. 5. Work more closely with third sector organisations to relieve pressure on health and social care services and provide community-based care and support for local residents. This will include any learning from the DwD pathfinder sites working with the Red Cross.

Evaluation of Edinburgh HSCP Performance – Winter 2021-22

Overall commentary

Since October 2021 the EIJB has received updates describing the significant system pressures being faced by the wider Lothian health and social care system as society opened up and restrictions eased. This is also reflected nationally and many of these pressures are not new although they have been exacerbated by the EU exit and the covid pandemic.

We saw both an increase in referrals to our Assessment and Care Management teams for requests for service, and an increasing number of people being assessed as requiring a service since March 2021. Other drivers for increasing demand include people being de-conditioned (i.e. frailer, less confident) following periods of lockdown, family/unpaid carers who are exhausted having cared for people during the pandemic returning to work following furlough, and a general build-up of demand emerging as messaging about services being 'open as usual' have been released. Coupled with this increasing demand for services, we were also faced with a decrease in care capacity available to support people, compounding an already challenging position.

As a result, we entered winter 2021 in an already difficult position with pressures being felt across the health and social care system. This was reflected in the high number of delays at the start of the winter period. Despite this challenging position, we were able to maintain delays at a relatively similar level throughout December and January, avoiding the increase in the number of delays usually seen in January each year.

Since January, our delays have been on a decreasing trend through the remainder of winter, with delays in March 18% lower than in November, a trend that has not been seen in previous years. This has also bucked the national trend, with a 14% drop in delays at census point for 18+ between the peak in January and March in Edinburgh compared to a 7% rise across the rest of Scotland and a 17% drop in monthly bed days occupied for 18+ between the peak in January and March in Edinburgh compared to a 5% rise across the rest of Scotland[1].

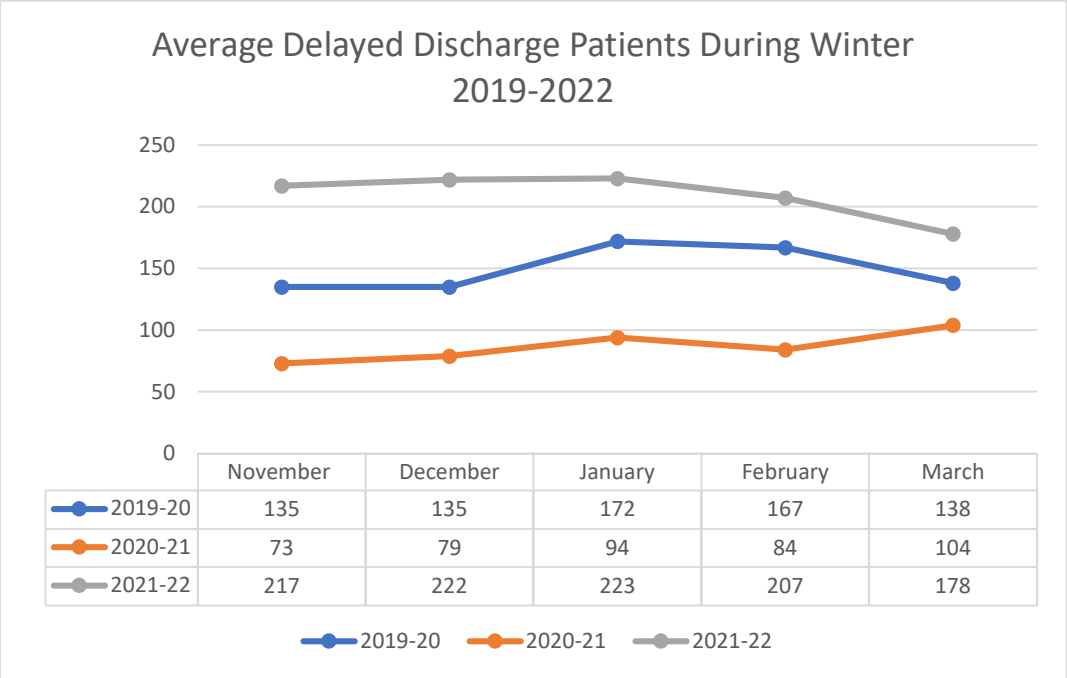
[1] Taken from Public Health Scotland's monthly delayed discharges report - https://publichealthscotland.scot/publications/delayed-discharges-in-nhsscotland-monthly/delayed-discharges-in-nhsscotland-monthly-figures-for-march-2022/

1.0 Delayed Discharge

1.1 Average number of delay discharge* (DD) patients by month during the winter period

This covers Edinburgh HSCP, acute and non-acute sites.

The average number of delayed discharge patients for the winter months across Edinburgh acute and non-acute sites have increased by **141%** in comparison with the previous winter 2020/21. This is an increase of 40**%** in comparison to the pre covid winter 2019/20. This data doesn't include delayed discharge numbers in the Royal Edinburgh Hospital.

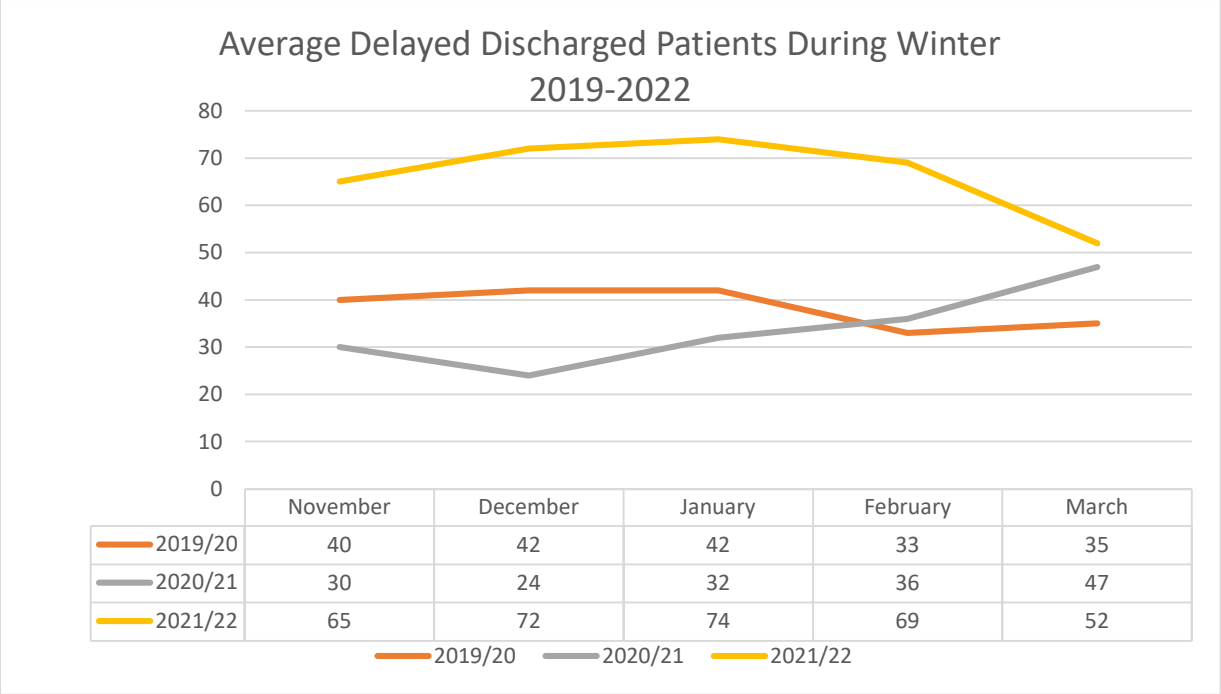


	November	December	January	February	March
2019-20	135	135	172	167	138
2020-21	73	79	94	84	104
2021-22	217	222	223	207	178

*Standard delays plus code 9 delays – this definition matches the nationally reported delay figures.

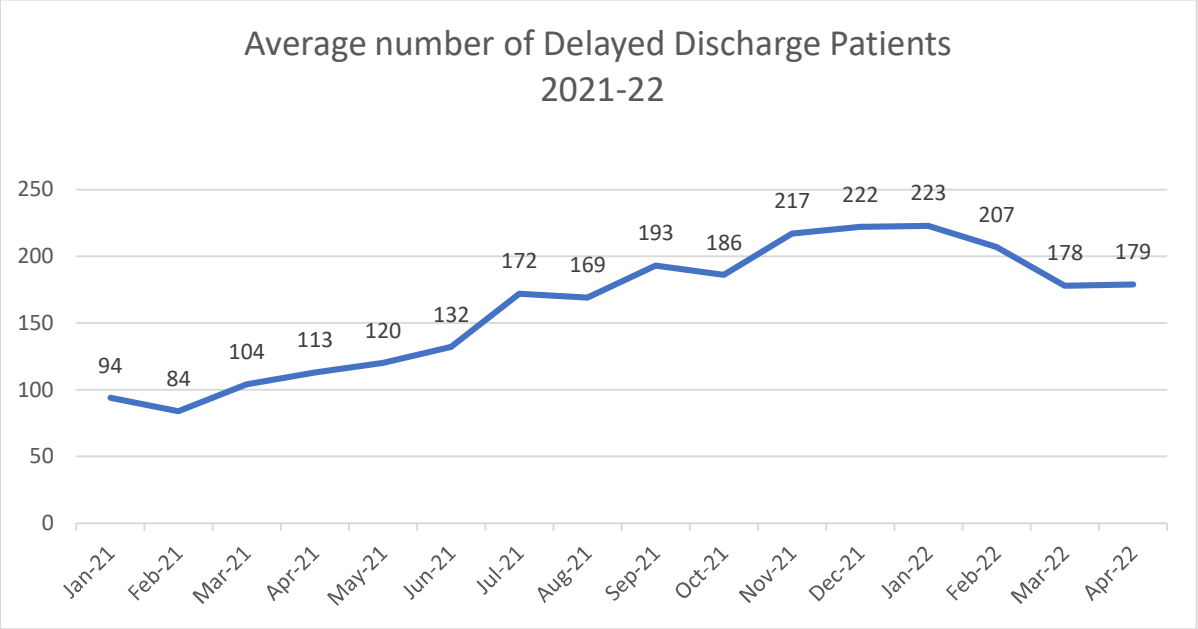
1.2 Average Delay Discharge (DD) in community settings

Average number of Delay Discharge (DD) patients by month during the winter period in community hospitals and interim placement. This covers Edinburgh HSCP non-acute sites, with the exception of the Royal Edinburgh Hospital. Average number of delayed discharge patients have increased by **96%** this winter in comparison to the previous winter.

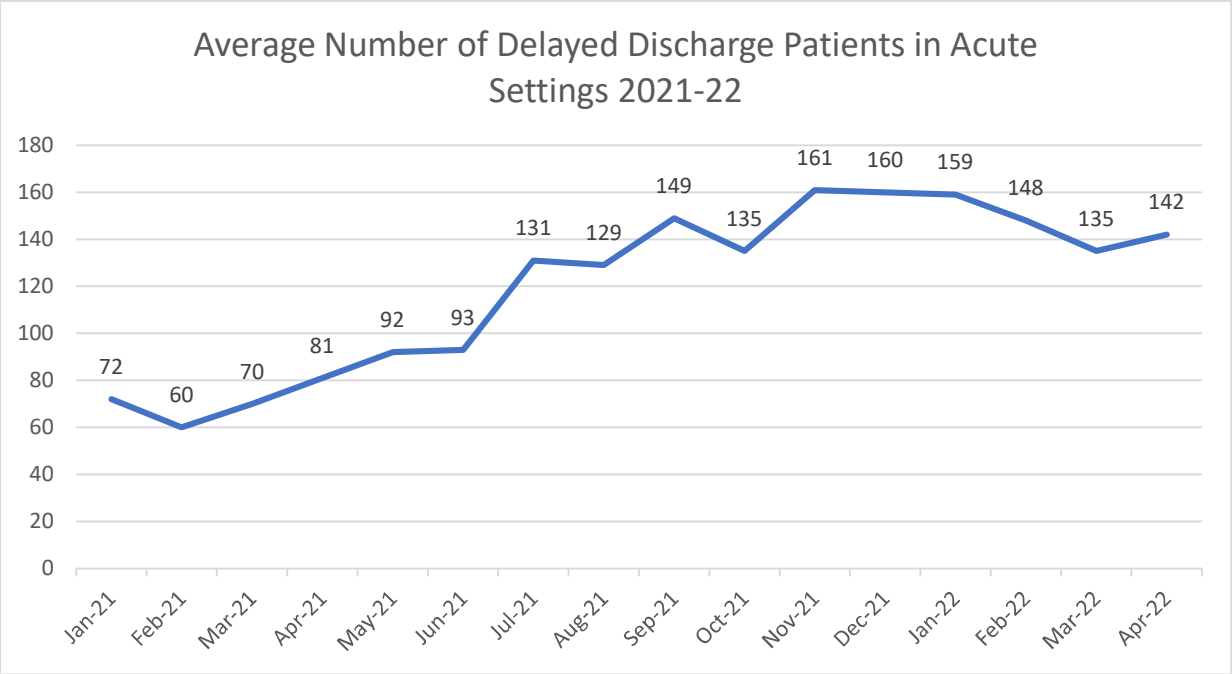


1.3 Average Delayed Discharge Edinburgh 2021-22

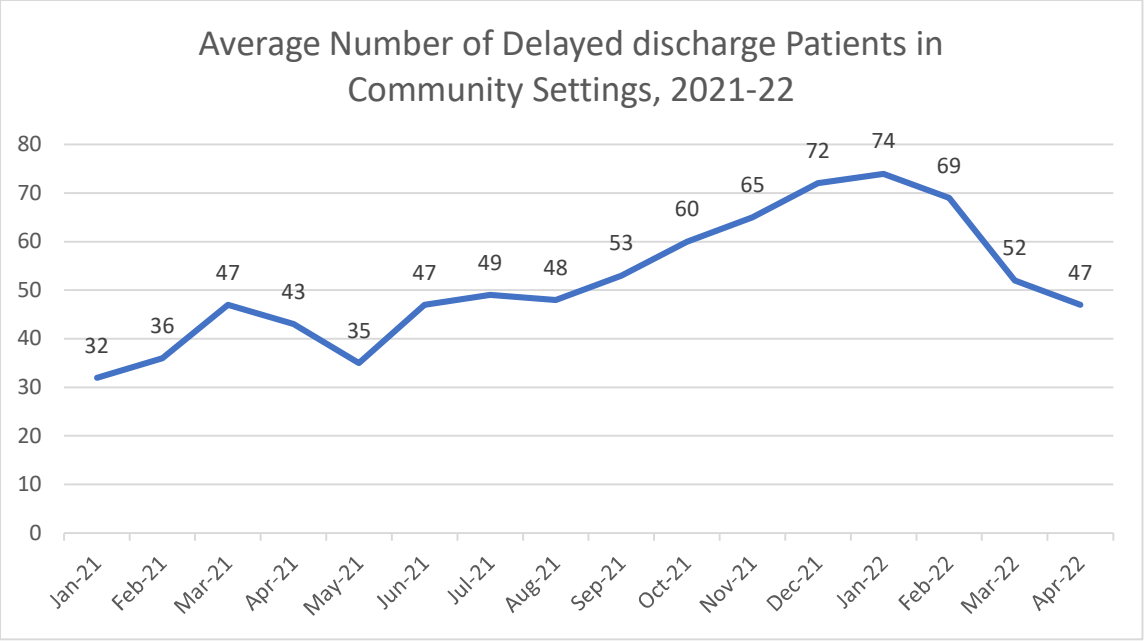
The below graph shows the trends on delayed discharge patients during the year 2021 and 2022 in Edinburgh. The average number of patients delayed in acute and non- acute settings was steady during the first five months of the year however these delays have increased since May 2021.



1.4 Average number of delayed discharge patients in acute sites 2021-22

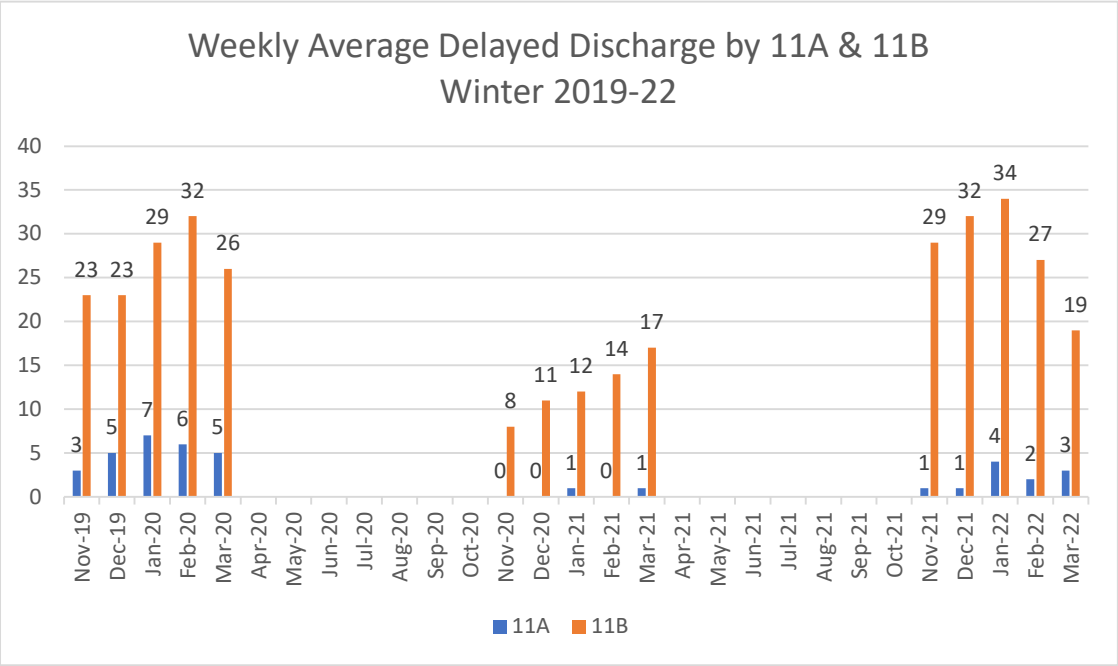


1.5 Average number of delayed discharge patients in community hospitals 2021-22



1.5 Weekly Average of Delayed Discharge by reason of delay- Social Care Delays 11 A and 11B during 2021-22.

The graph below shows the weekly average number of social care delays by month in Edinburgh acute and community hospitals.

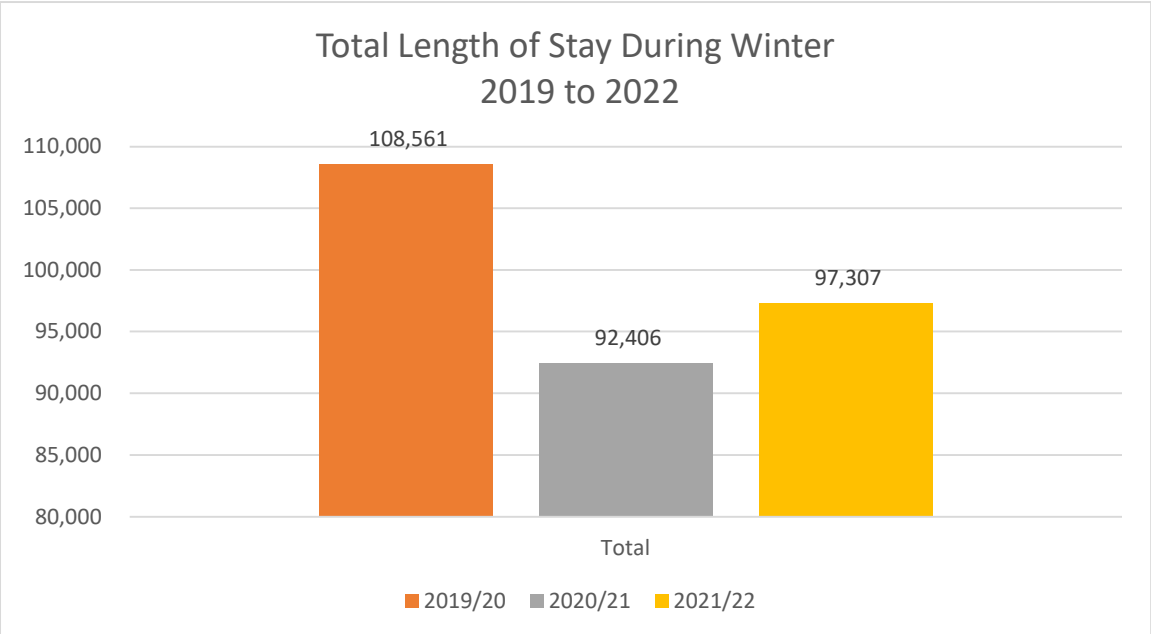


2.0 Length of stay

2.1 Length of Stay in Hospital – Winter Months

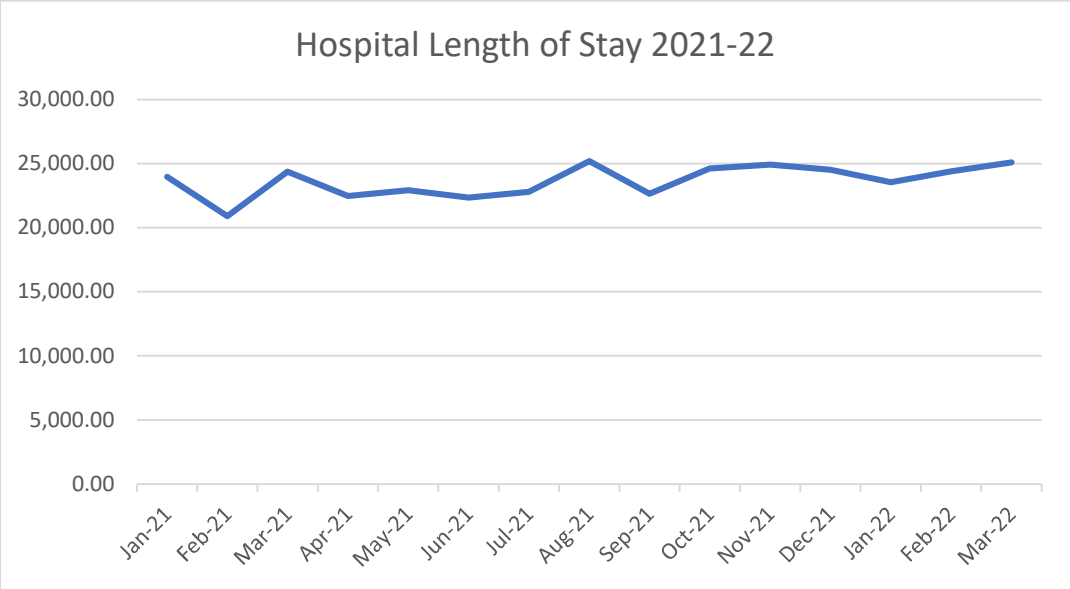
The graph below shows a three-year comparison of Length of Stay (days) in acute settings. The length of stay (LOS) in hospital increased this winter by **5%**. LOS days for the winter 2021/22 are still showing a positive position compared to the year 2019/20 with a reduction of **10%**.

The total LOS for the past four winters (2019-2022)



2.2 Length of Stay in Acute Settings

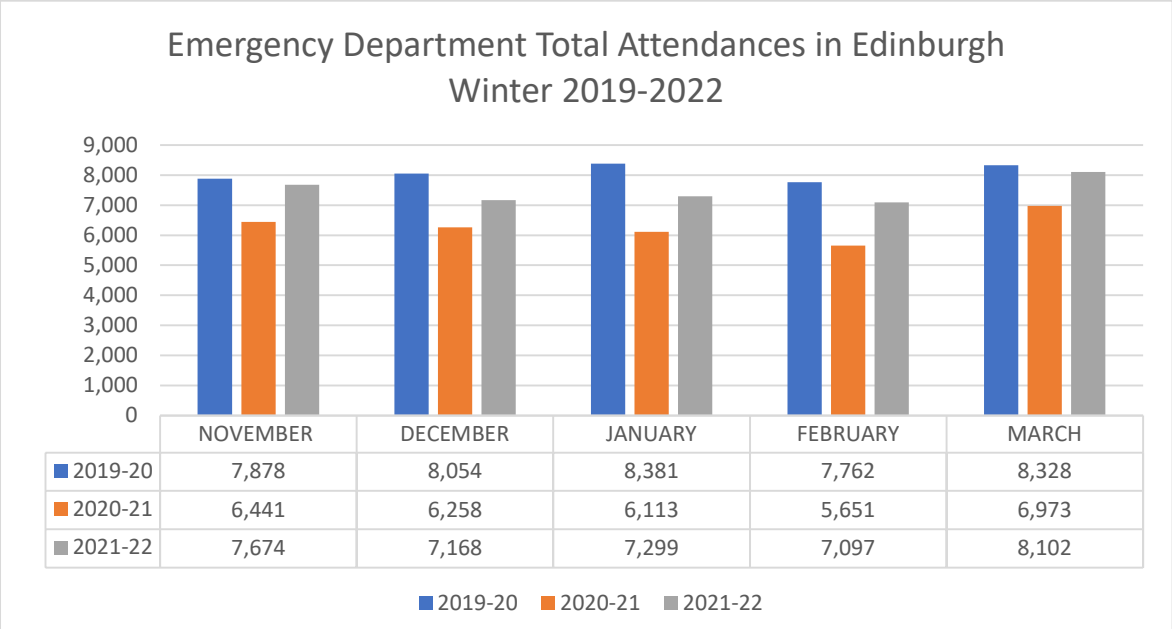
The LOS trend line for year for acute settings show similar steady numbers of days across the year with the months of winter remaining similar with no heavy changes during months with surge in demand.



3.0 Admissions to A&E

3.1 Attendances to Emergency Department

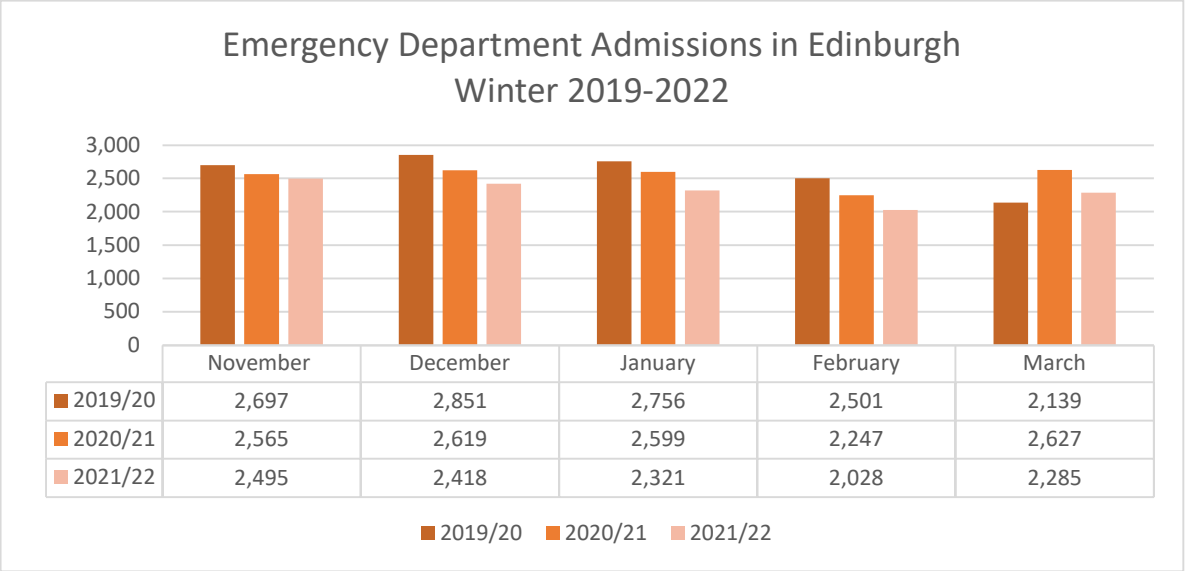
Despite attendances remaining low this winter, increased complexity, pressures on staffing (partly due to self-isolation requirements) and reduced flow through hospital resulted in significant challenges for emergency departments. Attendances have increased compared to the previous winter; however attendances were lower than 2019-20. A comparison of the past three winter periods from 2019 -20 to 2021-22 is shown below:



	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
2019-20	7,878	8,054	8,381	7,762	8,328
2020-21	6,441	6,258	6,113	5,651	6,973
2021-22	7,674	7,168	7,299	7,097	8,102

3.2 Admissions to A&E

Emergency admissions in 2021/22 were lower than previous winters. Admissions to A&E decreased by **9%** in comparison to 2020/21. The graph below shows emergency admissions by month, for both the RIE and WGH sites, across the last three winters.



	November	December	January	February	March
2019/20	2,697	2,851	2,756	2,501	2,139
2020/21	2,565	2,619	2,599	2,247	2,627
2021/22	2,495	2,418	2,321	2,028	2,285