AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**12 September 2017**
Report By:	**Louise Long Corporate Director, (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/36/2017/HW**
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Subject:	**INVERCLYDE HSCP 2016/17 WINTER REVIEW AND 2017/18 PLAN, AND 2017/18 SELF-ASSESSMENT**		

1.0 PURPOSE

1.1 The purpose of this report is to present the Inverclyde IJB with a review of our Winter 2016/2017 arrangements, our Winter 2017/18 self-assessment, and our new Winter Plan 2017/2018.

2.0 SUMMARY

2.1 This review of 2016/2017 arrangements highlights what went well and the lessons learned from its implementation. The review process also informs the key priorities in the development of planning for the 2017/2018 reporting period. The 2017/2018 Plan has been developed in accordance with Scottish Government guidance, and the self-assessment has been completed using the template issued by the Scottish Government Directorate for Health Performance & Delivery, on 4th August 2017. There is a requirement for us to submit our Winter Plan to the Scottish Government Health Directorate by the end of October 2017.

3.0 RECOMMENDATIONS

3.1 The IJB is asked to note the collaborative work of the HSCP and NHS Greater Glasgow and Clyde Health Board (NHSGGC) acute sector in producing this review.

3.2 The IJB is asked to approve the Winter self-assessment and Plan 2017/18, for submission to the Scottish Government.

Louise Long
Corporate Director, (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 In 2015 local winter reviews were shared with the Scottish Government. This was a beneficial exercise which helped to identify key pressures and performance, which fed into the 'National Health and Social Care: Winter in Scotland 2015/16 Report'.

4.2 To continue to improve winter planning across Health and Social Care, NHS Scotland have asked for local systems to lodge a draft of their local winter plans for 2017/18 with the Scottish Government by the end of August 2017, and a final version by the end of October. These requirements were included in the self-assessment and winter planning guidance that was issued on 4th August 2017.

4.3 The Scottish Government has requested that this year's review should include:

- the named executive officer leading on winter reviews across the local system;
- key learning points and future recommendations / planned actions;
- identifying the top 5 local priorities to be addressed in the 2017/18 winter planning process;
- providing views on the effectiveness of the wider winter planning process, particularly from Health and Social Care Partnerships, and suggestions on continuous improvement.

4.4 In line with the guidance and template, the 2017/18 Plan itself follows on from the review and covers the requirements noted at 4.3. It has been shaped to be as succinct as possible, with the top five priorities flowing from the lessons learned in 2016/17. To that end, the plan is short and to the point, but further detail is to be found within the self-assessment, which is a companion document to the Plan.

5.0 IMPLICATIONS

FINANCE
There are no financial implications from this report.

5.1 Financial Implications:

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

5.2 There are no legal implications from this report

HUMAN RESOURCES

5.3 There are no human resource implications from this report

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO

5.4.1 Neither the Review nor the Plan introduce new policy, therefore there is no requirement to produce an Equalities Impact Assessment.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications, although the Clinical and Care Governance Executive Group will oversee the implementation of the Plan.

NATIONAL WELLBEING OUTCOMES

How does this report support delivery of the National Wellbeing Outcomes?

5.6 The Inverclyde HSCP meets the delivery of the National Well-being outcomes as highlighted below in grey.

5.6.1 **People are able to look after and improve their own health and wellbeing and live in good health for longer.**

The review of the HSCP winter plan 2016/2017 promotes service users' independence, resilience and use of support networks and communities as assets to support better outcomes and discharge as soon as the service user is medically fit to do so. This flows through to the planned priorities for 2017/18.

5.6.2 **People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**

The Winter Planning process is based on the promotion of support and independence.

5.6.3 **People who use health and social care services have positive experiences of those services, and have their dignity respected.**

The winter planning process is centred on the wellbeing and dignity of service users. The overarching outcomes from the winter plan review are to build on success, identify issues and take action to ensure good health, make use of alternative ways to prevent unnecessary hospital admissions and delay discharge which can be distressing and disorienting for service users.

5.6.4 **Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

The winter planning process ensures that service users admitted to hospital are provided with a quality service which effectively supports the transition from admission of service users to their planned date of discharge.

5.6.5 **Health and social care services contribute to reducing health inequalities.**

The review of the winter plan informs and identifies improvements to reducing the health inequalities of service users by ensuring a robust and quality health and care system which is responsive to the population of Inverclyde as well as being sensitive to individual service users'

needs.

5.6.6 **People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.**

The winter planning process is designed to ensure engagement and communication with carers and service users to ensure their important input is taken on board and is a valuable asset to the wellbeing and recovery of their relative, friend or loved one.

5.6.7 **People using health and social care services are safe from harm.**

The winter planning process ensures the most vulnerable people in our communities are provided with the assessed support they need to maintain independence and to live in good health at home for longer. The focus on infection control also contributes to reducing the harm that can be caused through healthcare acquired infection or cross-contamination.

5.6.8 **People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

The winter plan and review process is designed to ensure adequate and sufficient information to enable staff to engage and provide the right information at the right time to the population of Inverclyde. We have also committed to accelerating our efforts to improve staff uptake of flu vaccination.

5.6.9 **Resources are used effectively in the provision of Health and Social Care.**

The preventative elements of the winter plan will help to reduce the need for more expensive interventions that might be required in circumstances where the preventative stage has been missed or applied too late.

6.0 CONSULTATION

6.1 This document has been developed by the HSCP, in collaboration with key stakeholders including Community Planning Partners, Acute Sector colleagues, and local GPs.

7.0 LIST OF BACKGROUND PAPERS

7.1 http://www.sehd.scot.nhs.uk/dl/DL(2016)18.pdf

7.2 http://www.gov.scot/Publications/2015/11/9014

INVERCLYDE

HSCP

Health and Social Care Partnership

Preparing for winter 2017/18

Winter Preparedness: Self-Assessment

Winter Preparedness: Self-Assessment Guidance

Note: The RAG status definition table is a visual evaluation indicator on the status of the winter preparedness against each action.

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
1.1	The NHS Board and Health and Social Care Partnership (HSCP) has robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose.	☒		Annual review of Business Continuity Plan (BCP), in collaboration with the Civil Contingencies Service.
	Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans.	☒		Routine monitoring through review of BCP.
1.2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCP; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios.	☒		Covered in the BCP annual review.
	Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner.	☒		Covered in the BCP annual review, and risk register regularly reviewed by SMT.
	The partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	☒		Mutual aid arrangements with Renfrewshire HSCP.
1.3	The NHS Board and HSCP have HR policies in place that cover: • what staff should do in the event of severe weather hindering access to work, and • how the appropriate travel advice will be communicated to staff and patients	☒		Similar arrangements also in place, relating to Council-employed staff.
1.4	The NHS Board's and HSCP's websites will be used to advise on travel to appointments during severe weather and prospective cancellation of clinics.	☒		Issued through established communications channels.
1.5	The NHS Board, HSCPs and local authority 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.	☒		Included in Pandemic Plan.
1.6	*The effectiveness of winter plans will be tested with all stakeholders by 30 October. The final version of the winter plan has been approved by NHS Board and HSCPs*	☐		To be confirmed

2	Unscheduled / Elective Care Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
Clinically Focussed and Empowered Management				
2.1	Clear site management process is in place across NHS Board and HSCP with operational overview of all emergency and elective activity.	☒		Routine monitoring as part of delayed discharge management arrangements
2.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked.	☐		To be confirmed.
2.3	Effective communication protocols are in place between key partners, particularly across local authority housing, social work and homecare services, equipment and adaptation services, Mental Health Services, and the independent sector.	☒		Regular review and updates to the Emergency Contacts Directory.
2.4	A Target Operating Model has been communicated to all staff. Escalation policies are well defined, clearly understood, and well tested.	☒		Included in the BCP and Pandemic Plan.
2.5	Escalation policies are in place and consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU.	☒		Included in Pandemic Plan
2.6	Escalation policies are focused around in-patient capacity across the whole system including community beds and care at home services	☒		Included in the BCP and Pandemic Plan.
2.7	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.	☒		Included in the BCP.

Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity. This has specifically ta ken into account the surge in unscheduled activity in the first week of January.				
2.8	Demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated.	☒		Routine monitoring as part of delayed discharge management arrangements
2.9	A range of analysis and management tools to enable effective and related planning and management of scheduled and unscheduled services have been implemented.	☒		Routine monitoring as part of delayed discharge management arrangements
2.10	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions.	☒		Routine monitoring as part of delayed discharge management arrangements
2.11	Pre-planning and modelling has been undertaken around elective activity to plan responses, escalation and recovery to minimise the impact of winter peaks in demand on the delivery of routine elective work.	☒		Routine monitoring as part of delayed discharge management arrangements
2.12	NHS Boards review and take stock of their performance against the British Association of Day Surgery (BADS) Directory version 5 to ensure that they have achieved optimum performance against the surgical procedures identified as being suitable for day case surgery.	☐		To be confirmed – delivered by Acute
Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities such as MDTs, and projected peaks in demand. These rotas should include services that support the management of inpatient pathways, (e.g.) diagnostics, pharmacy, phlebotomy, AHPs, IPCT, portering, cleaning etc.				
2.13	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.	☐ ☒		To be confirmed – delivered by Acute Routine monitoring as part of delayed discharge management arrangements

2.14	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.	☒		Routine monitoring as part of delayed discharge management arrangements
2.15	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc.	☒		Included in the BCP.
2.16	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.	☒		NHSGGC are currently reviewing GPOOH arrangements, however "Choose the Right Service" is in place and routine communication routes are in place.
2.17	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.	☐		To be confirmed – delivered by Acute
Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge process which includes determining an Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of simple discharge, ensuring there are no delays in patient pathways.				
2.18	Discharge planning in collaboration with HSCP 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.	☒		Routine monitoring as part of delayed discharge management arrangements
2.19	Discharge planning will support all patients and carers to plan required transport arrangements. There will be on-going engagement with SAS, and third sector partners, to effectively plan provision for appropriate patient transport services when it is known, or anticipated, that patients will require transport home or to another care setting.	☒		Routine monitoring as part of delayed discharge management arrangements
2.20	Multi-disciplinary ward and board rounds will be embedded to proactively manage the patient journey and prepare for discharge detailing the estimated date of discharge. Utilise electronic whiteboards and Criteria Led Discharge where appropriate.	☒		Routine monitoring as part of delayed discharge management arrangements
2.21	Regular daily ward rounds and bed meetings will be conducted to ensure a proactive	☒		Routine monitoring as part of

	approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate.			delayed discharge management arrangements
2.22	Predictive data will be used to assess the hourly demand for beds allowing for patients to be discharged as soon as fit and as early as possible in the day to optimise flow.	☒	■	Routine monitoring by Acute.
2.23	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon.	☒	■	Routine monitoring by Acute.
Ensure that senior clinical decision making capacity is available for assessment, care planning, MDTs and discharge and that AHP rotas are structured, to facilitate the discharging of patients throughout weekends and especially during the fortnight in which the two festive holiday periods occur in order to maximise capacity.				
2.24	There is adequate medical, nursing and AHP cover across both, the festive holiday period, and over weekends to conduct assessments, plan effective care programmes and perform dedicated discharge rounds.	☒	■	Included in the BCP and delayed discharge managements arrangements, and routine monitoring by Acute.
2.25	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. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this.	☒	■	Included in the BCP and delayed discharge managements arrangements.
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.				
2.26	There is 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.	☒	■	Routine monitoring and review of commissioning arrangements. Also covered within governance of external organisations arrangements.
2.27	On-going and detailed engagement around the capacity of social care services to accommodate predicted discharge levels will start no later than October.	☒	■	Routine monitoring, and full review workshop arranged for 30th

				October 2017.
2.28	A clear escalation plan is in place to resolve issues that might arise in provision of service.	☒		Included in the BCP and governance of external organisations arrangements.
2.29	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised, where possible.	☒		Routine monitoring as part of delayed discharge management arrangements.
2.30	Host partnerships are taking the discharge requirements of patients who are receiving treatment at the Golden Jubilee Foundation into account.	☒		Routine monitoring by Acute.
2.31	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.	☒		Routine monitoring as part of delayed discharge management arrangements.
2.32	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.	☒		Routine monitoring as part of delayed discharge management arrangements.
Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.				
2.33	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as soon as they occur, and that escalation procedures are invoked at the earliest opportunity.	☒		Routine monitoring through review of BCP.
2.34	Demand, capacity, and activity plans across emergency and elective provision are fully integrated and communicated to all stakeholders	☒		Routine monitoring as part of delayed discharge management arrangements.
2.35	Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector.	☒		Routine monitoring as part of delayed discharge management arrangements, and through the Strategic Planning Group and Housing Partnership Group.

2.36	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.	☒		Routine monitoring as part of our Communications Plan implementation.

3	Out of Hours Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
3.1	The OOH plan covers the full winter period and pays particular attention to the festive period.	☒		NHSGGC are currently reviewing GPOOH arrangements, however "Choose the Right Service" is in place and routine communication routes are in place.
3.2	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.	☒		Routine monitoring as part of delayed discharge management arrangements.
3.3	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.	☒		Our New Ways Tests of change have provided some innovative insights into managing demand, some of which will support our winter planning arrangements.
3.4	There is reference to direct referrals between services.	☒		Routine monitoring as part of delayed discharge management arrangements, and will be further enhanced at review of Strategic Plan.
3.5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☒		Arrangements in place as part of our Records Management Plan. Will be further developed at the 30th October workshop.
3.6	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.	☒		Routine monitoring as part of delayed discharge management arrangements.
3.7	Ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☒		Patient pathways fully integrated from CMHT right through to IPCU.

3.8	Ensure that there is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres	☐		To be confirmed by OHD
3.9	The plan displays a confidence that staff will be available to work the planned rotas.	☒		Routine review of BCP.
3.10	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.	☒		Included in Communications Plan.
3.11	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.	☒		Routine monitoring as part of delayed discharge management arrangements. SAS Paramedics Service being tested as part of New Ways programme.
3.12	There is evidence of joint working between the Board and NHS 24 in preparing this plan.	☒		To be confirmed.
3.13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan.	☒		Planning colleagues from both Acute and OOH have been central contributors to this plan.
3.14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan.	☒		Distributed across key stakeholders for comment and input, and taken to IJB for approval.
3.15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic plan including provision for an escalation plan.	☒		BCP regularly reviewed and updated, and Pandemic Plan approved by Clinical and Care Governance Executive Group.

4	Prepare for & Implement Norovirus Outbreak Control Measures *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
4.1	NHS Boards must ensure that staff have access to and are adhering to the guidance provided by the National Infection Prevention and Control Manual.	☒		Routine monitoring of Datix incidents by the Clinical and Care Governance Executive Group.
4.2	IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts.	☒		Routine monitoring of admissions to hospital from care homes/
4.3	HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.	☒		Available through StaffNet, and access available to Council-employed HSCP staff. Infection control Datix incidents monitored by the Clinical and Care Governance Executive Group.
4.4	NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time.	☒		System in place for routine distribution of up-to-date information.
4.5	Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks.	☒		System in place within Acute.
4.6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.	☒		System in place to inform and cascade.
4.7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.	☐		To be confirmed
4.8	NHS Boards must ensure arrangements are in place to provide adequate IPCT 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.*	☐		To be confirmed

4.9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple 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.*	☐		To be confirmed
4.10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *This could include the notification of 'tweets', where appropriate, to help spread key message information.*	☐		To be confirmed
4.11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message.	☒		System in place to inform and cascade.

5	**Seasonal Flu, Staff Protection & Outbreak Resourcing** *(Assessment of overall winter preparations and further actions required)*		RAG	**Further Action/Comments**
5.1	At least 50% of all staff 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, as recommended in the CMOs seasonal flu vaccination letter due to be published in mid Aug 2017. *This will be evidenced through end of season vaccine uptake submitted to HPS by each NHS board. Local trajectories have been agreed and put in place to support and track progress. Uptake of vaccine in 2016/17 was still significantly below target, at 35.4%.*	☐		To be confirmed
5.2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2017) 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.	☒		Staff Clinics are set up each year, including Council-employed HSCP staff. Uptake rates are monitored.
5.3	The winter plan takes into account the predicted surge of 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.	☒		Routine monitoring as part of delayed discharge management arrangements. Escalation arrangements included in Pandemic Plan.
5.4	HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity.	☒		Arrangements described in Pandemic Plan.
5.5	Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods.	☐		Arrangements described in Pandemic Plan.

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*		RAG	**Further Action/Comments**
There is an effective, co-ordinated respiratory service provided by the NHS board.				
6.1	Clinicians (GPs, 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.	☒		Overseen, updated and cascaded by the Clinical and Care Governance Executive Group.
6.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☐		To be confirmed
6.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times.	☒		Routine monitoring as part of delayed discharge management arrangements.
6.4	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.	☒		Messages disseminated as per Communications Plan.
There is effective discharge planning in place for people with chronic respiratory disease including COPD				
6.5	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.	☒		Included within Respiratory Discharge Protocol.
6.6	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.	☒		Included within Respiratory Discharge Protocol.
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.				

6.7	Anticipatory Care Plans (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease.	☒		Included within Respiratory Discharge Protocol and 'Compassionate Inverclyde' procedures.
There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board				
6.8	Staff are aware of the procedures for obtaining/organising home oxygen services.	☒		Included within Respiratory Discharge Protocol.
	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)	☐		To be confirmed
	Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period.	☒		Included as part of delayed discharge management arrangements.
	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.	☐		To be confirmed
People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.				
6.9	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.*	☐		To be confirmed

7	**Management Information** *(Assessment of overall winter preparations and further actions required)*		RAG	**Further Action/Comments**
7.1	Admissions data will be input to the System Watch predictive modelling system as close to real time as possible. Local quality assurance of the site and board level data is in place.	☐		To be confirmed
7.2	Effective reporting lines are in place to provide the Scottish Government with routine weekly management information and any additional information that might be required on an exception / daily basis.	☒		Routine submission process in place.
7.3	Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise.	☒		Routine submission process in place.

8	**Sign Off** *(Assessment of overall winter preparations and further actions required)*		RAG	**Further Action/Comments**
8.1	Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online.	☒		Process in place. Once Plan is approved by IJB (anticipated 12th September 2017), it will be submitted to NHSGGC and SG.
8.2	Arrangements are in place to include governance of winter planning within local Unscheduled Care Management Groups or other relevant management groups as appropriate.	☒		Overseen by the Clinical and Care Governance Executive Group.

9	Key Roles / Services Integrated into Planning Process		RAG	Further Action/Comments
9.1	Heads of Service	☒		Head of Strategy is the Lead Officer, with targeted inputs from the Chief Officer, the other three Heads of Service, and all relevant Service Managers.
9.2	Nursing / Medical Consultants	☒		Inputs to overarching NHS Board work are cascaded to HSCPs and incorporated into their planning processes.
9.3	Consultants in Dental Public Health	☐		To be confirmed by OHD.
9.4	AHP Leads	☒		Through Strategic Planning Group.
9.5	Infection Control Managers	☒		Represented on Clinical and Care Governance Executive Group.
9.6	Managers Responsible for Capacity & Flow	☒		Direct inputs to plans, and wider discussion at Strategic Planning Group and HSCP Leadership Team. Supported by the HSCP Quality and Development Team.
9.7	Pharmacy Leads	☒		Represented on Clinical and Care Governance Executive Group, and regular presentations delivered to IJB.
9.8	Mental Health Leads	☒		Direct inputs to plans, and wider discussion at Strategic Planning Group and HSCP Leadership Team. Supported by the HSCP Quality and Development Team.
9.9	Business Continuity / Emergency Planning Managers	☒		Lead on the development of BCP and Civil Contingency Plans.
9.10	OOH Service Managers	☐		To be confirmed.
9.11	GPs	☒		Outputs from GP Forum are incorporated into plans.
9.12	NHS 24	☐		To be confirmed.

9.13	SAS	☐		To be confirmed.
9.14	Territorial NHS Boards	☐		To be confirmed.
9.15	Independent Sector	☒		Through Strategic Planning Group.
9.16	Local Authorities	☒		Through Strategic Planning Group and Community Planning Partnership.
9.17	Integration Joint Boards	☒		Through direct instruction to HSCP.
9.18	Strategic Co-ordination Group	☒		Strategic Planning Group.
9.19	Third Sector	☒		Through Strategic Planning Group.
9.20	SG Health & Social Care Directorate	☒		Through incorporation of policy directives, and through submission of plans as required.

Health & Social Care: Local Review of Winter 2016/17

HSCP	Inverclyde HSCP	Winter Planning Executive Lead	Helen Watson Head of Strategy & Support Services Helen.Watson2@inverclyde.gov.uk

1	**Business continuity plans tested with partners.**	National Outcome: The local system has fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather.	Local indicator(s): Progress against any actions from the testing of business continuity plans.

1.1 What went well?

- Local process implemented with ownership across all key partners.
- Lead roles and responsibilities clearly identified with information supplied to partners.
- Weekly update of Information ensured consistency and accuracy of approach.
- Weekly meetings set with required attendance by all key partners to review and address any identified issues.
- Implementation of single access point and out of hours pathways for community services.
- Practices ensured their business continuity plans were up to date and that emergency contact details were accessible in the event of an incident.
- Winter plan linked to HSCP Business Impact Analysis as well as Flu plan and Councillors Resilience Plan.

1.2 What could have gone better?

- No adverse issues became apparent during our planning due to the mild winter.

1.3 Key lessons / Actions planned

- Recognising that pressures on the health and social care system are not seasonal. Locally we have agreed to reconvene the Winter Plan Operational Group at any time with our data pack being produced weekly and routinely, and not just throughout the winter period.
- Business continuity ‘trial’ practice should be introduced to test and review.

2	**Escalation plans tested with partners.**	National Outcome: Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.	Local indicator(s): • attendance profile by day of week and time of day managed against available capacity; • locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over 2, 4 hours; • all indicators should be locally agreed and monitored.

2.1 What went well?

- No adverse issues became apparent during our planning due to the mild winter.

2.2 What could have gone better?

2.3 Key lessons / Actions planned

- No adverse issues became apparent during our planning due to the mild winter.

3	**Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January.**	National Outcomes: • Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period. • The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimised. • Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.	Local indicator(s): • daily and cumulative balance of admissions / discharges over the festive period; • levels of boarding medical patients in surgical wards; • delayed discharge; • community hospital bed occupancy; • number of Social Work assessments including variances from planned levels.

3.1 What went well?

- Early identification of process of vulnerable people at risk of admission to Inverclyde Royal Hospital in community.
- Early identification of people in IRH for discharge - the 'Fit' List.
- Operational discharge meeting attended by key operational individuals including community leads who assist in planning discharge of complex cases.
- The process between Community Nursing and Homecare teams in partnership with Acute and Out of Hours services supporting the safe and effective hospital discharges during weekends and holidays.
- Single point of access for discharge team at local health centre.
- Our Home First initiative whereby a District Nurse and OT in - reach were been appointed to facilitate communication between acute and community and assist assessment and support planning for quicker discharge home.
- Falls pathway in place and linked to initial referral to HSCP to take preventative approach.

3.2 What could have gone better?

- At times, the communication between Homecare and the wards.
- The unavailability of Edison Business Objects impacted on the effective management of preparing care packages for discharge.

3.3	Key lessons / Actions planned

- Homecare in-reach post in situ to facilitate communication and assessment of the service user prior to discharge**.**

4	Strategies for additional surge capacity across Health & Social Care Services	Outcome: • National risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans for additional surge capacity across health and social care services are agreed in October. The planned dates for the introduction of additional acute, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment.	Local indicator(s): • planned additional capacity and planned dates of introduction; • planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds; • planned number of additional intermediate beds in the community and the planned date of introduction of these beds; • levels of boarding; • planned number of extra care packages; • planned number of extra home night sitting services • planned number of extra next day GP and hospital appointments.

4.1	What went well?	

- Care home capacity monitored daily in order to identify pressures.
- System for prioritising emergency patients in place.
- Continuation of Step-Up bed pilot to reduce possible admissions.
- Criteria for identification of most vulnerable adults at risk of admission such as Mental Wellbeing; ill-health/elderly carer; complex cases.
- Development of Friday Allocation Meetings to identify capacity issues - complex cases.
- The Community Nursing teams introduced *Patient Status at a Glance Team* - this involved having daily update meetings with details of vulnerable patients as well as patients with changing needs to identify d those at risk of admission. The nurses link in with our GPs and HCC to identify patients who could potentially be vulnerable during the winter period Liaison Nurses/ AHP peer group supported work with care homes to identify residents at risk of admission.

4.2 What could have gone better?

- As no adverse issues became apparent during our planning due to the mild winter - perhaps having a 'trial' practice with our acute colleagues in the future would be useful.

4.3 Key lessons / Actions planned

- As no adverse issues, we will convene the working group meetings in autumn to implement the plan for 2017/18.

5	**Whole system activity plans for winter: post-festive surge/ respiratory pathway.**	National Outcome: The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.	Local indicator(s): • daily number of cancelled elective procedures; • daily number of elective and emergency admissions and discharges; • number of respiratory admissions and variation from plan.

5.1 What went well?

- GPs implemented agreed contingency arrangements over the festive period as per LMC guidance.
- Practices advised Patients of closure via SOLUS Screens and encouraged patients to order prescriptions in advance.
- Home Care capacity - exception reporting was included in Winter Plan Data Pack.
- Established cut off referral dates over Christmas and New Year.
- Cut off referral time of 2pm for next day discharge.
- Direct communication channels between Ward and Home Care.
- The work of the staff in Acute and Community who went extra mile in getting people returned home safely.
- The mild weather was most beneficial for all.

5.2 What could have gone better?

- No adverse issues became apparent during our planning due to the mild winter.

5.3 Key lessons / Actions planned

- Continuity and attendance at Winter Planning of Operational group required throughout winter period.

6	**Effective analysis to plan for and monitor winter capacity, activity, pressures and performance**	National Outcome: • Local systems have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.	Local indicator(s) : • Agreed and resourced analytical plans for winter analysis.

6.1 What went well?

- The Data pack is fit for purpose and now produced weekly
- Ad hoc data packs were also produced
- HSCP Staff are actively encouraged to be vaccinated and local peer vaccination sessions were organised
- Reviewed annual leave requests to ensure sufficient cover

6.2 What could have gone better?

- Edison Business Objects system unreliable impacting planning preparation

6.3 Key lessons / Actions planned

- The necessity for robust systems - reported through NHSGGC Board and flagged up to national services

7	**Workforce capacity plans & rotas for winter/festive period agreed by October.**	National Outcomes: • Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective admission and discharge of emergency and elective patients. This should encompass all relevant health and social care services. • Maintain discharges at normal levels over the two 4 day festive holiday periods.	Local indicator(s): • workforce capacity plans & rotas for winter/festive period agreed by October; • effective local escalation of any deviation from plan and actions to address these; • extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements; • number of discharges on each of the 4 day festive holiday periods compared to number if normal daily discharges.

7.1 What went well?

- HSCP rotas over winter period created/confirmed with duty cover at IRH in terms of back up & support.
- Acute daily staffing report produced/ received.
- Community weekly staffing numbers reported.
- Having a RAG status chart across all service for staffing levels.

7.2 What could have gone better?

- There were no issues in respect of capacity plans.

7.3 Key lessons / Actions planned

- The mild winter did not result in concerns over staffing levels.

8	**Discharges at weekends & bank holidays**	National Outcome: • Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital. Medical and Nurse Directors provide monthly report on weekend (pre-noon) discharge rate progress and performance.	Local indicator(s): • % of discharges that are criteria led on weekend and bank holidays; • daily number of elective and emergency admissions and discharges.

8.1 What went well?

- Having access to equipment out with working hours.
- A stock of equipment left at several points across Inverclyde -the Joint Equipment store staff ensures that equipment is always stocked at all venues. This allows for 24 hour access to equipment if required.
- The district nursing service also holds moving and handling equipment, mattresses, commodes etc.

8.2 What could have gone better?

- Care Homes are unable to admit at weekends.

8.3 Key lessons / Actions planned

- To identify need for discharges at weekends.
- Liaise with local care homes around admissions outwith office hours and at weekends.

9	**The risk of patients being delayed on their pathway is minimised.**	National Outcome: • Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer. Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance.	Local indicator(s): • distributions of attendances/ admissions; • distribution of time to assessment; • distribution of time between decision to transfer/discharge and actual time; • % of discharges before noon; • % of discharges through discharge lounge; • % of discharges that are criteria led; • levels of boarding medical patients in surgical wards.

9.1 What went well?

- Twice daily huddle established in IRH - HSCP included.
- Partners advised of Winter and Holiday referral and discharge process provided prior to the festive period.
- Duty rota for winter and festive period provided to IRH for back-up and support.
- Early identification of Patients requiring supported discharge.
- Home First Action Plan in place.

9.2 What could have gone better?

- No adverse issues were identified.

9.3 Key lessons / Actions planned

- No issues were identified on which to test this element.

10	**Communication plans**	National Outcome: • The public and patients are kept informed of winter pressures, their impact on services and the actions being taken.	Local indicator(s) : • daily record of communications activity; • early and wide promotion of winter plan.

10.1 What went well?

- Winter Planning on agenda at HSCP communication group.
- Information circulated on available community services and clinics during the festive period, including pharmacy open times, to GP practices.
- Collated a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP.
- Information regarding GP availability throughout the festive period was provided through the NHSGG&C Winter Booklet.
- Posters also be provided and made available to the public through public facing websites and displayed in GP Practices.
- The Clinical Director re-enforced these messages to GP Practices.
- Advice leaflet to patients with chronic conditions on source of help during winter period developed.

10.2 What could have gone better?

- The communication between Community and Acute at times of high pressure.

10.3 Key lessons / Actions planned

- Continue discussion around discharges from acute.

11	**Preparing effectively for norovirus.**	National Outcome: • The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).	Local indicator(s): • number of wards closed to norovirus; • Application of HPS norovirus guidance.

11.1 What went well?

- Twice Daily huddles in place.
- The weekly/winter planning update sharing.
- Infection control protocols in place to manage outbreaks by local Care Homes, GP and acute sector services.
- However, no pressure placed on the system over the winter period.

11.2 What could have gone better?

- No adverse issues were identified.

11.3 Key lessons / Actions planned

- No issues were identified on which to test this element.

12	**Delivering seasonal flu vaccination to public and staff.**	National Outcome: • CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance.	Local indicator(s): • % uptake for those aged 65+ and 'at risk' groups; • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

12.2 What went well?

- Local drop-in clinics across all HSCP staff buildings - reasonable uptake by HSCP staff.
- Communication ongoing.
- GP Flu vaccination programme for elderly or at risk patients.
- Vaccination to staff in local care homes and home care providers.

12.3 What could have gone better?

- Higher uptake of flu vaccine by staff.

12.4 Key lessons / Actions planned

- Further raise awareness with HSCP staff around flu vaccination.

13 Additional Detail

Include detail around when this review is likely to be considered by the Boards senior management team.

This review will be presented to the IJB in September 2017.

14 Top Five Local Priorities for Winter Planning 2017/18

- Recognising that pressures on health and social care system are not seasonal.
- Having a local agreement in place to reconvene the Winter Planning Operational Group at any time.
- Weekly data pack to be produced and analysed as an ongoing requirement.
- Ensuring that national data systems are reliable at all times in order for HSCPs to have access to live data.
- Reinforcing effective channels of communication between Acute and Community.

15	Views on Wider Winter Planning Process & Suggestions for Improvement

Identified Priority	Local Indicator	Identified Action	Strategic Lead	Target Date for implementation
Pressures on health and social care system are not seasonal.	Progress against any actions from the testing of business continuity plans.	• 'Winter planning' to be removed and rebranded as weekly planning. • Articulate rebranding to all partners for consistency of approach.	Quality and Development Service	31/10/2017
Having a local agreement in place to reconvene the Winter Planning Operational Group at any time	Progress against any actions from the testing of business continuity plans.	• Data pack to be issued to all key partners on a weekly basis.	Quality and Development Service	Immediate on IJB Approval
Weekly data pack to be produced and analysed as an ongoing requirement	Agreed and resourced analytical plans for winter analysis.	• Standardised and agreed data pack to be produced and circulated on a weekly basis. • Norovirus data and reports to be included in the shared data pack.	Quality and Development Service All Partners	Report revisions to be complete by 31/10/2017
Ensuring that national data systems are reliable at all times in order for HSCPs to have access to live data	Agreed and resourced analytical plans for winter analysis.	• Robust systems to be followed by all partners to ensure continuity of intelligence.	Partner leads	31/10/2017
Reinforcing effective channels of communication between Acute and Community	Daily and cumulative balance of admissions / discharges over the festive period Levels of boarding medical patients in surgical wards Delayed discharge Community hospital bed occupancy Number of Social Work assessments including variances from planned levels.	• Improvement and development of robust communication systems between Ward and Homecare. • A data management plan which is fit for purpose to be developed and prevent unnecessary delays to discharge due to the administration of care packages	Ward and HSCP homecare leads Quality and Development Service	31/10/2017 31/10/2017

The Scottish Government
Directorate for Health Performance & Delivery

Scottish Government
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Dear Colleague

Preparing for Winter 2017/187

Summary
This guidance will help to ensure that Health & Social Care services are well prepared for this winter. The national report 'Health & Social Care: Winter in Scotland in 2016/17' has been integrated into this year's guidance (Appendix 2). Winter plans should provide safe and effective care for people using services and should ensure effective levels of capacity and funding are in place to meet expected activity levels. This will support service delivery across the wider system of health and social care.

Background
The importance of a collaborative approach to planning across local systems, building OOH capacity, improving delayed discharge and the six essential actions underpin this guidance. The guidance is also focused on planning for the additional pressures and business continuity challenges that are faced in winter.

Action
You are asked to lodge draft winter plan(s) with the Scottish Government by the end of August and final plans by the end of October. Plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Plans should also have senior joint sign-off reflecting local governance arrangements and should be published online. Plans should be sent to Winter_Planning_Team_Mailbox@gov.scot

Yours sincerely

ALAN HUNTER
Director for Performance and Delivery

GEOFF HUGGINS
Director for Health and Social Care Integration

DL (2017) (New Number)

4 August 2017

Addresses

To
1. Chief Executives
2. Local Authority Chief Execs
3. IJB Chief Officers
4. Unscheduled Care Leads

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Preparing for Winter 2017/18

1. Introduction

1.1 Planning for winter is a particularly important part of all-year-round service delivery, given the additional pressures placed on local systems from seasonal flu, norovirus, severe weather and public holidays. The importance of a collaborative approach to planning, improving delayed discharge, building OOH capacity and a focus on the six essential actions (Annex A) underpin the planning guidance for winter 2017/18. This will help to ensure that Health & Social Care Services are well prepared for the additional pressures that winter brings. Winter plans should ensure that effective levels of capacity and funding are in place to provide safe and effective care and to meet expected service demand.

1. 2. Earlier this year the Scottish Government supported local systems to undertake a local review of service pressures and performance. In June we held a winter planning event to consider winter planning priorities from a collaborative perspective.

1.3 The national report 'Health & Social Care: Winter in Scotland in 2016/17 has been integrated into this year's guidance (Appendix 2).The official statistics show that Health & Social Care Services in Scotland sustained A&E performance throughout the winter of 2016/17 and continued to outperform other UK countries. Local systems also completed reviews of pressures and performance across their health and social care services to help prepare for this winter.

1.4 Over the summer we engaged with local health and social care systems to improve our approach to winter planning. The guidance has been updated to take into account some of the emerging findings from the 4 day public holiday review and local systems will want to ensure that their planning processes take full account of the recommendations from this review.

1.5 Unscheduled and elective care performance in Scotland compares favourably with other UK comparators. Robust planning and analysis should facilitate NHS Boards to pursue further sustainable improvement through 95% performance towards the 98% 4 hour Emergency Access Standard. This should also support the Treatment Time Guarantee (TTG) and ensure delayed discharges are kept to an absolute minimum. Health and Social Care Partnerships are expected to increase the percentage of people who are discharged within 72 hours of being ready and reduce the bed days associated with delays.

1.6 A balanced approach to the effective planning and scheduling of elective and unscheduled care and the impact that this is likely to have across the wider system will be needed. This will be particularly important in light of predicted emergency activity over the festive period, when any surge in respiratory and circulatory admissions over the winter can increase pressures, particularly towards the end of December and into January and February. Support to understand the capacity and demand of each site is available through the Unscheduled Care 6 Essential Actions Improvement programme. Developing the Basic Buildings Blocks model (Essential Action 2) will provide a baseline of the whole system and enable robust planning. The focus of the Whole System Patient Flow Programme and Guided Patient Flow Assessment will also contribute to this overall picture.

1.7 Forward planning should ensure that cancer patients who have a MDT, diagnostic or treatment target date occurring over the festive period are not delayed and that 31 day and 62 day cancer waiting times are not adversely impacted. In addition, NHS Boards should work through Regional Planning Groups to ensure that both local and regional cancer treatment dates are maintained through the winter period.

1.9 Changes in the cohorts of admitted patients and their care requirements over the festive period should be monitored. This will be particularly important within respiratory, circulatory and ICU pathways. Primary care and community services should be engaged in minimising transfers of care through use of anticipatory care planning. A directory of services and alternatives to admissions should be available, covering primary and community services and also third and independent sector social care provision. Any additional capacity in these areas should be highlighted. Consideration should also be given to planning arrangements around end of life care.

1.10 Robust analysis should be undertaken to plan capacity and demand levels for this winter. Data available from ISD, via the Health and Social Care Data Integration and Intelligence Project (Source), can help with such analysis, including system watch. Recent years activity levels and improvements in flow should be taken into account as part of this process. Trends over three to five years should be considered. We also expect winter plans to address variation in demand.

1.11 Local Systems should ensure that NHS 24 and OOH services are supported and that adequate resources are in place across the whole system. Plans must be explicit around the additional capacity planned for winter, including staffed medical and intermediate care beds, care packages, home/night sitting services accessible by GPs/NHS 24 and next day GP and hospital appointments. Deliverable plans for workforce capacity over the winter period must be agreed by October and detailed in the winter plan – these are important milestones. Nursing rotas that are made up for the festive period should not include the use of agency staff and should conform to workload planning tool guidance. It is important that this capacity is in place before the risk of boarding medical patients in surgical wards increases and that appropriate indicators of potential surge are monitored on a daily basis. Analysis should include triggers for whole system escalation processes to prevent access block. Local Systems should also ensure that Primary Care Risk Registers are in place.

1.12 Sustainably achieving safe and effective patient flow is critical to maintaining performance as a standard operating model across the winter period. Utilising the improved communication and leadership of the 6 Essential Actions Programme, including Safety Huddles, should focus on a Daily Dynamic Discharge Approach which includes: proactive discharge planning including, pre noon discharges, weekend discharges, utilisation of discharge lounge and criteria led discharge. A review of support services such as portering, cleaning, pharmacy and transport should be undertaken to ensure capacity is aligned to demand, not just within hours, but also across 7 days and out of hours periods.

1.13 The Chief Medical Officers strongly encourage all staff are vaccinated against seasonal flu, particularly front-line staff and those working in areas where patients might be at greater risk (paediatric, oncology, maternity, care of elderly, haematology, ICUs). The aim is to vaccinate 50% of front line staff and efforts should be made to make the vaccine available at times and places that are convenient for staff. Senior clinicians and NHS Managers should ensure their staff understand the benefits of the vaccine to healthcare workers and to patients.

2. Critical Areas, Outcomes and Indicators

2.1 The critical areas identified below remain key to effective winter planning and should be the bedrock on which winter plans are built. The local indicators, which underpin each critical area, should be included in relevant local management processes to achieve the outcomes described. Indicators should also align with the unscheduled care 6 Essential Action Improvement Programme (summarised at Annex A). Winter plans should set out the geographies and frequency of the local indicators being monitored and provide further detail on how these indicators might be developed, where applicable.

1. Business continuity plans tested with partners. *(Appendix 1 - Checklist 1 refers)*
Outcome: • Local health and social care systems have fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather.
Local indicator(s): • progress against any actions from the testing of business continuity plans.

2. Escalation plans tested with partners. *(Appendix 1 - Checklist 2:1 refers)*
Outcome: • Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.
Local indicator(s): • attendance profile by day of week and time of day managed against available capacity • locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over 2, 4 hours • all indicators should be locally agreed and monitored.

3. Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January. *(Appendix 1 - Checklist 2:2 and 2:4 refers)*
Outcomes: • Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period. • The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimised. • Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.
Local indicator(s): • daily and cumulative balance of admissions / discharges over the festive period • levels of boarding medical patients in surgical wards • delayed discharge • community hospital bed occupancy • number of Social Work assessments including variances from planned levels.

4. Strategies for additional surge capacity across Health & Social Care Services

(Appendix 1 - Checklist 2:2 refers)

Outcomes:

- Risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised.
- Staffing plans for additional surge capacity across health and social care services is agreed in October.
- Planned dates for the introduction of additional acute, OOH, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment.

Local indicator(s):

- planned additional capacity and planned dates of introduction
- planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds;
- planned number of additional intermediate beds in the community and the planned date of introduction of these beds;
- levels of boarding.
- planned number of extra care packages
- planned number of extra home night sitting services
- OOH capacity
- planned number of extra next day GP and hospital appointments

5. Whole system activity plans for winter: post-festive surge / respiratory pathway.
(Appendix 1 - Checklists 2:2 and 6 refers)

Outcomes:

- The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.
- Monthly Unscheduled Care Meetings of hospital triumvirate, including IJB Partnerships and SAS (clinical and non-clinical) colleagues.

Local indicator(s):

- daily number of cancelled elective procedures;
- daily number of elective and emergency admissions and discharges;
- number of respiratory admissions and variation from plan.

6. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance
(Appendix 1 - Checklist 2:2 refers)

Outcome:

- NHS Boards have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.

Local indicator(s) :

- Agreed and resourced analytical plans for winter analysis.
- Use of System Watch

7. Workforce capacity plans & rotas for winter / festive period agreed by October.

(Appendix 1 - Checklist 2:3 refers)

Outcomes:

- Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective health and social care. This should encompass all relevant health and social care services.
- Maintain discharges at normal levels over the two 4 day festive holiday periods
- Right level of senior clinical decision makers available over the two 4 day festive holiday periods.

Local indicator(s):

- workforce capacity plans & rotas for winter / festive period agreed by October;
- effective local escalation of any deviation from plan and actions to address these;
- extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements.
- number of discharges on each of the 4 day festive holiday periods compared to number of normal daily discharges

8. Discharges at weekends & bank holidays
(Appendix 1 - Checklists 2:3 and 2:4 refers)

Outcome:

- Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow.
- Robust planning and decision making midweek to support discharges for patients over a public holiday weekend for example IDLs, Pharmacy Scripts, Transport and Equipment to minimise delays

Local indicator(s):

- % of discharges that are criteria led on weekend and bank holidays;
- daily number of elective and emergency admissions and discharges.
- discharge lounge utilisation

9. The risk of patients being delayed on their pathway is minimised.
(Appendix 1 - Checklist 2:4 refers)

Outcomes:

- Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflects the arrival patterns and potential waiting times for assessment and/or transfer/discharge.
- Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer.
- Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance.

Local indicator(s):

- distributions of attendances / admissions;
- distribution of time to assessment;
- distribution of time between decision to transfer/discharge and actual time;
- % of discharges before noon;
- % of discharges through discharge lounge;
- % of discharges that are criteria led;
- levels of boarding medical patients in surgical wards.

10. Communication plans *(Appendix 1 - Checklist 2:7 refers)*
Outcomes: • The public and patients are kept informed of winter pressures, their impact on services and the actions being taken • Effective local and national winter campaigns to support patients over the winter period are in place. • Staff are engaged and have increased awareness of the importance of working to discharge patients over the two 4 day festive holiday periods.
Local indicator(s) : • daily record of communications activity; • early and wide promotion of winter plan

11. Preparing effectively for norovirus. *(Appendix 1 - Checklist 4 refers)*
Outcome: • The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).
Local indicator(s): • number of wards closed to norovirus; • application of HPS norovirus guidance.

12. Delivering seasonal flu vaccination to public and staff. *(Appendix 1 - Checklist 5 refers)*
Outcome: • CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance.
Local indicator(s): • % uptake for those aged 65+ and 'at risk' groups; • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

3. Self-Assessment Checklists

3.1 The self-assessment checklists (Appendix 1) provide further detail to support the development of local winter plans. These checklists should be used by local governance groups to assess the quality of winter preparations and to ascertain where further action might be required. There is no requirement for these checklists to be submitted to the Scottish Government.

3.2 A National Unscheduled Care Event will be held on 14th September at Stirling Management Centre and will include sessions on a range of initiatives designed to support local health and social care systems to effectively prepare for winter.

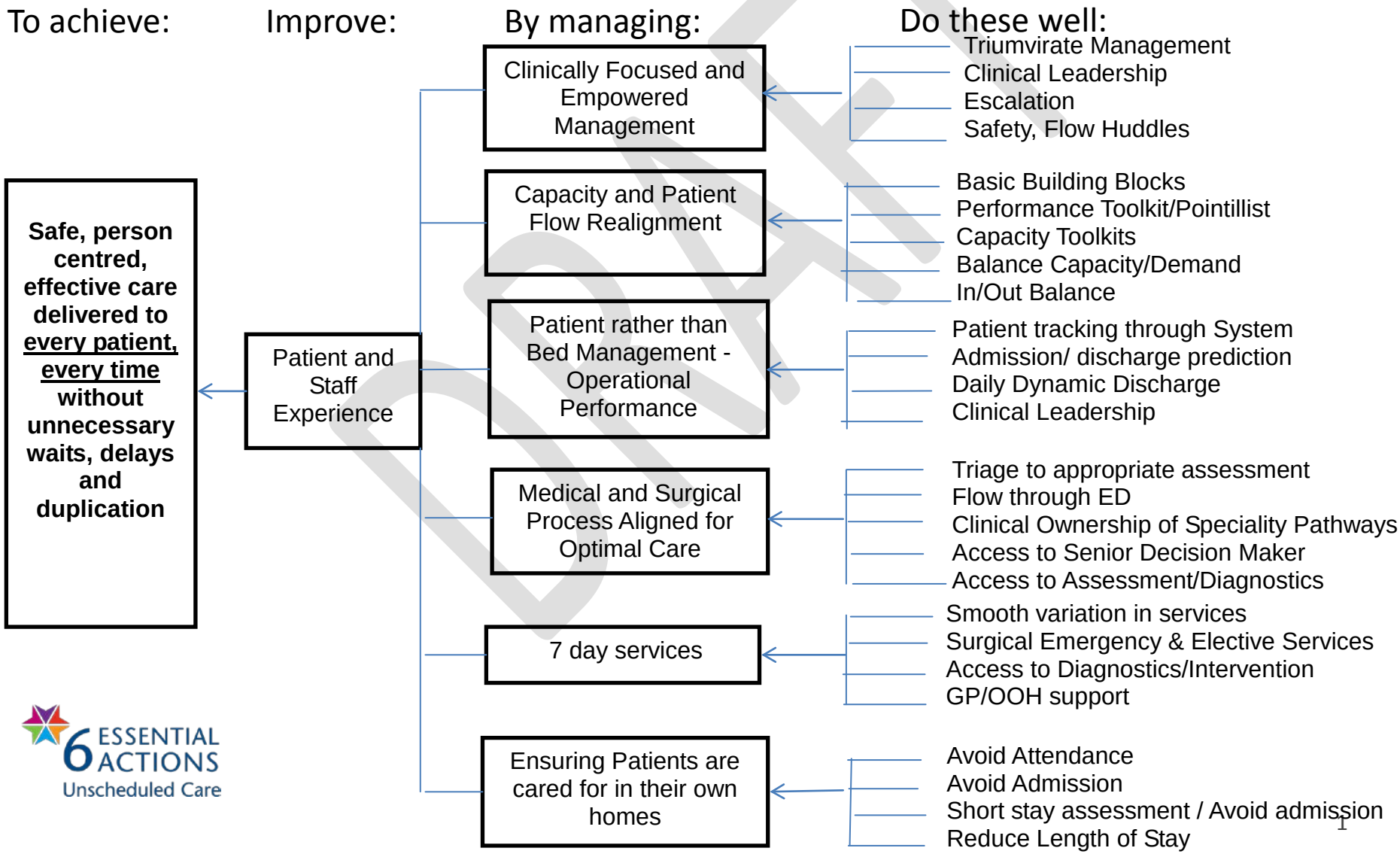
4. Winter Plan Sign-Off

4.1 Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August and final plans by the end of October. Plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Plans should have senior joint sign-off reflecting local governance arrangements and should be published online. Plans should be sent to Winter_Planning_Team_Mailbox@gov.scot .

4.2 I recognise the tremendous commitment made by the workforce across Health and Social Care services in meeting the challenges of winter and I would be grateful if you could pass on my appreciation of their dedication and valued contribution.

Annex A

6 Essential Actions to Improving Unscheduled Care Performance



Appendix 1:

Preparing for Winter 2017/18

Winter Preparedness: Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Seasonal Flu**
6. **Respiratory Pathway**
7. **Management Information**
8. **Sign-Off**
9. **Integration of Key Partners / Services**

These checklists should be read in conjunction with the Preparing for Winter 2017/18 Guidance.

- NHS Territorial Boards and Health & Social Care Partnerships should consider all of these actions, in detail, as part of their winter planning preparations.
- NHS Special Boards should review all of these actions to identify those most applicable to their own area of operations.
- Special Boards should also consider how they can best support Territorial Boards and Health & Social Care Partnerships across the full complement of actions and initiate supportive partnership working where required.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups should use the attached checklists to self-assess the quality of overall winter preparations and to ascertain where further action is required to ensure that winter preparedness priorities are met.

- There is no requirement for these checklists to be submitted to the Scottish Government.

- Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online. Plans / links to plan(s) should be sent to Winter_Planning_Team_Mailbox@gov.scot

- Winter Plans should consider the critical areas highlighted in the Preparing for Winter 2016/17 Guidance and demonstrate effective integration of key partners and services.

- The following RAG status definition table is offered as a guide to help you evaluate the status of your overall winter preparedness against each action.

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

1	Resilience Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose.	☒		Annual review of Business Continuity Plan (BCP), in collaboration with the Civil Contingencies Service.
	Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans.	☒		Routine monitoring through review of BCP.
2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios.	☒		Covered in the BCP annual review.
	Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner.	☒		Covered in the BCP annual review, and risk register regularly reviewed by SMT.
	The partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	☒		Mutual aid arrangements with Renfrewshire HSCP.
3	The NHS Board and HSCPs have HR policies in place that cover: • what staff should do in the event of severe weather hindering access to work, and • how the appropriate travel advice will be communicated to staff and patients	☒		Similar arrangements also in place, relating to Council-employed staff.
4	The NHS Board's and HSCPs websites will be used to advise on travel to appointments during severe weather and prospective cancellation of clinics.	☒		Issued through established communications channels.
5	The NHS Board, HSCPs and local authority 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.	☒		Included in Pandemic Plan.
6	The effectiveness of winter plans will be tested with all stakeholders by 30 October The final version of the winter plan has been approved by NHS Board and HSCPs	☒		Acute Sector winter plans are shared and discussed with local HSCPs through established formal processes. It is a standard process for the collated system wide plan to be reviewed and approved by the NHS Board.

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 process is in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity.	☒		Routine monitoring as part of delayed discharge management arrangements
1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked.	☒		Routine communication processes and local escalation in place. Mullti disciplinary hospital safety huddles well established and embedded as part of the daily communication/escalation processes.
1.3	Effective communication protocols are in place between key partners, particularly across local authority housing, social work and homecare services, equipment and adaptation services, Mental Health Services, and the independent sector.	☒		Regular review and updates to the Emergency Contacts Directory.
1.4	A Target Operating Model has been communicated to all staff. Escalation policies are well defined, clearly understood, and well tested.	☒		Included in the BCP and Pandemic Plan.
1.5	Escalation policies are in place and consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU.	☒		Included in Pandemic Plan
1.6	Escalation policies are focused around in-patient capacity across the whole system including community beds and care at home services	☒		Included in the BCP and Pandemic Plan.
1.7	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.	☒		Included in the BCP.
2	**Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, 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	Demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated.	☒		Routine monitoring as part of delayed discharge management arrangements
2.2	A range of analysis and management tools to enable effective and related planning and	☒		Routine monitoring as part of delayed

	management of scheduled and unscheduled services have been implemented.			discharge management arrangements
2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions.	☒	■	Routine monitoring as part of delayed discharge management arrangements
2.3	Pre-planning and modelling has been undertaken around elective activity to plan responses, escalation and recovery to minimise the impact of winter peaks in demand on the delivery of routine elective work.	☒	■	Routine monitoring as part of delayed discharge management arrangements
2.4	NHS Boards review and take stock of their performance against the British Association of Day Surgery (BADS) Directory version 5 to ensure that they have achieved optimum performance against the surgical procedures identified as being suitable for day case surgery.	☒	■	Reviewed routinely within established productivity and performance processes
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities such as MDTs, and projected peaks in demand. These rotas should include services that support the management of inpatient pathways, (e.g.) diagnostics, pharmacy, phlebotomy, AHPs, IPCT, portering, cleaning etc.**			
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. 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.	☒ ☒	■ ■	Workforce routinely reviewed and there are established and contracted arrangements in place to secure locum and bank cover where required. Workforce discussions and contingency planning are part of the established daily safety huddles Routine monitoring as part of delayed discharge management arrangements
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.	☒	■	Routine monitoring as part of delayed discharge management arrangements
3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc.	☒	■	Included in the BCP.
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.	☒	■	NHSGGC are currently reviewing GPOOH arrangements, however "Choose the Right Service" is in place and routine communication routes are in place.

3.5	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.	☒	■	Theatre capacity is routinely planned as part of the established winter planning procedures. Urgent patients are prioritised.
4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge process which includes determining an Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of simple discharge, ensuring there are no delays in patient pathways.**			
4.1	Discharge planning in collaboration with HSCPs 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.	☒	■	Routine monitoring as part of delayed discharge management arrangements
4.2	Discharge planning will support all patients and carers to plan required transport arrangements. There will be on-going engagement with SAS, and third sector partners, to effectively plan provision for appropriate patient transport services when it is known, or anticipated, that patients will require transport home or to another care setting.	☒	■	Routine monitoring as part of delayed discharge management arrangements
4.3	Multi-disciplinary ward and board rounds will be embedded to proactively manage the patient journey and prepare for discharge detailing the estimated date of discharge. Utilise electronic whiteboards and Criteria Led Discharge where appropriate.	☒	■	Routine monitoring as part of delayed discharge management arrangements
4.4	Regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate.	☒	■	Routine monitoring as part of delayed discharge management arrangements
4.5	Predictive data will be used to assess the hourly demand for beds allowing for patients to be discharged as soon as fit and as early as possible in the day to optimise flow.	☒	■	Routine monitoring by Acute.
4.6	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon.	☒	■	Routine monitoring by Acute.
5	**Ensure that senior clinical decision making capacity is available for assessment, care planning, MDTs and discharge and that AHP rotas are structured, to facilitate the discharging of patients throughout weekends and especially during the fortnight in which the two festive holiday periods occur in order to maximise capacity.**			
5.1	There is adequate medical, nursing and AHP cover across both, the festive holiday period, and over weekends to conduct assessments, plan effective care programmes and perform dedicated discharge rounds.	☒	■	Included in the BCP and delayed discharge managements arrangements, and routine monitoring by Acute.

5.2	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. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this.	☒	■	Included in the BCP and delayed discharge managements arrangements.
6	**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.**			
6.1	There is 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.	☒	■	Routine monitoring and review of commissioning arrangements. Also covered within governance of external organisations arrangements.
6.2	On-going and detailed engagement around the capacity of social care services to accommodate predicted discharge levels will start no later than October.	☒	■	Routine monitoring and full review workshop arranged for 30th October 2017.
6.3	A clear escalation plan is in place to resolve issues that might arise in provision of service.	☒	■	Included in the BCP and governance of external organisations arrangements.
6.4	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised, where possible.	☒	■	Routine monitoring as part of delayed discharge management arrangements.
6.5	Host partnerships are taking the discharge requirements of patients who are receiving treatment at the Golden Jubilee Foundation into account.	☒	■	Routine monitoring by Acute.
6.6	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.	☒	■	Routine monitoring as part of delayed discharge management arrangements.
6.7	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.	☒	■	Routine monitoring as part of delayed discharge management arrangements.
7	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
7.1	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as soon as they occur, and that escalation procedures are invoked at the earliest opportunity.	☒	■	Routine monitoring through review of BCP.
7.2	Demand, capacity, and activity plans across emergency and elective provision are fully integrated and communicated to all stakeholders.	☒	■	Routine monitoring as part of delayed discharge management arrangements.
7.3	Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector.	☒	■	Routine monitoring as part of delayed discharge management arrangements, and through the Strategic Planning

				Group and Housing Partnership Group.
7.4	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.	☒		Routine monitoring as part of our Communications Plan implementation.

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.	☒		NHSGGC are currently reviewing GPOOH arrangements, however "Choose the Right Service" is in place and routine communication routes are in place.
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.	☒		Routine monitoring as part of delayed discharge management arrangements.
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.	☒		Our New Ways Tests of change have provided some innovative insights into managing demand, some of which will support our winter planning arrangements.
4	There is reference to direct referrals between services.	☒		Routine monitoring as part of delayed discharge management arrangements, and will be further enhanced at review of Strategic Plan.
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.	☒		Arrangements in place as part of our Records Management Plan. Will be further developed at the 30th October workshop.
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	☒		Routine monitoring as part of delayed discharge management arrangements.
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.	☒		Patient pathways fully integrated from CMHT right through to IPCU.
8	In conjunction with HSCPs, ensure that there is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres	☐		To be confirmed by OHD
9	The plan displays a confidence that staff will be available to work the planned rotas.	☒		Routine review of BCP.

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.	☒		Included in Communications Plan.
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.	☒		Routine monitoring as part of delayed discharge management arrangements. SAS Paramedics Service being tested as part of New Ways programme.
12	There is evidence of joint working between the Board and NHS 24 in preparing this plan.	☒		NHS 24 interface with the NHS Board, which in turn ensures consistent approach with Partnerships.
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan.	☒		Planning colleagues from both Acute and OOH have been central contributors to this plan.
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan.	☒		Distributed across key stakeholders for comment and input, and taken to IJB for approval.
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic plan including provision for an escalation plan.	☒		BCP regularly reviewed and updated, and Pandemic Plan approved by Clinical and Care Governance Executive Group.

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 guidance provided by the National Infection Prevention and Control Manual.	☒		Routine monitoring of Datix incidents by the Clinical and Care Governance Executive Group.
2	IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts.	☒		Routine monitoring of admissions to hospital from care homes/
3	HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.	☒		Available through StaffNet, and access available to Council-employed HSCP staff. Infection control Datix incidents monitored by the Clinical and Care Governance Executive Group.
4	NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time.	☒		System in place for routine distribution of up-to-date information.

5	Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks.	☒		System in place within Acute.
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.	☒		System in place to inform and cascade.
7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.	☒		Standard and established processes are in place
8	NHS Boards must ensure arrangements are in place to provide adequate IPCT cover across the whole of the festive holiday period.	☒		IPCT cover in place.
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days.	☒		Established processes and contingencies exist. Surge capacity identified as part of winter planning processes
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.	☒		Established communication processes in place for winter period
11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message.	☒		System in place to inform and cascade.

5	**Seasonal Flu, Staff Protection & Outbreak Resourcing** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	At least 50% of all staff 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, as recommended in the CMOs seasonal flu vaccination letter due to be published in mid Aug 2017.	☒		Established vaccination programme rolled out across Board and is available across all acute sites. Key communications issued to all staff in this regard
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2017) 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.	☒		Staff Clinics are set up each year, including Council-employed HSCP staff. Uptake rates are monitored.
3	The winter plan takes into account the predicted surge of 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.	☒		Routine monitoring as part of delayed discharge management arrangements. Escalation

				arrangements included in Pandemic Plan.
4	HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity.	☒		Arrangements described in Pandemic Plan.
5	Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods.	☒		Arrangements described in Pandemic Plan.

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.	☒		Overseen, updated and cascaded by the Clinical and Care Governance Executive Group.
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☒		Telehealth hub at home for approx 20 COPD patients in our local community who self assess daily (vital signs /respiratory secretions etc) Clinical Parameters are set by Medical colleagues. Anticipatory medicines including antibiotics and steroids in patients home, and whole system checked daily for any alerts by DNs which are then followed up to ensure patient wellbeing and safety Home Support respiratory services available over 7 days. DNs support any patient over 7 day period alongside homecare colleagues and GPs, to ensure that patients are able to remain at home if at all possible. The HSCP's main support in this

				area is via Telecare hubs. The main community provision, particularly post discharge, is via the secondary care's Respiratory Nurse Specialists.
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times.	☒	■	Routine monitoring as part of delayed discharge management arrangements.
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.	☒	■	Messages disseminated as per Communications Plan.
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.	☒	■	Included within Respiratory Discharge Protocol.
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.	☒	■	Included within Respiratory Discharge Protocol.
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.	☒	■	Included within Respiratory Discharge Protocol and 'Compassionate Inverclyde' procedures.
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	☒ ☒ ☒	■ ■ ■	Included within Respiratory Discharge Protocol. All oxygen prescribing / dispensing whether it be short term supply or Long Term Oxygen Therapy is initiated, monitored by Medical Lead and Specialist Respiratory Team at IRH. Included as part of delayed

	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.	☒		discharge management arrangements.
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.	☒		District nurses carry small hand held pulse oximeters which check peripheral circulating O2 via a patients finger tip. This aids the nurses' diagnostic assessment and gives some indication of the urgency (alongside other vital signs recordings in conjunction with patients presenting symptoms). Our local OOH centres also have pulse oximeters readily available to clinical staff.

7	**Management Information** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	Admissions data will be input to the System Watch predictive modelling system as close to real time as possible. Local quality assurance of the site and board level data is in place.	☒		Local monitoring in place with on going and predicted capacity discussed at hospital safety huddles.
2	Effective reporting lines are in place to provide the Scottish Government with routine weekly management information and any additional information that might be required on an exception / daily basis.	☒		Routine submission process in place.
3	Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise.	☒		Routine submission process in place.

8	Sign Off *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online.	☒		Process in place. Once Plan is approved by IJB (anticipated 12th September 2017), it will be submitted to NHSGGC and SG.
2	Arrangements are in place to include governance of winter planning within local Unscheduled Care Management Groups or other relevant management groups as appropriate.	☒		Overseen by the Clinical and Care Governance Executive Group.

9	Key Roles / Services Integrated into Planning Process		RAG	Further Action/Comments
	Heads of Service	☒		Head of Strategy is the Lead Officer, with targeted inputs from the Chief Officer, the other three Heads of Service, and all relevant Service Managers.
	Nursing / Medical Consultants	☒		Inputs to overarching NHS Board work are cascaded to HSCPs and incorporated into their planning processes.
	Consultants in Dental Public Health	☐		To be confirmed by OHD.
	AHP Leads	☒		Through Strategic Planning Group.
	Infection Control Managers	☒		Represented on Clinical and Care Governance Executive Group.
	Managers Responsible for Capacity & Flow	☒		Direct inputs to plans, and wider discussion at Strategic Planning Group and HSCP Leadership Team. Supported by the HSCP Quality and Development Team.
	Pharmacy Leads	☒		Represented on Clinical and Care Governance Executive Group, and regular presentations delivered to IJB.
	Mental Health Leads	☒		Direct inputs to plans, and wider discussion at Strategic Planning Group and HSCP Leadership Team. Supported by the HSCP Quality and Development Team.
	Business Continuity / Emergency Planning Managers	☒		Lead on the development of BCP and Civil Contingency Plans.

	OOH Service Managers	☐		To be confirmed by NHS Board.
	GP's	☒		Outputs from GP Forum are incorporated into plans.
	NHS 24	☐		To be confirmed by NHS Board.
	SAS	☐		To be confirmed by NHS Board.
	Territorial NHS Boards	☐		To be confirmed by NHS Board.
	Independent Sector	☒		Through Strategic Planning Group.
	Local Authorities	☒		Through Strategic Planning Group and Community Planning Partnership.
	Integration Joint Boards	☒		Through direct instruction to HSCP.
	Strategic Co-ordination Group	☒		Strategic Planning Group.
	Third Sector	☒		Through Strategic Planning Group.
	SG Health & Social Care Directorate	☒		Through incorporation of policy directives, and through submission of plans as required.

Appendix 2

Health & Social Care: Winter in Scotland in 2016/17

Scottish Government
Riaghaltas na h-Alba
gov.scot

Health & Social Care: Winter in Scotland in 2016/17

Summary

1. Health & Social Care systems in Scotland sustained A&E performance in winter 2016/17 and continued to outperform other UK countries.

Purpose

2. Winter disruptions can include increased demand and activity due to seasonal flu, respiratory and circulatory illness; increased numbers of falls and trips; and wards closed to admission due to higher levels of norovirus. There are also business continuity challenges associated with managing workforce rotas during the festive period, to ensure that patients continue to be safely and effectively admitted, diagnosed, treated and discharged.

3. This report draws together the key official statistics on activity, pressures and performance. Unless otherwise stated, within the charts and tables, winter is defined as the two quarters ending December and March.

4. This report should be considered alongside the Preparing for Winter 2017/18 Guidance, which has been issued at the same time as this report.

Planning for Winter 2016/17

5. The Scottish Government and local partnerships reviewed the winter 2015/16 as part of the planning process for 2016/17. The Scottish Government developed winter guidance with NHS Boards and their partners over the summer of 2016. Winter guidance was issued on 12 August 2016. A National Unscheduled Care planning event was held on 08 September 2016. Local plans were published.

Levels of activity in Winter 2016/17

6. The Scottish Ambulance Service introduced a new clinical response model during the 2016/17 winter period on 23 November 2016. The new model is designed to ensure that patients get the right clinical resource first time every time. The model did not have any direct impact on emergency demand during the winter period. Demand since go live, has remained stable and within normal expected levels. The acuity levels within the demand have however changed with significantly less calls being triaged as immediately life threatening. The Service responded to 250,357 Emergency incident during winter 2016/17, 880 incidents less than the previous winter.

7. A&E attendances in winter 2016/17 were at 783,099 similar to winter 2015/16 (788,025). Provisional statistics show emergency inpatient discharges down by over 10,000 or 3.6 per cent this winter.

8. Calls to NHS 24 core services decreased by 16,462 or 2.1 per cent compared to last winter. During the winter 2016/17, 4 of the 6 months reflect this overall reduction, with October and December 2016 however showing an increase. March 2017 shows a significantly lower year on year variance, a decrease of

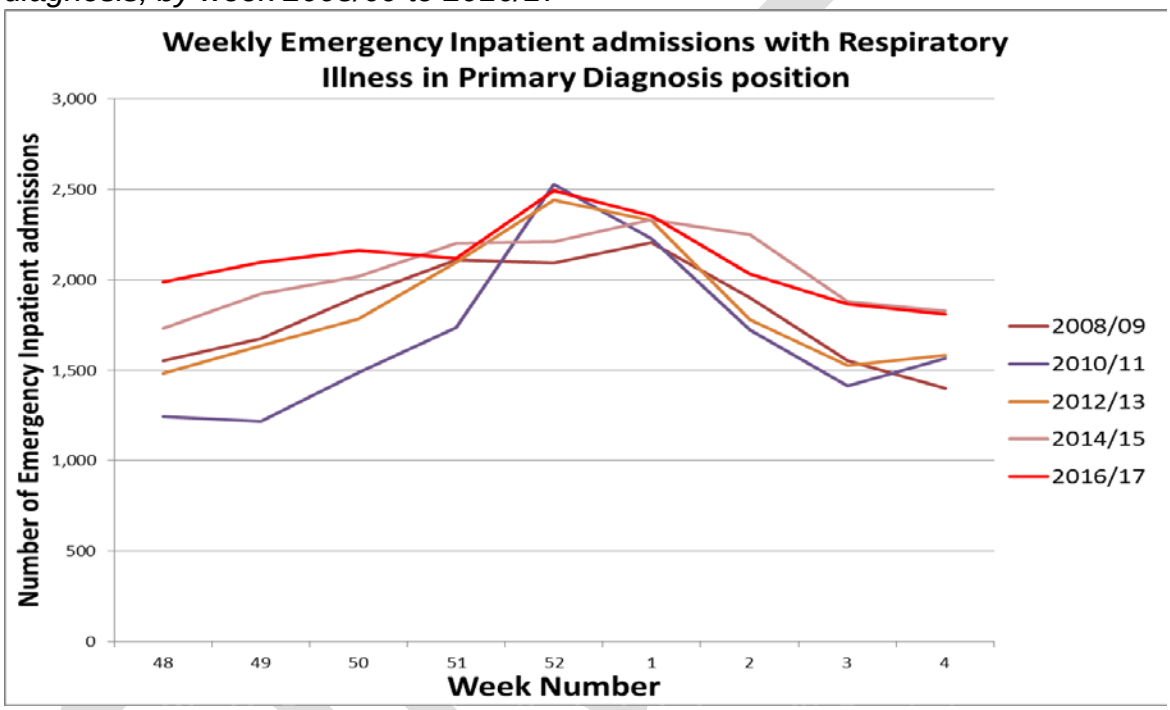
14.2% (20,476 calls) which was heavily influenced by Easter falling in April in 2017, as opposed to March in 2016.

9. GP Out of Hours data will be published in the near future.

Respiratory conditions and influenza

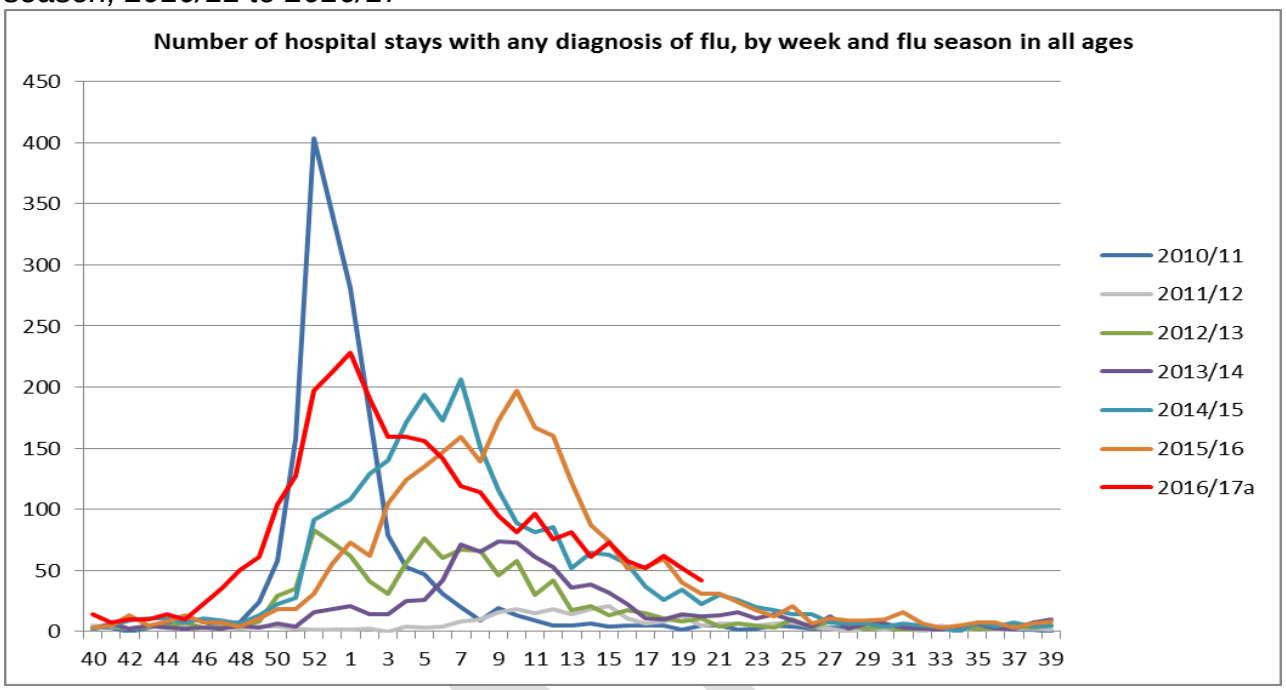
10. Weekly emergency inpatient admissions with respiratory illness are above the recent long term average.

Chart 1: Weekly emergency inpatient admissions with respiratory illness as a primary diagnosis, by week 2008/09 to 2016/17



11. Within the general community, impact on general practice was low and below the levels expected in a normal influenza season across the whole of the 2016/17 season. However, the provisional data on the number of influenza hospital admissions for 2016/17 is similar to 2014/15 and 2015/16, and higher than previous seasons.

Chart 2: The Number of hospital stays with 'any diagnosis' of flu, by week and flu season, 2010/11 to 2016/17

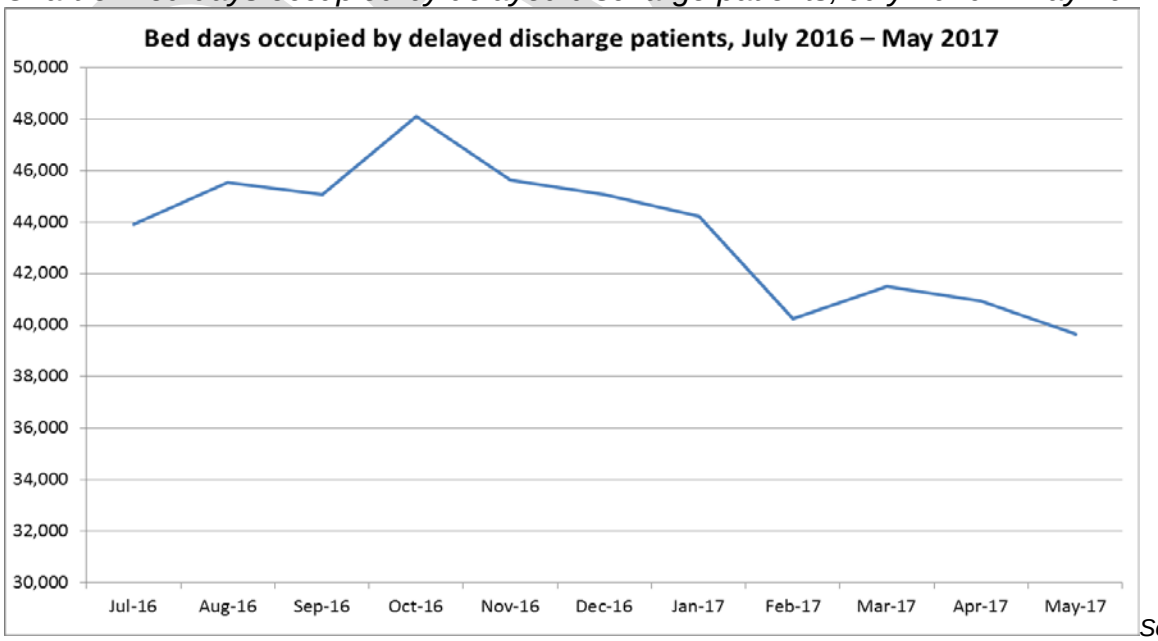


Source: Health Protection Scotland

Delayed discharge

12. During winter 2016/17, the number of bed days occupied by delayed discharge patients have reduced from 48,104 in October 2016 to 41,493 in March 2017.

Chart 3: Bed days occupied by delayed discharge patients, July 2016 – May 2017



Source: ISD Scotland

Norovirus was relatively mild, and the weather was not particularly cold

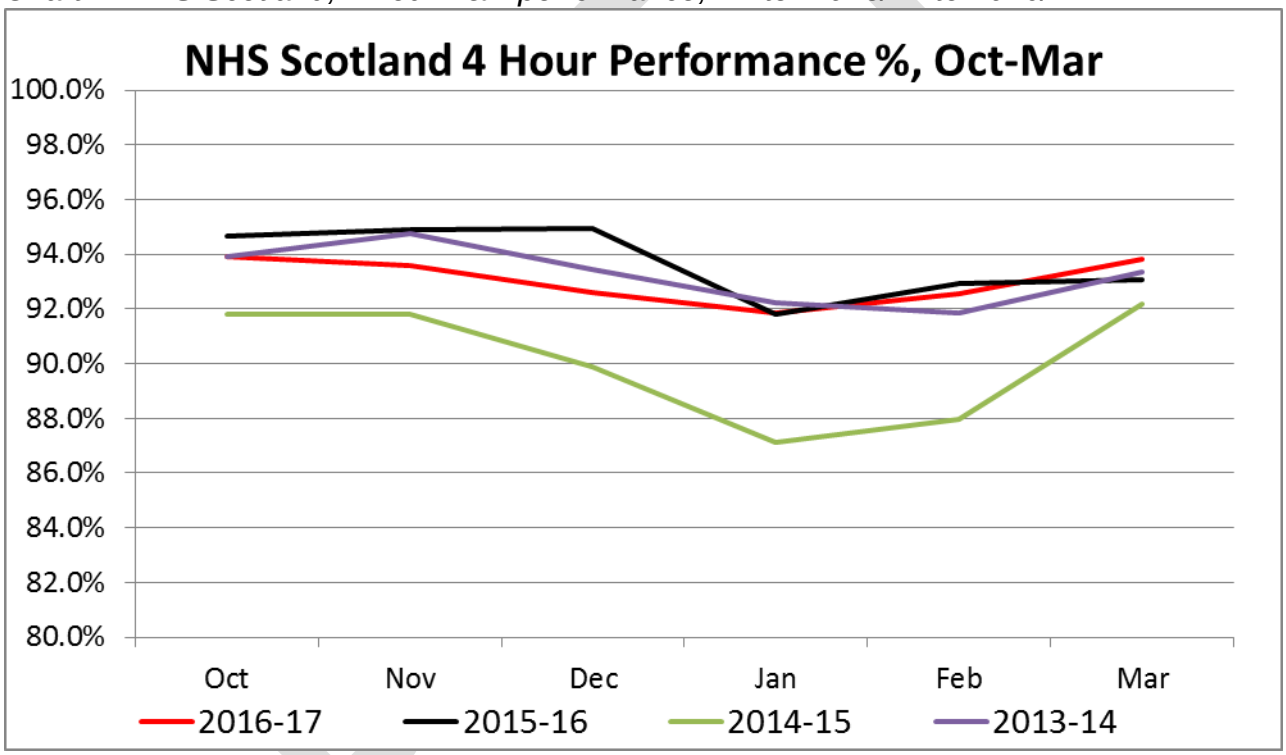
13. The norovirus season 2016-17 was relatively low compared to the 2010-2015 season average.

14. The average temperatures this winter were slightly above the 30 year averages.

A&E waiting times

15. The length of time A&E patients wait to be seen, treated and discharged can be a proxy measure of how the Health and Social Care system is managing the pressures it is facing. Official statistics show 4 hour A&E performance in March 2017 at its highest level since March 2012.

Chart 4: NHS Scotland, 4 hour A&E performance, winter 2013/14 to 2016/17



Source: ISD Scotland, A&E Datamart

Core A&E waiting times performance was higher in Scotland compared to other UK countries in Winter 2016/17

16. Official statistics on waiting times in large Accident & Emergency departments are published by each of the four UK countries. This report does not consider the nature of the pressures faced in other parts of the UK. This winter, performance in Scotland was significantly above that in England, Northern Ireland and Wales.

Table 1: UK A&E "Core" sites 4 Hr Performance, winter 2016/17, percentage

	'Winter'
	Oct-Mar 2016-17
Scotland	92.1%
England	81.6%
Wales	76.4%
Northern Ireland	68.8%

Source: ISD Scotland, NHS England, NHS Wales Informatics and DHSSPSNI

Elective and cancer waiting times

17. Statistics for January to March 2017 show that 82.1% of inpatients and day-case patients were treated within 12 weeks this compares to 89.0% for July to September 2016. Statistics also show 80.7% of patients waiting for a new outpatient appointment at 31 March 2017 had been waiting 12 weeks or less, compared to 79.3% at the end of September 2016. For January to March 2017, 62 day performance for Cancer Waiting times was 88.1%, which was up from the quarter ending September 2016 (87.1%).

Season Flu Vaccination

18. Early (provisional) data on seasonal flu uptake by staff in 2016/17 was 35.3 per cent, a 3.3 percentage point improvement on 2015/16 which saw an uptake figure of 32.0 per cent. The 2016/17 figures are broadly in line with uptake from 2014/15 which reached 35.6 per cent. However, overall recorded uptake remains low and below the 50 per cent target.

19. Last winter more than two million Scots were offered the free flu vaccine. People at greater risk from flu, including those with underlying health conditions, pregnant women and those aged 65 were encouraged to get the vaccine. Provisional uptake rates are shown in the table below.

Table 2: Provisional seasonal flu uptake rates, 2016/17

Eligible Groups	Uptake	Target
65 and over	72.8%	75%
Under 65 at risk	44.9%	75%
Pregnant Women (without risk factors)	49.3%	75%
Pregnant Women (with risk factor)	58.0%	75%
2-5 year olds (not yet at school) – vaccinated at GP practice	59.0%	65%
Schoolchildren aged 5-11 (P1-P7) – vaccinated at school	73.0%	75%

*Source: HPS (**National Influenza Report - week ending 31 May 2017)***

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