AGENDA ITEM NO:6

Report To:	**Inverclyde Integration Joint Board**	**Date: 15 May 2018**
Report By:	**Louise Long** **Corporate Director, (Chief Officer)** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No: IJB/27/2018/AS**
Contact Officer:	**Helen Watson** **Head of Strategy and Support Services** **Inverclyde Health and Social Care Partnership**	**Contact No: 01475 715285**
Subject:	**REVIEW OF THE INVERCLYDE HSCP 2017/18 WINTER PLAN**	

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Inverclyde Integration Joint Board (IJB) with a review of the Inverclyde Health and Social Care Partnership (HSCP) Winter Plan 2017/2018, and the key arrangements that will be put in place to manage demand over Winter 2018/19.

1.2 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 and to identify the key priorities to be taken forward in preparation for Winter 2018 - 2019.

2.0 SUMMARY

2.1 In line with Scottish Government guidance, this review of the winter plan 2017/2018 provides an overview of what went well, the lessons learned from its implementation and identifies improvements that could be made to enhance performance. The review process also informs the key priorities in the development of planning for the 2018/2019 reporting period, underpinned by the self-assessment included in the guidance.

3.0 RECOMMENDATIONS

3.1 The IJB is asked to note the findings of the review and the key priorities for the development of the Winter 2018/2019 plan.

3.2 The IJB is asked to approve submission of the review and forward plan to the Scottish Government.

Louise Long
Corporate Director, (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 Since HSCPs were set up, there has been a focus on identifying key pressures on our own as well as wider health and care systems. This work feeds into the National Winter Reports.

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 review for 2017/18 with the Scottish Government to support national and local winter planning preparations for 2018/19.

The HSCP review sets out the local key priorities for the 2018/2019 Winter Plan.

4.3 NHS Scotland have requested that this year's review should again include:

- the named executive officer leading on winter reviews across the local system;
- key learning points and future recommendations / planned actions;
- identify the top 5 local priorities to be addressed in the 2018/19 winter planning process;
- to provide views on the effectiveness of the wider winter planning process, particularly from Health and Social Care Partnerships, and suggestions on continuous improvement.

4.4 If approved by the IJB, the attached papers will be submitted to the Scottish Government.

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 As this is an NHS Scotland operational review of performance 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

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 Wellbeing outcomes as highlighted below.

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 2017/2018 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.

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.

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.

5.6.3 **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.

5.6.4 **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 system which is responsive to the population of Inverclyde as well as being sensitive to individual service users' needs.

5.6.5 **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.

5.6.6 **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.

5.6.7 **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.

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

6.0 CONSULTATION

6.1 This document has been developed by the HSCP.

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

7.3 NHS Scotland: Preparing for Winter 2017/18, 4th August 2017

Health & Social Care: Local Review of Winter 2017/18

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?

- We sustained local performance despite the exceptional circumstances and challenges to the Health & Social Care system.
- Local processes were implemented with ownership across all key partners.
- Lead roles and responsibilities were clearly identified with information supplied to partners.
- Weekly updates of information ensured consistency and accuracy of approach and understanding, across partners.
- Weekly meetings were set with required attendance by all key partners to review and address any identified issues - in particular with regard to the adverse weather and the high level of respiratory illness across the local population.
- Implementation of single access point and out of hours pathways for community services gave clarity to staff and patients.
- GP 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 was linked to our Pandemic Flu Plan and the Council's Resilience Plan.

1.2 What could have gone better?

- Ensuring improved co-ordination and implementation of our Business Continuity Plan in light of the adverse weather.
- There were transport issues due to adverse weather – future planning will include better co-ordination of transport for staff.

1.3 Key lessons / Actions planned

- Recognising that pressures on health and social care systems are not seasonal. Locally we schedule the 'Winter Plan Operational Group' at regular times with our data pack being produced weekly all year round, not just throughout the winter period.
- Business continuity 'trial' practice should be introduced to test and review.
- Weekly planning meetings now held at the hospital.

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?

- Escalation plans were renewed and further developed with attention given to the service/departmental level action cards. Local processes were implemented with ownership across all key partners.
- Lead roles and responsibilities were clearly identified, with information supplied to partners.
- GP 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 was linked to our Pandemic Flu Plan and the Council's Resilience Plan.
- Points from the previous section are all relevant.
- Additional capacity was opened as required, as part of escalation processes.
- Daily conference calls took place, to communicate across Acute Services, HSCPs and Scottish Ambulance Services.

2.2 What could have gone better?

- Full testing would have helped identify potential issues in advance.
- Ensuring improved co-ordination and implementation of our Business Continuity Plan in light of the adverse weather.
- There were transport issues due to adverse weather – future planning will include better co-ordination of transport for staff.

2.3 Key lessons / Actions planned

- Recognising that pressures on health and social care systems are not seasonal. Locally we schedule the 'Winter Plan Operational Group' at regular times with our data pack being produced weekly all year round, not just throughout the winter period.
- Business continuity 'trial' practice should be introduced to test and review.
- Weekly planning meetings are now held at the hospital.

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?

- Positive joint working and communications between Acute and HSCP teams.
- Early identification of vulnerable people in the community, at risk of admission to Inverclyde Royal Hospital.
- Collaborative working of medical, nursing and AHP staff across all specialties maintained a proactive approach to communication ensuring safe, speedy and effective patient discharges were achieved through the Daily Dynamic Discharge process. This included early identification of people in the IRH for discharge - the 'Fit List'.
- Operational discharge meetings were attended by key individuals, including community leads who assist in planning the discharge of complex cases.
- Joint working between Community Nursing and Homecare teams in partnership with Acute and Out of Hours services supporting safe and effective hospital discharges during weekends and holidays.
- There was a single point of access for the discharge team at the local health centre, meaning that discharge staff could contact the right people quickly and easily.

- Our Home First initiative whereby a District Nurse and OT in-reach have been appointed to facilitate communication between acute and community and assist assessment and support planning for quicker discharge to home.
- Falls pathway now in place and linked to initial referral to HSCP to take preventative approach.
- The elective programme across all Acute sites was managed down to focus on urgent and cancer patients, this was planned in advance to avoid unnecessary disruption and reviewed daily over the holiday period.
- Joint working with the Council roads department to clear specific streets and thereby enable timely hospital discharge.

3.2 What could have gone better?

- Acute to review process of email communication rather than phone calls.
- Double checking Edison Business Objects.
- While communication was a key focus, at times the communication between Homecare and the wards could have been better.
- Different IT systems run the risk of intelligence not being fully co-ordinated.

3.3 Key lessons / Actions planned

- Homecare in-reach post in situ to facilitate communication and assessment of the service user prior to discharge.
- Good forward planning for winter 2018/9 and a level of additional winter funding will be important to help maintain the progress made during this recent winter period.
- Identified need for Homecare in-reach post to facilitate communication and assessment of 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	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;

		alongside appropriate arrangements to create a safe and person centred environment.	• 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 was 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 the most vulnerable adults at risk of admission (such as mental wellbeing; ill-health/elderly carer; complex cases).
- Locality meetings in place to ensure good information as close to service users as possible.
- The Community Nursing teams introduced *Patient Status at a Glance* - this involved having daily update meetings with details of vulnerable patients as well as patients with changing needs to identify those at risk of admission. The nurses linked in with our GPs and Adult Health and Community Care Services 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. There were clear plans in place for additional acute bed capacity from December.
- Plans were enacted to reduce the elective programme and provide extended pharmacy opening.
- Some additional AHP cover was put in place throughout the winter period in the Clyde Sector generally.

4.2	What could have gone better?

- Dedicated/ aligned Planning Support would have been useful.
- Workforce planning for surge wards was delayed due to uncertainty of funding. In some areas this led to an over dependence on bank and agency staff. In Clyde sector generally, fill rates are lower than the Board averages and as a consequence substantive medical ward teams were disrupted to meet the gaps.
- Exceptional pressures required more capacity to be opened – in future it will be described in winter plans as escalation steps.
- Delays with patient transfers continued to be challenging, leading to delays in bed availability.

4.3	Key lessons / Actions planned

- Implementation of key learning points

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.
- GP Practices advised patients of closures via SOLUS Screens and encouraged patients to order prescriptions in advance.
- Home Care capacity - exception reporting was included in Weekly Plan Data Pack.
- We established cut-off referral dates.
- Cut-off referral time of 2pm for next day discharge was put in place, which encouraged referrals at a time of day when support could be more readily organised.
- Direct communication channels between Ward and Home Care were established.
- The work of the staff in Acute and Community who went the extra mile in getting people returned home safely (e.g. getting roads cleared or accessing appropriate transport.
- Daily Huddles on all sites provide a clear picture of admissions and discharges, with additional meetings held as part of escalation processes.
- Point of Care testing used on all acute sites for Flu – allowed patients to be discharged with clear advice and allowed precautions to be put in place quickly – minimal spread of flu within the hospitals.
- HSCP Chief Officer linked with NHSGG&C Acute Division and other Partnership Chief Officers to maintain a collective perspective on performance issues, pressures and escalation arrangements which required action.
- Situation reports (SITREPs) were shared between the Community and Acute Services to inform escalation pressures.

5.2 What could have gone better?

- Transport issues – the extreme weather was challenging for our vehicles, and some were not able to function.
- Emergency care summaries from GP anticipatory care plans need to be available to emergency clinicians electronically to inform decision making.

5.3 Key lessons / Actions planned

- Continuity and attendance at ongoing weekly Planning Operational Group is required throughout the year.
- Continued work under the COPD UCC workstream is starting to show better coordination of care across the entire patient pathway and this work will continue in 2018.

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 are also produced.
- HSCP staff are actively encouraged to be vaccinated and local peer vaccination sessions were organised.
- We reviewed annual leave requests to ensure sufficient cover – this was linked to our business continuity plans.
- Acute Sector Flow Hubs were established in October to provide a central coordination point for information and action planning. The hubs are informed on a daily basis of the operational position in relation to demand and capacity using daily predictive tools to estimate demand and plan for the day ahead. The sector is using the Microstrategy Dashboard, TrakCare and Portertrak to establish the current status of patient movements and this information continues to inform the operation teams to manage demand.

6.2 What could have gone better?

- Edison Business Objects system is often unreliable, impacting planning preparation – this needs to be addressed.
- A higher uptake of staff being vaccinated might have reduced levels of staff sickness absence.

6.3 Key lessons / Actions planned

- The necessity for robust information systems.
- There is considerable development work ongoing to produce Dashboards to support the tracking of admissions and patient flow for specific cohorts of patients; a current SG funded project is focused on developing a COPD dashboard which will establish a platform that can be adapted for other patient groups.

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 were created and confirmed, including duty cover at the IRH.
- An acute daily staffing report was produced and shared.
- Community staffing numbers were reported weekly.

- Having a RAG status chart across all service for staffing levels helped identify gaps.
- In Acute, a senior decision maker was available over PH weekends and immediate days thereafter.
- GP OOH rota was fully populated due to enhanced rates.

7.2 What could have gone better?

- Transport issues for staff meant that some staff were unable to get through the snow.
- Additional staffing is required over the winter period each year, however recruitment does not begin until there is confirmation of funding. Recruitment is generally into temporary contracts. This is providing significant challenge in nursing and AHP professions with both services experiencing difficulties in filling 'winter' posts.
- Medical Staffing continued to have gaps. Following rotation in February, 50% of middle grade posts were vacant forcing closure of winter wards sooner than anticipated.
- Clyde continues to have lowest rates across the Board for filling nurse bank and retinue requests.

7.3 Key lessons / Actions planned

- Transport issues for staff meant that some staff were unable to get through the snow. This will be reviewed before next winter.
- Earlier planning of surge capacity and consideration of authorisation processes for advance recruitment of staff.

8.8	**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 enabled prompt and safe discharge.
- A stock of equipment is left at several points across Inverclyde - the Joint Equipment store staff ensure that equipment is always stocked at all venues. This allows for 24 hour local access to equipment if required.
- Also shared equipment with the hospital
- The district nursing service also holds moving and handling equipment, mattresses, commodes etc.
- Rigorous monitoring of pre-noon discharges and weekend discharges is in place, detailing performance down to individual ward level.
- Data is shared widely across the sector in weekly and monthly reports.
- Hospital site presence of Senior Managers ensured continued emphasis of priorities.

8.2 What could have gone better?

- Care Homes generally in the past unable to admit at weekends. We are working with local providers to have this addressed, and it was during the adverse weather this year.

8.3 Key lessons / Actions planned

- Identify and quantify the need for discharges at weekends, so that these can be properly resourced.
- We will liaise with local care homes around admissions outwith office hours and at weekends.
- A reliable system for increasing the number of patient discharges at weekends is necessary.

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	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;

		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.	• % 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, and HSCP staff were included.
- Partners were advised of Winter and Holiday referral and discharge process prior to the festive period.
- Duty rota for winter and festive period was provided to IRH for back-up and support- maintaining staffing levels was key to safe and timely discharge.
- Early identification of patients requiring supported discharge ensured that the right packages could be put in place.
- Home First Action Plan is in place.
- Joint working with the Council Roads department to clear specific streets and thereby enable timely hospital discharge.

9.2 What could have gone better?

- Business continuity 'trial' practice should be introduced to test and review.
- Patient flow remains vulnerable in the out of hours period.

9.3 Key lessons / Actions planned

- Testing of Contingency planning

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?

- Significant communications were issued at Board level through a number of media avenues, to help patients understand who they should contact and when.
- Representatives from the HSCP were at the acute sector daily Huddle.
- Winter Planning is on the agenda of the HSCP communication group.
- Information was circulated with regard to available community services and clinics during the festive period, including pharmacy and GP Practice opening times.
- We collated a range of information regarding staff rotas, service operating hours and lead contact details, circulated these widely throughout the HSCP.
- Information regarding GP availability throughout the festive period was provided through the NHSGG&C Winter Booklet.
- Posters were also 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 leaflets were given to patients with chronic conditions on source of help during the winter period.

10.2 What could have gone better?

- Being clear about communication routes between Community and Acute, at times of high pressure.

10.3 Key lessons / Actions planned

- Continue discussion around discharges at 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?

- Norovirus activity was low this year
- Twice Daily huddles in place, so everyone was kept aware of the norovirus status.
- The weekly winter planning update was shared.

- Infection control protocols are in place to manage outbreaks in a range of settings, including local Care Homes, GP Practices and acute sector services.

11.2 What could have gone better?

N/A

11.3 Key lessons / Actions planned

N/A

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 vaccination clinics were set up across all HSCP staff buildings, with good uptake by HSCP staff.
- Communication ongoing to ensure that as many staff as possible know when and where clinics are taking place.
- The GP flu vaccination programme for elderly or at-risk patients had good uptake.
- Vaccination was made available to staff in local care homes and home care providers.

12.3 What could have gone better?

- We would have wished for a higher uptake of Flu vaccine by Inverclyde HSCP staff.

12.4 Key lessons / Actions planned

- We will do more to raise awareness with staff around flu vaccination in advance of next winter.

13	**Additional Detail** *Include detail around when this review is likely to be considered by the Board's senior management team.*

Winter Plan 2017/18

The key priorities for winter 2017/18 have been developed through the review process for Winter 2017/18 arrangements, and the joint undertaking of the self-assessment included in the Scottish Government Guidance.

14	**Top Five Local Priorities for Winter Planning 2017/18**

- Recognising that pressures on health and social care system are not seasonal and contingency planning should be in place at all times.
- Having a local agreement in place to reconvene the Contingency Planning 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 local health and social care systems to have access to live data.
- Reinforcing effective channels of communication between Acute and Community services.

15	**Actions for Winter 2017/18**

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' removed and rebranded as weekly planning. • Articulate rebranding to all partners for consistency of approach.	Quality and Development Service	October 29017 Achieved
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	September 2017 Achieved
Weekly data pack to be produced and	Agreed and resourced analytical plans for winter analysis.	• Standardised and agreed data pack to	Quality and Development	September 2017 Achieved

analysed as an ongoing requirement		be produced and circulated on a weekly basis. • Norovirus data and reports to be included in the shared data pack.	Service All Partners	
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	October 2017 Achieved
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 developed to prevent unnecessary delays to discharge due to the administration of care packages	Ward and HSCP homecare leads Quality and Development Service	September 2017 Achieved

Inverclyde HSCP Review of Winter Plan

Winter Plan Data Analysis (Nov 17 to Mar 18)

No. of Delayed Patients (from weekly planning file)

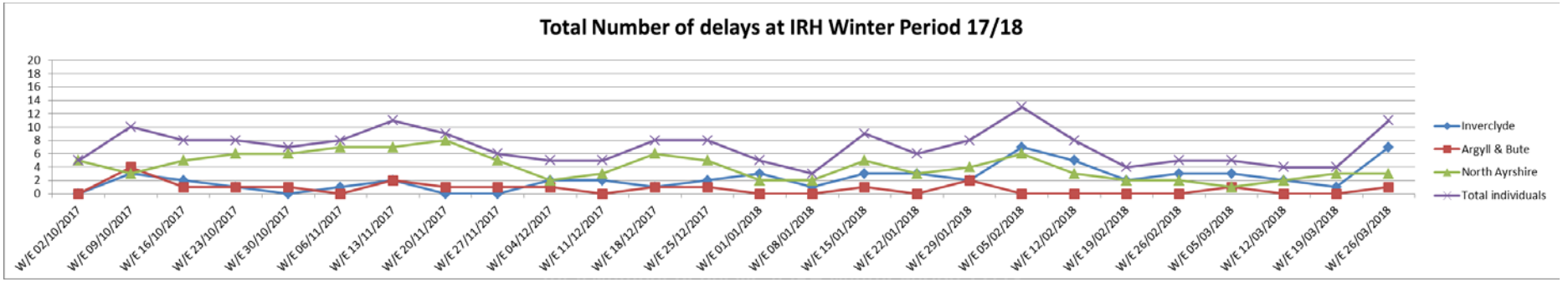
This data set illustrates the number of occupied beds within Inverclyde Royal Hospital (which includes the Larkfield Unit) which are considered to be “delayed discharges”. In the main, 3 local authorities tend to be the highest users. Inverclyde HSCP being the obvious Local Authority, but also North Ayrshire and Argyll & Bute.

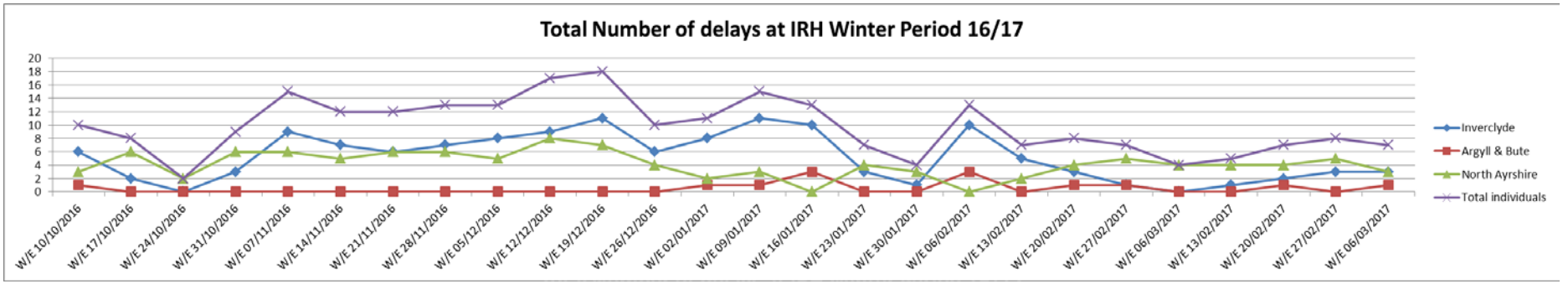
An examination of the data since Nov 17 (week ending 02/11/2017) until Mar 18 (week ending 26/03/2018) shows that during this period, North Ayrshire had the highest number delayed patients on the IRH site. Inverclyde only exceed North Ayrshire on 6 occasions during the entire period, on 5 occasions Inverclyde and North Ayrshire had an equal number of delayed patients

Over this period, the weekly average number of patients attributed to Inverclyde was 2.23 delayed patients, with North Ayrshire’s average for the same period being 4.07 delayed patients. For information, Argyll and Bute’s average was 0.73 patients. Inverclyde achieved 3 periods of 0 delayed patients during this time.

A seasonal spike was recorded week ending 05/02/2018 where the number of patients delayed within the week rose to 13, with Inverclyde contributing 7 of these delays.. A further rise at the end of the period (week ending 26/03/2018) was recorded with Inverclyde contributing 7 patients.

For the most part, Inverclyde HSCP managed to keep the number of delays per week below 4 delays.

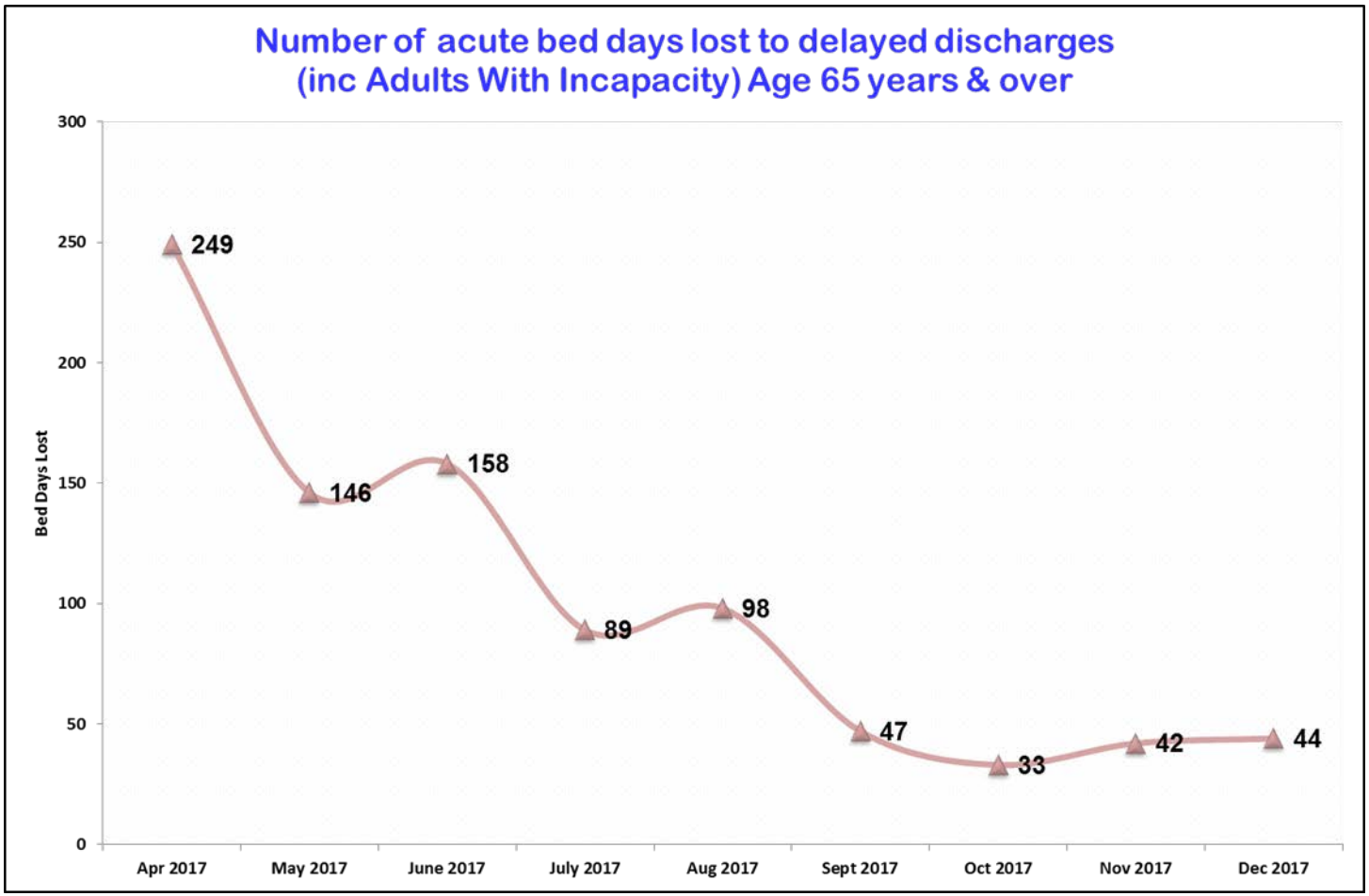




Bed Days lost to Delayed Discharge (GG&C Older Peoples Summary and ISD Bed Days lost)

In terms of bed days lost due to delayed discharge. Inverclyde HSCP has performed well during the winter months with the peak number of bed days lost for those patients 18+ occurring in January with 84 bed days lost during the month. The total number of bed days lost for those aged 65 and over in this same month was 47 bed days lost. The average number of bed days lost from October 17 to January 18 for those aged 18+ was 71.5 bed days lost and for those aged 65 and over the average was 42 bed days lost.

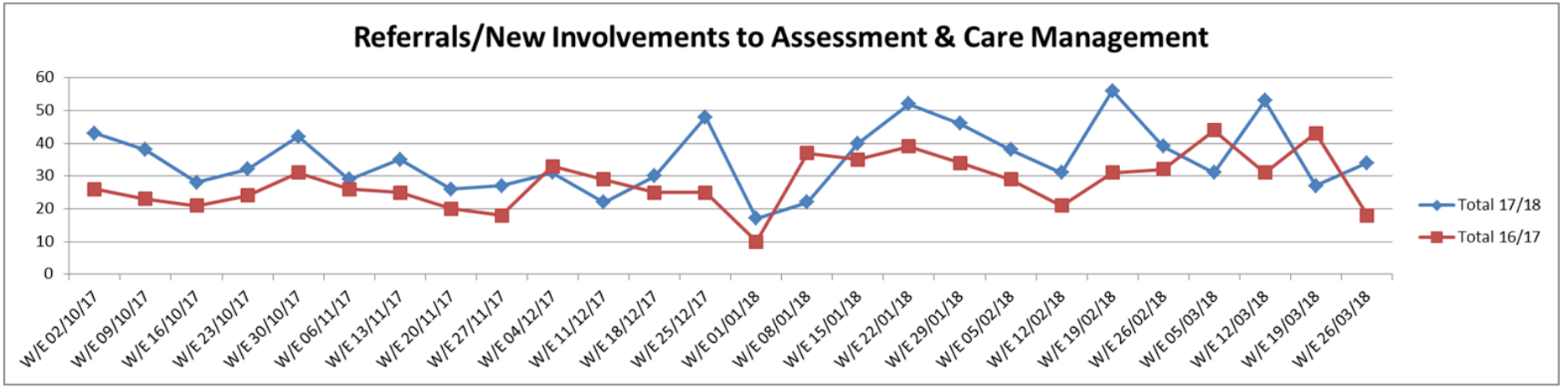
Given the extreme weather in the months of February 18 and March 18, the HSCP expects the bed days lost to delayed discharge to rise during this period as the ability to discharge patients in a timely manner was hampered by the unusually bad weather.



Referrals/New Involvements to Assessment & Care Management (from Weekly Planning File)

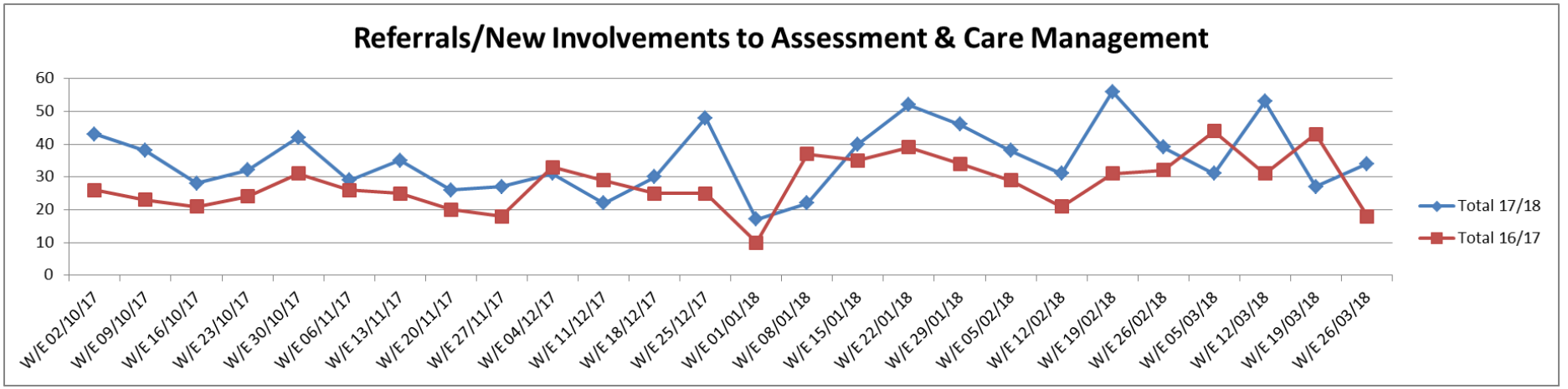
Information gathered for the Weekly Planning Group shows that from October 17 to March 18 referrals to the Assessment and Care Management team were consistently higher than for the same period last year. The total number of referrals received by this team from Oct 17 to Mar 18 was 917, for same period for last year the total was 730, an increase of 187 referrals on last year. This demonstrates the incredible efforts made by the team given the good performance of the Bed Days Lost to Delayed Discharge performance measure.

The average number of referrals for the ACM team for this period was 35.27 referrals per week as opposed to 28.08 referrals per week for the same period in 16/17. The highest number of referrals for any given week this year was 56 (week ending 19/02/2018), this was quickly followed 2 weeks later with another high spike of 53 (week ending 12/03/2019). This period coincided with the extreme weather encountered at the end of February and the beginning of March.



Community Referrals to Care at Home Services (from Weekly Planning File).

The number of referrals to Care at Home Services was only slightly higher than last year for the same period last year, with an increase of only 6 over the period. The linear trend line for this year however is not as pronounced as for the same period last year with last year's linear trend line having a slightly great incline. This, in layman's terms means as the period progressed, the number of referrals increased more than they did this year. It should be noted however that this year's data illustrates that the highest number of referrals in single week occurred this year with a total of 20 (week ending 15/01/2018), with the highest number of referrals in a single week for the same period last year being 15, although this level of referrals occurred on 2 occasions last year.

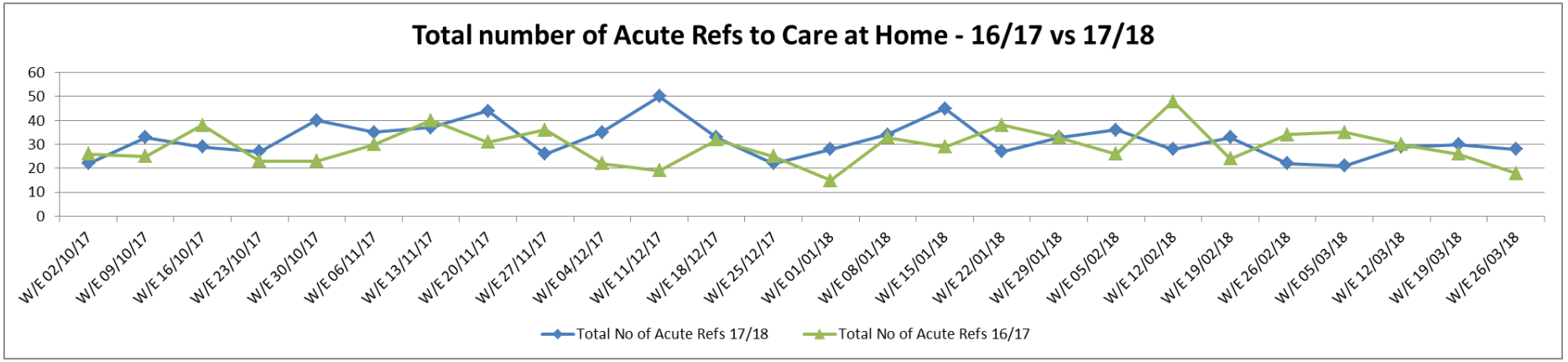


Acute Referrals to Care at Home Services (Including Referrals to Reablement - from Weekly Planning File)

Total Number of Referrals from Acute

The total number of acute referrals to Care at Home Services from October 17 to March 18 was 827 for the period. For the same period last year the number of referrals were 759. This amounts to an increase of 68 referrals on last year. There is no discernable pattern from either year with 16/17 numbers being higher some weeks with 17/18 being higher in other weeks. The Weekly averages for both periods' shows that 2016/17 winter period had a higher average at 31.81 referrals per week as opposed to 29.19 for the same period in 17/18. The data does show whoever that in the week leading up to Christmas, the number of referrals dropped in both periods.

The linear trend lines show a slight decline for 17/18 but a barely noticeable incline for 16/17.



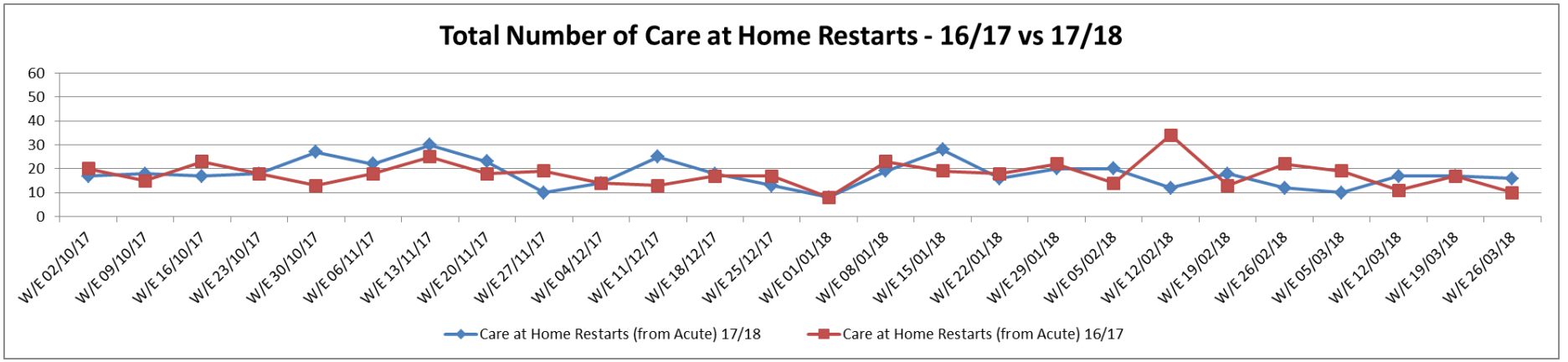
Care at Home restarts (after an acute episode of care - from Weekly Planning File)

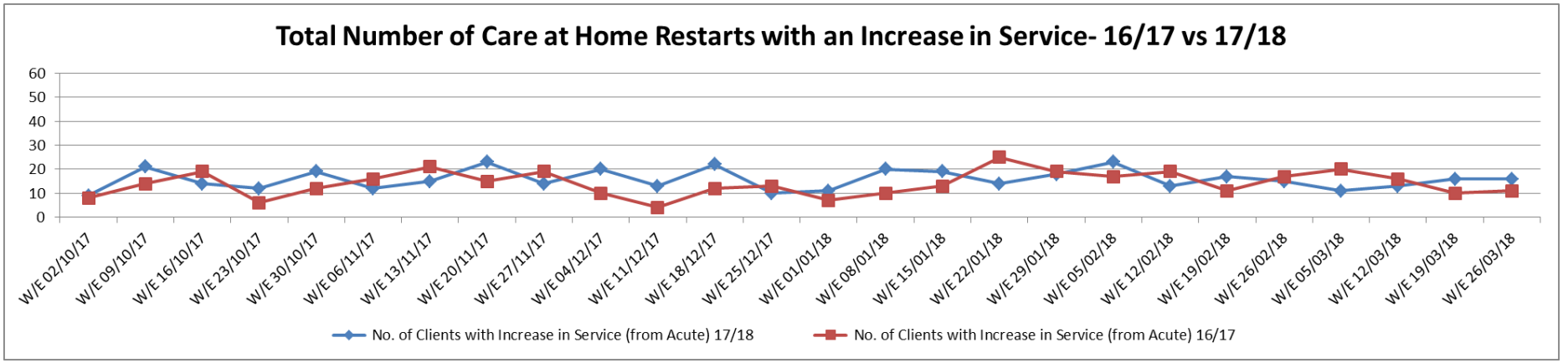
Cares at Home restarts are clients who were in receipt of a service before their acute episode.

The total number of Care at Home restarts in both years (i.e. 16/17 and 17/18) was 460 for the same time period. The highest number of referrals in a single week for 17/18 was for week ending 17/11/20 and reached 30 referrals. The highest number of referrals in a single week for 16/17 was 34 (for week ending 13/02/2017). Again, no discernable pattern of referrals can be seen during the winter period for both years.

The average number of referrals in 17/18 was 17.88 referrals per week, for the same period for 16/17 the average was 17.69 referrals per week.

In regards to the level of care being delivered rising to this client group after the acute episode of care, an increase of 12% has been recorded in the number of service increase requests. The total number of service increases in the 16/17 winter period was 364, with the number rising in 17/18 to 410. The average number of service increases for 17/18 was 15.77 per week; the average for the same period in 16/17 was 14.00 per week.





Referrals to Reablement Services (from Weekly Planning File)

Referrals to the Reablement Service in 2017/18 were significantly higher than the previous winter period with the total number of referrals in 17/18 being 362 with the total number of referrals for 16/17 being 297, which is a 22% increase on the previous period.

For the most part 17/18 referrals were higher week on week than 16/17, with the 16/17 period exceeding the number of referrals per week on only 6 occasions from November 16 to March 17.

The referral trend for 17/18 shows the linear trend line decreasing ever so slightly over the entire winter period as opposed to a slow increase in 16/17.

The average number of referrals per week in 17/18 was 13.92 with the average in 16/17 for the same time period being 11.42 referrals per week.