

NHS Board Meeting
20th October 2015

Paper No 15/53

Director of Corporate Planning and Policy

Unscheduled care planning: Winter Plan 2016/17

Introduction and Purpose

We reported to the August Board meeting work in progress to develop our plan for unscheduled care this winter. The attached draft plan is presented for consideration and comment by the Board as part of the process through which it will be finalised by the end of the month. The focus of this detailed planning is to deliver high quality patient care throughout the pressurised period of the winter and to meet the national target to deliver care to 95% of Accident and Emergency attenders within 4 hours.

Activity Analysis

Thoroughly analysing activity is a critical part of this planning process. The draft plan sets out the challenges in developing that analysis with our new configuration of services and the analysis within it is work in progress which will be subject to collective scrutiny by the Acute Division team before the plan is finalised.

Resources

The Board final plan will include a detailed assessment of the resources required the current position is that we have received the following additional funding from Scottish Government:

- £7.1m for delayed discharge, passed in full to Partnerships as directed;
- £1.67m for the six essential actions programme which is already committed;
- £1.8m further winter monies;

In previous years the Board has used non recurrent resources to fund additional services and capacity for winter. In 2014/15 this included the following non recurring sources of funding:-

- £2.5m from internal additional Acute Division efficiencies
- £7m from the Board financial plan and LUCAP funding.

In the light of the reconfiguration of Acute Services we have less beds available this winter than previously and therefore Scottish Government have already agreed £5m additional funding to enable the new ways of working across the Acute Division to become embedded through the first six months of 2015. This additional funding underpins baseline activity and capacity relevant to achieving all extant Scottish Government waiting time targets.

In financial planning for 2015/16 we have allocated £4.5m from non-recurrent sources for the winter. However, we are already experiencing significant financial pressures with an overspend at month 5 within acute services. Local Authority and Partnership budgets for social care are also under pressure. At the Board time out we will need to finalise available additional resources to finalise this plan.

Conclusion

Over the next two weeks the plan will be finalised and will be available for detailed review by Board Members at the end of October time out session, prior to submission to Scottish Government.

Unscheduled care planning: Winter Plan 2016/17

1. Introduction

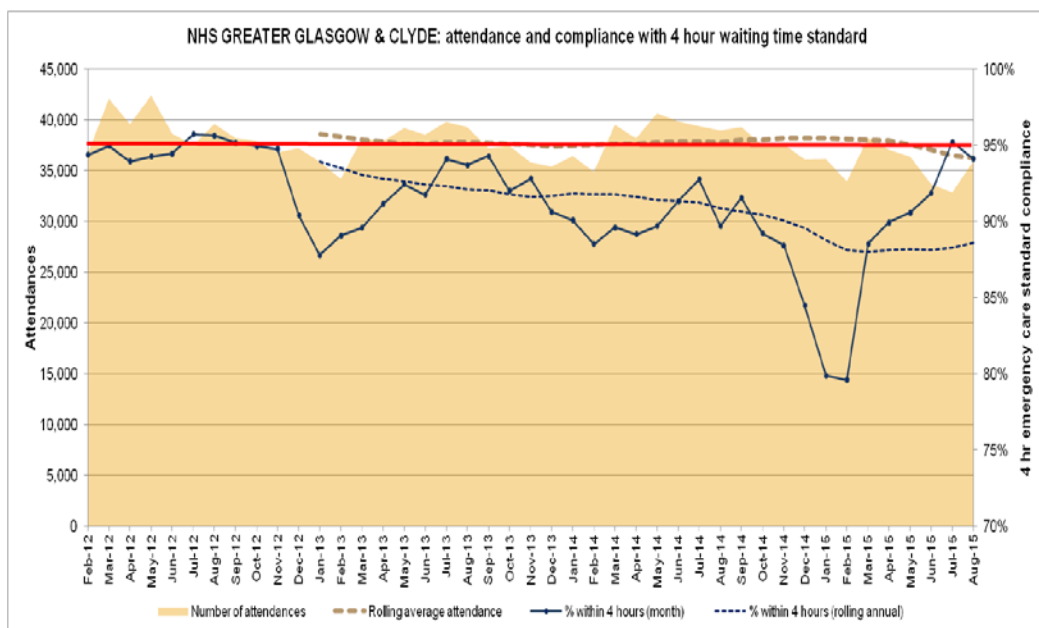
This plan has been developed through detailed review processes within the Acute Division and our Partnerships and collective consideration by the Board Chief Executive, Chief Officers and Directors across our system. That planning process reflects the fact that acute, community, primary care and social care service are interdependent and need to operate as a coherent system to achieve our objective to deliver high quality patient care throughout the pressurised period of the winter and to meet the national target to deliver care to 95% of Accident and Emergency attendees within 4 hours.

There are a number of key challenges:-

1.1 Current Pressures

There is current pressure on performance in relation to the Accident and Emergency target as shown in the graph below:-

A&E Performance



That pressure will increase as we enter the winter period;

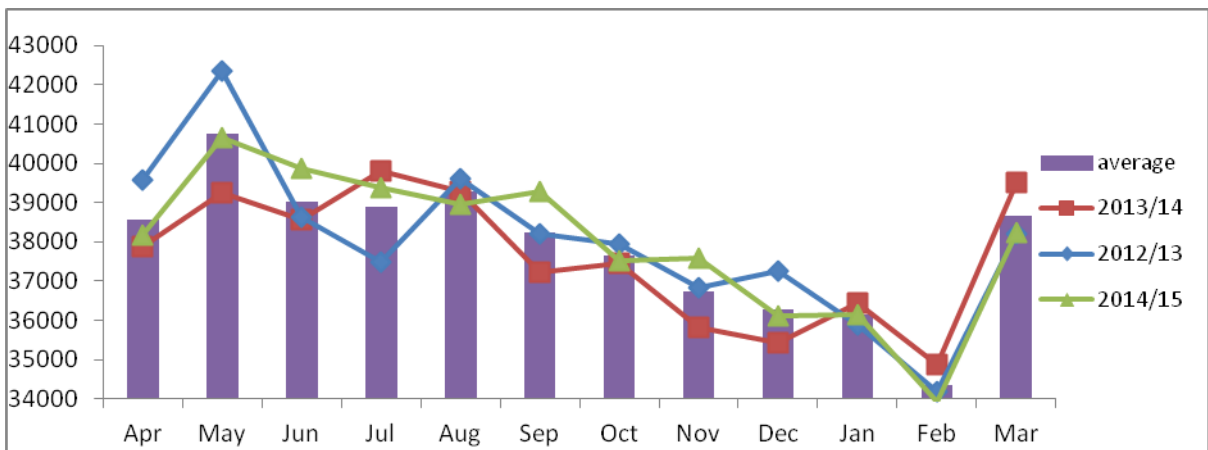
- 1.2 Configuration:** This is the first winter operating the new configuration of Acute services that poses particular planning challenges.
- 1.3 Resources:** There are significant pressures on resources in the NHS and in social care. The final version of this plan will set out the resources which are available for the winter period and how these will be deployed.

2. Whole Acute Division

This section sets out analysis and actions for the whole of the Acute Division, more detailed information is included in the subsequent sections for each Sector and the Women and Children's Directorate.

2.1 Analysis of capacity & demand

- This year's plans are being developed within a significantly different context following the reconfiguration of services associated with the opening of the Queen Elizabeth University Hospital and the closure of the former Southern General Hospital, the Victoria Infirmary and the Western Infirmary. With the opening of the new QEUH, new service models have been introduced for the management of GP urgent care referrals bypassing A&E into purpose designed assessment units. Patient flow has also been affected by boundary changes with South Lanarkshire Health Board, intended to divert demand mainly from the South sector towards Hairmyres Hospital.
- The changes make the ability to forecast demand using historic trends more challenging. We have approximately 20 weeks of experience upon which to build an understanding of the new patient flows, both across the city and within the QEUH.
- Our understanding of the year on year profile of A&E attendances is that overall numbers are stable with variance of annual totals of less than 1%. The variation in-year also follows a consistent profile with attendances rising during the spring but dropping in the winter months.



3 year trend in A&E Attendances

- Non-elective admissions over the last 5 years (2010/11-2014/15) shows an inconsistent pattern with variance from year to year. This monthly analysis indicates that activity varies throughout the year but not with significant seasonal variation. Monthly admissions from April to July 2015 map against the lower range of activity during this five year period (Fig.2)

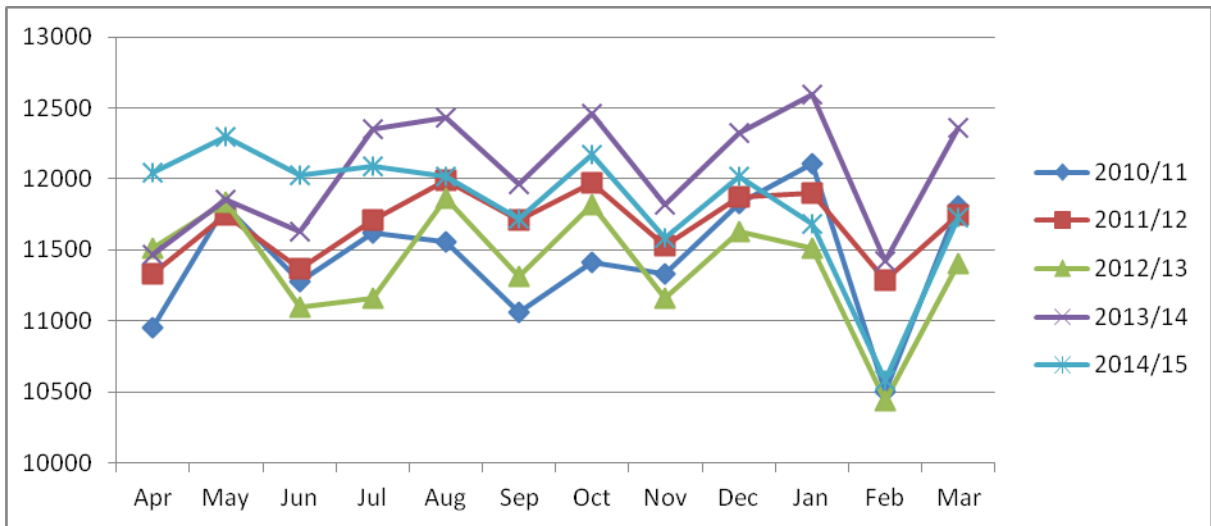


Fig.1 Total Non-elective admissions (2010-2015)

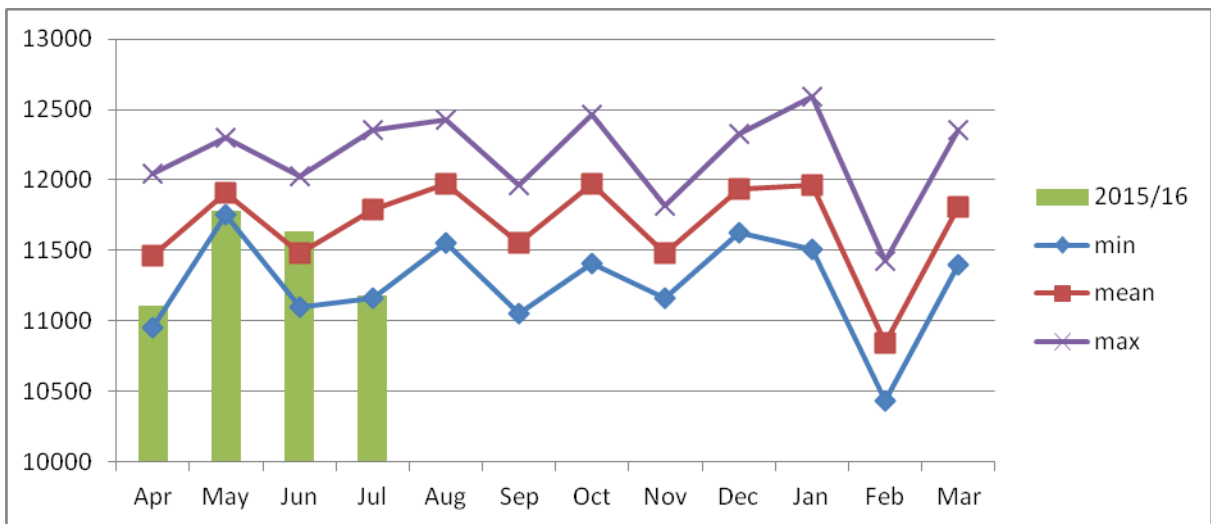


Fig. 2. Range in Total Non-elective admissions (2010-2015) with 2015 to date overlain.

- The monthly figures provide an overview of the volume of activity. Analysis of the day to day run-rate of non-elective admissions is being used to inform our Winter Plan. This analysis enables a focus on how, operationally, services would cope with surges in demand and will inform escalation policies. The analysis from last winter indicates that across the city, we can expect between averages of 426 to a peak of 545 admissions per day. We know that the beginning of the week (Monday – Tuesday) will consistently be higher than the average hence the 85th percentile of 483 admissions is the guide we should use to inform our planning.

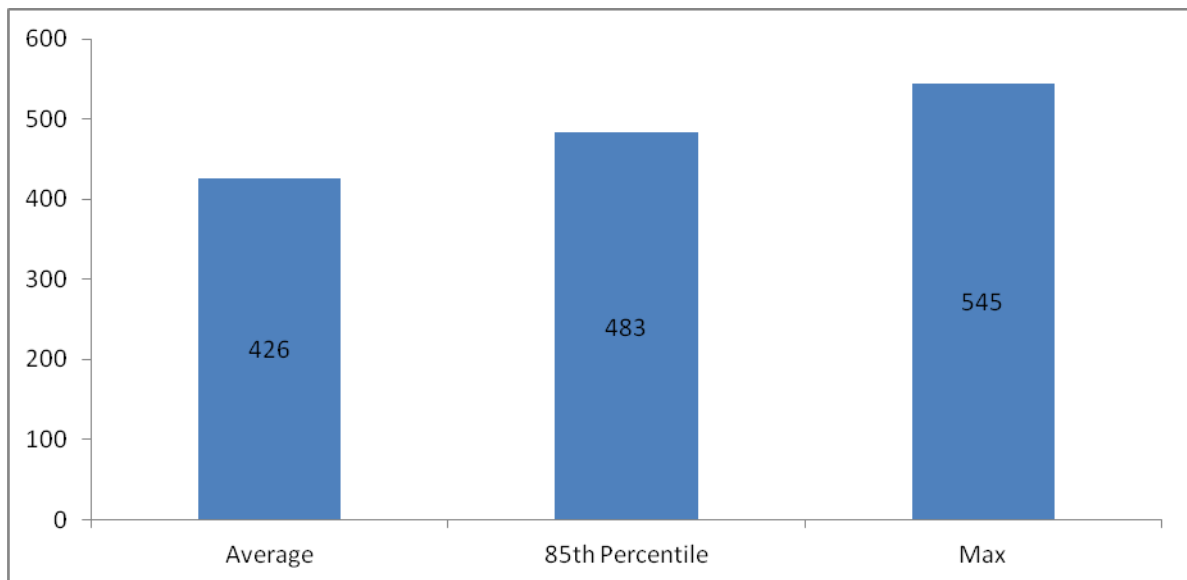


Fig 3. Range in Total Daily Non-elective admissions (1/11/14 -28/02/15)

Translation of demand into bed capacity requirements is being modelled using a similar day by day analysis of last winter.

Six Essential Actions Programme

The Scottish Government launched the Six Essential Actions Programme earlier this year to spread good practice in management of Unscheduled Care. These actions have been incorporated into the Winter Plan and improvement work is will improve our ability to manage patient flow and utilise beds more effectively.

Essential Action 1: Clinically Focussed and Empowered Hospital Management

The Board has restructured its management arrangements to established clear site leadership with a Sector Director supported by a Chief of Medicine and Chief Nurse. This structure is replicated through the Clinical Directorates and Specialties. Daily 'Huddles' are now in place on all sites ensuring effective communication and action to respond to the pressures as they present day to day.

Essential Action 2: Hospital Capacity and Patient Flow (Emergency & Elective) Realignment

This plan is being built on thorough analysis of activity trends underpinning our understanding of the likely workflow pressures over the winter.

Essential Action 3: Patient rather than Bed Management – Operational Performance Management of Patient Flow

We have benefitted from Government support in detailed analysis of 'front door' pathways to inform our understanding of how patients present through the day and where the bottlenecks present. Our information services have a programme to introduce close to real-time reports on patient flow. We are embedding the Expected Date of Discharge practice throughout the Board enabling greater understanding of when discharge is taking place and where action is needed. Our focus is on improving our rate of discharge before noon and expediting weekend rates.

Essential Action 4: Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway

The design of the QEUH 'front door' is predicated on cohorting patients to improve patient flow with Acute Receiving Units aligned to clinical specialties to expedite specialist assessment and rapid decision-making. The GRI, RAH and RHSC have assessment units as part of the infrastructure for managing demand. Learning from last year and the Renfrewshire pilot is being applied across the Board to introduce pathways and rapid access clinics as an alternative to unnecessary admission. Clinical practice on the wards is also changing, enhancing the practice of ward rounds to ensure a focus on expediting actions around patient care and creating the capacity for patients who need admission.

Essential Action 5: Seven Day Services Appropriately Targeted to Appropriately Reduce Variation in Weekend and Out of Hours Working

Building on the above actions, we have identified pathways and patient flow which can be problematic outside 'normal' working hours, evenings and weekends. Services and staffing plans are being introduced to ensure capacity is aligned to where this workload exists. This means extending hours of operation of Minor Injuries Units, Discharge Lounges and diagnostic facilities. More and more services are enhancing provision to provide a 7 day service.

Essential Action 6: Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting

We are working closely with the IJBs to join up planning of services to enable patients to be discharged safely and effectively following admission. Alternatives to admission are also intrinsic to this approach, providing GPs and Community teams with options to ensure access to urgent specialist care through 'hot clinics' and avoiding unnecessary admission.

2.3 Norovirus: the final plan will set out our approach to managing any outbreaks of norovirus this winter

2.4 Key performance indicators and reporting

The final plan will identify the key performance indicators which we need to achieve in order to deliver the target, covering:-

- Length of stay
- Delayed discharge (all reasons not just social care)
- Weekend discharge
- A and E and assessment discharge and admission rates
- Estimated date of discharge
- Boarders

2.5 Escalation process and actions: We are working on a Division wide escalation process which will be included in the final plan.

2.6 Paisley programme: We are planning the roll out across the Board area of the successful elements of the Paisley programme.

2.7 Elective work: the final plans for each Sector will set our plans for elective activity for the winter period to ensure we are able to have capacity to meet emergency demand.

3. Plans for each Sector and Women and Children's Directorate

This section sets out more detailed plans for each of the areas with responsibility for emergency services.

3.1 South Sector

In the final plan this section will begin with a detailed analysis of capacity & demand

The following developments are proposed to support delivery of the 95% A&E Standards:

- Assessment Capacity
 - Extend Ambulatory care capacity to create sufficient capacity to address 10 patients at time.
 - Relocate Surgical and Urology Assessment to extend capacity for Medical Assessment
 - Extend opening hours of Minor Injuries at Victoria ACH/Western Infirmary to midnight
 - Establish 'Hot clinics' as alternative for GP referrals to IAU.
 - Urgent Respiratory clinics to support early discharge/admission prevention
 - Apply learning from Renfrewshire Pilots:
 - Low risk Acute Coronary Syndrome
 - Older Adult Assessment Unit
- Flow Management
 - AHP 'Hit team' dedicated to supporting patient flow and take responsibility for Boarded patients.
 - Sunday Orthopaedic OT, implementation of 7 day service
- Optimise Capacity
 - Transfer some elective Orthopaedic capacity to GGH (12 beds)
 - Relocate care setting for patients requiring long term rehabilitation following lower limb amputation
 - Extend Medical Bed capacity at GGH (10 beds)
 - Work with GCC to reduce social care delays (15 beds)
 - Dermatology Beds to be reassigned to General Medicine during surge period (Early January)
- Discharge
 - AHP enhanced support to expedite morning discharge & identification of treatment plans.
 - Extension of Discharge Lounge opening (8 to 8, Mon-Fri)
 - Dedicated transport for patient transfers between QEUH, GGH, Victoria ACH & Partnership beds.
 - Joint initiative with British Red Cross to support discharge from A&E and receiving wards.
 - Extend Portering Capacity to expedite Ambulance discharges and transfers to GGH.

The sector has an escalation plan based on metrics defining expected level of activity.

3.2 North Sector

In the final plan this section will begin with a detailed analysis of capacity & demand

The following developments are proposed to support delivery of the 95% A&E Standards:

- Assessment Capacity
 - Extended hour evening consultant presence in AAU
 - Enhanced Flow coordinator role
 - Nursing staff for overflow areas in ED
 - Transport to divert minors to Stobhill MIU

- Establish a Urology stone hot clinic
 - Enhanced Trauma coordinator role
 - Additional trauma theatre capacity
 - Senior Nurse Practitioner in Surgical Assessment Unit
 - Enhanced theatre on call team
 - Additional hour of emergency endoscopy provision
- Flow Management
- Additional ward rounds from “boarding team”
 - Enhanced consultant ward rounds
 - Extended cardiology diagnostics
 - Enhanced surgical middle grade at weekend
 - Enhanced OT and Physio at weekends
 - Enhanced DME input to ortho rehab
 - Enhanced AHP cover at weekends
 - Extended opening hours for pharmacy
- Optimise Capacity
- Clinical agreement to relocate Gastro Day Activity from St Mungo to Ward 12/12A (End of October 2015) to create additional 17 medical beds
 - Flexible use of Ward 14 as extended discharge area or as 9 bedded ward
 - Continuation of 11 winter beds in Ward 18/19 for DME (11 beds)
 - Enhanced staffing of critical care areas
 - Additional 4 Urology beds in PRM
 - Weekend staffing of Ward 66 to full complement
 - Maintain elective delivery employing Stobhill ACH at weekends and Independent sector/GJNH capacity
 - Potential transfer of Urology & Orthopaedic work to GGH
- Discharge
- Extended discharge lounge in Ward 14
 - Additional SAS transport for discharge and transfers

The sector has an escalation plan based on metrics defining expected level of activity.

3.3 Clyde Sector

In the final plan this section will begin with a detailed analysis of capacity & demand

The following developments are proposed to support delivery of the 95% A&E Standards:

- Assessment Capacity
- Currently in Ward 1 (RAH) create a receiving complex with MAU and ARU being collocated to allow economies of scale and take greater number of GP pts and to pull from ED in a more efficient way, Medical Assessment will be relocated into Ward 18 creating a receiving complex with collocated MAU and ARU with economies of scale. Will enable greater number of GP patients to be accommodated and expediting movement from A&E.
 - 7 Day Service: Operational hours of RAH Medical and Surgical Assessment Unit to be extending into the weekend, relieving pressure on A&E.
 - Consolidation of Older people’s assessment unit, maintaining a minimum of 4 beds to expedite appropriate care, reducing length of stay and boarding of elderly people.
- Flow Management
- Enhance AHP support on the wards over weekends to ensure flow is maintained and reduce length of stay.
 - Ortho geriatrician routine ward rounds to commence
 - Enhance nursing, AHP, Diagnostic, Pharmacy and Phlebotomy support on wards to improve flow, with specific posts to enhance trauma liaison cover
- Optimise
- Additional 18 RAH beds to be opened for medicine to mitigate surge

<u>Capacity</u>	<p>demand and reduce boarding in Surgical beds.</p> <ul style="list-style-type: none"> - On IRH site, open 20 additional medical beds and further 12 elderly beds at Larkfield. Surgical beds to be maintained over weekends. - Introduce process to ensure patients identified from other sites can be repatriated to VOL early during their stay. - VOL Ward 6 to become surge capacity at points of peak demand.
<u>Discharge</u>	<ul style="list-style-type: none"> - RAH Discharge lounge targeted to address 300 discharges per month, enabling beds to be freed earlier in day. - Establish Discharge lounge on IRH site. - 7 Day transport 'hub' established on RAH site to co-ordinate SAS, Red Cross and local patient transport for RAH & VoL.

The sector has an escalation plan based on metrics defining expected level of activity.

3.4 Women and Children's Directorate

The new Children's Hospital deals with a substantial Accident and Emergency workload. This is the first year of operation in the new Hospital. In comparison to last winter, the following differences between RHSC and RHC should be noted:

- 40 Acute Receiving beds in RHC, compared to 48 in RHSC
- 20 bed CDU in RHC, compared to 12 bed MAU in RHSC
- 20 ITU and 2 HDU beds in RHC, compared to 17 ITU and 5 HDU in RHSC
- 22 beds from the previous RHSC inpatient complement are now dedicated 23 hour elective beds in RHC, operational Monday - Friday
- Significantly increased number of single rooms in inpatient wards. This will be beneficial from an infection control point of view.

The following developments are proposed to support delivery of the 95% A&E Standards:

<u>Assessment</u>	- Open further 10 beds in CDU to be used between ED and ARU
<u>Capacity</u>	<ul style="list-style-type: none"> - Extended hours for Gynae GP Direct Referral - Extend hours and introduce 7 day service for Early Pregnancy Assessment Service
<u>Flow Management</u>	- Extend Bed Management Arrangements to provide 7 day cover.
<u>Optimise Capacity</u>	<ul style="list-style-type: none"> - Diversion protocol established to manage access between RHSC and RAH, Ward 15. - Extend PICU to full 22 bed ITU capacity (uplift of 2 HDU beds)
<u>Discharge</u>	- Establish RSV/Bronchiolitis nurse led discharge pathway

4. Partnerships

Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. We have agreed through our whole system planning group that each Partnership would produce an operational unscheduled care plan with a particular focus on the winter period. The drafts of these plans are Annexe 1 and cover:-

- Delayed discharge
 - Reducing numbers
 - Delivering 72 hour discharge
- Measures to reduce admissions and attendances
- Delivery of key services including:-
 - Single point of access

- Nursing home support
- Anticipatory Care
- Capacity for AWI patients
- Equipment
- In reach to hospitals and rehabilitation
- Continuity and resilience particularly ensuring community health and social care services are available when required, including focussed recovery from periods of more limited cover;
- Developing an agreed set of indicators to monitor performance;
- Planning with GPs for the two long bank holidays including:-
 - prioritising emergency patients;
 - Advice to patients with chronic conditions on sources of help;
- Local communication

Specific plans for:

- The festive period: workforce and rotas and post festive surge;
- Flu vaccination

Business continuity plans: Confirmation of testing of business continuity plans

An important element of this planning is analysing demand and capacity in the same way as we are undertaking for acute services. The 6 essential actions are also relevant to planning delivery of community services and are included in the plans.

5. Whole NHS Greater Glasgow and Clyde System

In addition to the detailed planning within Partnerships and the Acute Division there are a number of key areas of planning which are developing across the Board area. This section covers those areas:-

5.1 Vaccination

The final plan will include up to date information on the vaccination programme

5.2 Escalation:

We are working on arrangements to ensure that where pressures are developing at any point in care services that we have a systematic approach to assess the need for additional action and to communicate that across the Acute Division. Those escalation arrangements will be included in the final plan.

5.3 Communication

Public information and communication is a critical part of our preparations and this section sets out the activity which will be led by our Corporate Communications team.

Early November

- Promote the NHS 24 national messages via social media, website, distribution of posters in community venues and local PR
- Develop and launch a high impact in-house video that we can publish on our YouTube channel and also show on our solus screens in health centres and hospitals encouraging people to make use of community NHS services in the holiday period.

Late November

- Publish the next edition of Health News (our 16 page magazine). We would include information on what the six HSCPs are planning to do to continue to provide community and primary care services over the two four day holiday periods and signpost people to the winter booklet that will be published in December. This will include detailed local information on pharmacy opening times and the ones opening throughout the four day holiday periods. The magazine is scheduled to be published in the Herald and Evening Times on 24 November,

when it will also be distributed throughout our hospitals, health centres and pharmacies We are looking to increase the circulation to include the Clyde area for pharmacies after we introduced them to GG in the summer for the opening of the new hospitals.

Early December

- Produce the winter booklet and distribute to GP surgeries and social work colleagues to share with their patients. An online version of booklet posted on our website and shared with NHS24 and local authorities
- Social media and media release to promote the booklet
- Local authorities asked to promote the booklet in their public magazines
- Co-ordinated social media activity with other SNS including Sandyford twitter account and website to promote the services that are open on the 2 x 4 day period.
- GPs to be encouraged to remind patients of closures.

In addition to the activity outlined above we will also run additional activity as follows:-

- Develop an eight page guide to **your NHS in winter** for every household in NHSGGC with key information about how to use emergency services, flu vaccinations, KWTTT. We would also heavily promote the online postcode finder facility for A&E and MIUs, which has already had more than 10,000 unique visitors and reinforce messages about GP OOH services and using NHS24 to access them and importantly advise what they are not suitable for.
- Run a short two week (on air and online) radio campaign to alert people to this door-to-door guide.
- Staff campaign on winter, including Staff Newsletter, Staffnet, Core brief, hot topics and winter preparedness web portal for staff and public.
- Social media will be used to promote the animation video and the household guide.

Drafted
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16/10/15

Unscheduled/winter Planning: Partnership Plans

Going forward Partnerships will be taking up their responsibility for strategic planning for unscheduled care. The Partnerships also have a critical role in operational planning for service delivery. We therefore agreed that each of the 6 Partnerships would produce their own Operational Winter Plan for delivery of the Community Health and Social Care services for which they are responsible. The current drafts of these plans are included in this appendix. Final versions will be part of our whole system plan.

Renfrewshire HSCP - Winter Plan

1. Introduction

Health and Social Care Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHS GG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period. These plans will cover:

- The community service aspects of the 6 essential actions (Appendix 1)
- Delayed discharge
- Measures to reduce admissions and attendances
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care
- Continuity and resilience
- Developing an agreed set of indicators to monitor performance
- Planning with GPs for the two long bank holidays

This Winter Plan identifies and addresses the local issues across the primary care and community services for which Renfrewshire Health and Social Care Partnership is responsible, to support the NHS GG&C whole system planning as detailed above. Many of the actions identified are required all year round – additional bank holidays, increased staff absence and additional demand over the festive period and into January will add to year round pressures.

2. Planning Arrangements

The Renfrewshire Development Programme (RDP) has provided a focus for change and efficiency improvements through four main projects: Older adults and chest pain assessment units, anticipatory care planning and out of hours community in reach.

The programme connects different services across primary, community and acute care to develop more effective working arrangements, improving handover between services, increasing the speed of access to required services and reducing bed days and lengths of stay. Evaluation is underway, but early learning will inform this plan. It is anticipated that the main projects will continue throughout the winter period.

This plan has been developed in partnership with service planners and operational managers at the RAH. It will be reviewed and monitored on an ongoing basis by the HSCP Senior Leadership Group.

3. Renfrewshire Actions Against the Scottish Government Key Themes

Scottish Government Key Themes	Renfrewshire Actions
Safe and Effective Admission and Discharge	<p><u>Avoiding Admission</u></p> <p>Three RDP projects will continue throughout the winter period. In particular, the older adults' assessment unit supported by the in reach Community OOH Service and the chest pain assessment unit will be supported to prevent unnecessary admissions.</p> <p>We will identify those care homes which have high levels of hospital admission and offer additional support to them. In particular, we will use our pharmacy team, our care home liaison nurses, community RES and our older adults liaison nurse to target those care homes.</p> <p>We will continue to remind GPs about the need to update the KIS.</p> <p>Our district nurses will support the national campaigns offering advice to patients with chronic conditions.</p> <p>We will continue to encourage DN and RES staff to use clinical portal to access KIS and other relevant information to support care planning and discharge planning.</p> <p>We will share information about community pharmacy services and times with Homecare staff and with the local A&E department.</p> <p>Other services to prevent admission (including Third Sector).</p> <p><u>Safe Discharge</u></p> <p>We will continue our existing good practice re discharge planning and avoiding lost bed days supported by a comprehensive social and health care response.</p> <p>The discharge lounge at the RAH is currently operational Monday to Friday. We will explore with acute colleagues the potential for extending this to the weekend, to optimise the community services currently available 7 days/week.</p> <p>We will use Darnley Court as a step-down facility for AWI patients, freeing up capacity in</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>acute inpatient beds.</p> <p>We will continue to participate in the daily huddle meetings at the RAH (and extend this participation to include mental health and addictions). We will formalise and share the key messages/outputs of these meetings on a need to know basis to promote whole system working.</p> <p><u>Mental Health</u></p> <p>i) <u>Adult Inpatients</u></p> <p>The admission and discharge data for inpatient hospitals has been assessed over the last 5 years through the Mental Health Bed Management system. The bed management systems and bed managers provide daily reports on bed occupancy and availability. These reports also report on any projected ward closures should this be necessary in exceptional circumstances e.g. Norovirus, influenza etc. Annual leave will be managed across the winter and festive period to ensure sufficient staffing to manage demand. The pattern of admissions and discharges over the winter period is similar to the pattern throughout the rest of the year. No special arrangements need to be put in place relating to psychiatric admissions and discharges.</p> <p>ii) <u>Community Services</u></p> <p>Intensive Home Treatment Team will provide 24 hour 7 day week provision for Mental Health Services which will assess patients for admission and discharge. These services will be in place over the festive period. The services include social care support. The Intensive Home Treatment Team will provide public holiday cover during the festive period.</p> <p>Community Mental health teams will operate throughout the festive period with skeleton staff during public holidays to facilitate discharge and prevent admission</p> <p>The services above receive referrals from Primary Care, Liaison Psychiatry and secondary Acute services.</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>iii) <u>Out of Hours Arrangements</u></p> <p>Mental Health Services in Greater Glasgow and Clyde provide Out of Hours services which receive referrals from the GP OOH service which triages calls from NHS 24. These services will be in place over the festive period. It is not anticipated that there would be an unusual pattern of referrals to psychiatry based on previous year's information.</p> <p>iv) <u>Acute Hospital Liaison</u></p> <p>Liaison Psychiatry Services are provided 7 days a week to Royal Alexandra Hospital by Psychiatric Liaison Nurse services and Intensive Home Treatment Team for deliberate self-harm over weekends and public holidays. This is in addition to direct referrals to the on-call psychiatry staff in psychiatric hospitals which is available to Acute services.</p>
Workforce Capacity Plans and Rotas	<p>All services will plan an enhanced level of cover and annual leave over the festive period, bearing in mind additional pressures and the potential for increased sickness absence. In addition, there is in place review and attendance plans to monitor absence. In the event of staff shortages access is available to the nurse bank. In exceptional circumstances community psychiatric nursing staff may be requested to work in inpatient services.</p> <p>Services will work with trade unions to agree a level of manageable leave. Service managers will be asked to confirm the process in their own area. Most services only allocate annual leave on a weekly basis as demand and capacity are reviewed.</p> <p>The Care at Home service has already highlighted a capacity issue, particularly in commissioned services. The Head of Adult Services is reviewing contracts and leading discussion with these providers to look at increasing capacity. It is likely that this will have a cost implication.</p> <p>We will seek assurances from the nurse bank that steps are being taken to increase capacity and ensure there is equal coverage across the Greater Glasgow and Clyde area.</p> <p>We have reviewed the adverse weather policies of our two host organisations to ensure consistency, and we will circulate them to all staff, emphasising the need for uniform application. Decisions about service changes due to adverse weather will be cascaded in</p>

Scottish Government Key Themes	Renfrewshire Actions
	<p>a managed way from the Chief Officer and the heads of service.</p> <p>There is now access to four wheeled drive vehicles and some vehicles will be fitted with winter tyres.</p> <p>In psychiatry, arrangements to ensure that senior staff are on-call and available over the festive period are in place. The on-call information will be held at each hospital and the centralised telephone service.</p>
Whole System Activity Plans – post Festive surge	<p>A joint meeting of the acute and community service managers is planned for the end of October.</p> <p>Key staff from the HSCP will be involved in the daily huddle meetings (including mental health and addictions) and will cascade relevant information to other health and social care professionals.</p>
Strategies for Additional Winter Beds and Surge Capacity	<p>We will explore (across the system) how to most effectively use the beds at Darnley Court, Ward 36 and residential care homes. This will include simplifying the care pathway where possible and creative ways of supplying nursing, AHP and medical cover (both money and people) within available resources.</p>
Risk of Patients being delayed on their Pathway is Minimised	<p>The availability of community staff over a 7 day period will ensure patients will transfer to the most appropriate care timeously according to individual care pathway.</p>
Discharges at Weekends and Bank Holidays	<p>We will continue to work with acute colleagues to make better use of the homecare weekend hours (currently under-utilised) to assist weekend discharges. We will also explore the potential for extending the days that the discharge lounge is available for (currently only Monday to Friday).</p> <p>We have identified the need for the ASeRT service to be available for the extra Social Work bank holiday. This will have a financial implication.</p> <p>We are currently exploring the cost and practicalities of extending hospital social work services to cover the two extended bank holiday periods and in the early evenings.</p>

Scottish Government Key Themes	Renfrewshire Actions
Escalation Plans tested with Partners	We will agree a core set of indicators to be shared by acute colleagues as an early alert system. These indicators will alert primary, community and social care services of activity surges.
Business Continuity Plans tested with Partners	<p>We are completing an exercise to review and update current business continuity plans in health and social care services. All services will have a robust business continuity plan by the end of October 2015, using a consistent template. Our Clinical Director will remind GPs about need to have robust business continuity plans, as he visits practices.</p> <p>The HSCP is involved in regular Council-led civil contingency meetings.</p>
Preparing Effectively for Norovirus	We recognise that Norovirus has the potential to affect both access to beds and availability of staff. We will follow infection control guidelines. We will ensure business continuity planning takes account of this, as it is known risk every year.
Delivering Seasons Flu Vaccination to Public and Staff	<p>We will encourage all frontline staff to take up the offer of flu vaccination, recognising the different processes for health and social care staff. We will review the contract for commissioned home care to ensure that this staff group is offered vaccination.</p> <p>We will support GPs and community nurses to encourage high uptake of vaccination among vulnerable groups of patients, particularly the housebound, those in nursing/care homes and those in receipt of home care services.</p>
Communication to Staff and Primary Care	<p>We will use team brief and staff newsletters to share this plan with all staff. We will also widely circulate the Council's Severe Winter Weather Response Guide 2015/16.</p> <p>We will use the planned meeting in November with the 29 Integration Liaison GPs and the GP Forum on 24th November to emphasise the need for robust business continuity planning and winter planning. We will also prepare a single communication for GPs/primary care with details of services available and times over the festive period.</p> <p>We are exploring a system of using group text messaging to communicate simultaneously with large staff groups.</p> <p>The availability and access to Mental Health Services is included in the Greater Glasgow & Clyde Board's public communication information issued for the festive period.</p>

Scottish Government Key Themes	Renfrewshire Actions
<p>Effective Analysis to Plan for and Monitor Winter Capacity, Activity, Pressures and Performance</p>	<p>Key indicators:</p> <ul style="list-style-type: none"> - Bed days lost due to delayed discharge - Bed days lost due to delayed discharge (AWI) - Emergency admissions 75+ - Uptake of flu vaccinations (staff) - Uptake of flu vaccinations (GP population) - Referrals to services which prevent admission. <p>We will work with acute colleagues to agree a suite of indicators discussed at daily huddle meetings, which can be circulated through the HSCP to influence referral patterns, and respond when acute services and other inpatient sites under pressure.</p> <p>In the event of exceptional circumstances such as a flu pandemic/novovirus/extreme weather conditions then there would be additional costs associated with staff cover including overtime and other costs.</p>



Glasgow City Health & Social Care Partnership

Winter Plan

2015/16

October 2015

1. INTRODUCTION

- 1.1 This draft plan outlines Glasgow City Health & Social Care Partnership's (HSCP) preparations for winter 2015/16 in order to minimise any potential disruption to the provision of health and social care services to patients, service users and carers. This is first such plan for Glasgow City, and therefore the plan will be subject to ongoing review in the light of experience, with regular reports made to the (shadow) Integration Joint Board (IJB).
- 1.2 The plan has been prepared in the context of national guidance from the Scottish Government on unscheduled care, and guidance from both NHS Greater Glasgow & Clyde and Glasgow City Council. The plan also forms part of the NHS Board's and Glasgow City Council's wider plans to prepare for this winter.
- 1.3 The plan should be seen as a precursor to the IJB's overall plan to enable delivery of effective unscheduled care from April 2016 onwards. The unscheduled care plan will also describe how the IJB proposes to fulfil its responsibilities for strategic planning of these services, as described in the Integration Scheme for Glasgow City. A draft of this plan will be produced in early 2016 for discussion with clinicians, key partners including secondary care, housing and the third and independent sectors.

2. UNSCHEDULED CARE – PREPARATIONS FOR WINTER 2015/16

- 2.1 This document focuses on the HSCP's plans to manage the potential additional pressures in the health and social care system, including adult mental health services, that arise over the winter period.
- 2.2 The plan also articulates the HSCP's actions to contribute towards the mitigating of pressure on the acute hospital system in Glasgow City, and with a particular focus on actions under the twelve key themes in the Scottish Government's winter planning guidance DA (2015) 20, including measures to avoid admissions and manage delayed discharges.
- 2.3 To manage the delivery of this plan, co-ordinate our activity and initiate appropriate HSCP responses when required, the HSCP has set up a winter planning group. The HSCP winter planning group will meet fortnightly until the end of the financial year and will report to the Operations Executive Group, and the (shadow) IJB.
- 2.4 Development of this winter plan for 2015/16 is seen as key stepping stone in developing the planning process for 2016/17 and onwards when the IJB formally takes on responsibility for the strategic planning of acute services associated with the unscheduled care pathway as outlined in the integration scheme. The terms of reference and membership of the winter planning group will be revised and expanded in early 2016 to reflect this broader remit, and include input from primary and secondary care, the housing sector and third and independent sectors.

3. CRITICAL AREAS – KEY ACTIONS

- 3.1 This section of the plan describes the measures being put in place by the HSCP in line with the twelve key themes described in the national winter planning guidance DA (2015) 20. In addition, the actions outlined below have taken into account the health and social care aspects of the *Six Essential Actions to Improving Unscheduled Care Performance*.

i) Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January.

In this winter plan the HSCP has placed a particular focus on preventing admission to hospital. Across all health and social care services in Glasgow City we have systems in place to predict or identify vulnerable patients at risk so that the necessary support can be given to avoid unnecessary admission to hospital, and help people remain in their own homes. Specific elements of this programme include:

(a) Anticipatory Care Planning

- Community nursing, working with GPs to identify patients at risk of admission, and offer assessment and support. Completed anticipatory care plans are uploaded by GPs onto their electronic information system, eKIS;
- We are also scoping the potential to utilise GP capacity in the care homes medical practice to support the delivery of anticipatory care plans for residents in care homes with high hospital admission rates;
- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within eKIS which is shared with acute and the Scottish Ambulance Service.
- The introduction of the Glasgow Community Respiratory Service (£600k from the integrated care fund) to support patients with COPD. The service was tested and evaluated in the North West and is now being introduced across the city. The roll out has been accelerated to ensure that full coverage is achieved by December 2015. Based on activity data from the test site, it is anticipated that initially the service will support between 75-100 referrals per month. These typically comprise 50% referrals related to urgent intervention (either GP rapid response to avoid admission or Early Supported Discharge to reduce acute bed days), and 50% COPD patients who are stable but at risk of deterioration. The service will work with this cohort of patients to develop self-management strategies and the development of Anticipatory Care Plans.
- Within social work, older people's services will seek to identify those considered to be potentially most at risk, and information provided to Social Work Standby Services is regularly updated by social work staff;
- A programme is in place in the North West to provide anticipatory care plans for people in Intermediate Care beds and extend this to other units in the city; and,
- We will also develop a wider programme to extend anticipatory care plans to all care home settings, working with the independent sector, Cordia and others.

b) Admission Avoidance

Specific measures in place to prevent admission in addition to those above include:

- Community Nursing teams working collaboratively with GPs and third sector providers (e.g. Marie Curie Cancer Care) to manage vulnerable patients with nursing needs and those with palliative care needs. Those at greatest risk are subject to frequent clinical monitoring and case review to ensure all measures are in place to avoid admission to hospital. District Nurses will check if other services are attending and if any issues will contact relevant agency;
- The Rapid Response Link within community rehabilitation teams offer the same day access for patients referred by a GP and who are at risk of admission;
- The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team;

- Social Work Services will review all vulnerable elderly people, known to them in the community, through the use of professional supervision. Resource Screening groups will continue to prioritise care home allocation to those in most needs including vulnerable people living in the community;
- For those at risk of falling, we will pilot in the North East community rehabilitation service and the Scottish Ambulance Service (SAS) an alternative pathway where hospital attendance is not required which if successful we will roll out across the city. Implementation of the pathway will reduce inappropriate hospital attendances, and reduce the number of repeat incidents (emergency callers);
- We will also work with the SAS and acute hospitals to explore the efficiencies in the process of patient arrival at A&E; and,
- Community Mental Health Crisis Services will provide 24 hour 7 day week provision which will assess patients for admission and discharge. These services will be in place over the festive period. The services covering the Glasgow City & Clyde area include social care support. The Crisis Teams will provide public holiday cover during the festive period.

c) Expediting Discharge from Hospital

The HSCP has established a Hospital Discharge Operations Group (HDOG) charged with improving hospital discharge performance and consistency across the three localities in Glasgow. From November 2015 to March 2016 this group will meet on a weekly basis to accelerate the improvement programme, and ensure regular scrutiny of discharge performance and individual case management. We will aim to maintain our current performance (see annex A) over the winter period with a particular focus on the city's two A&E departments.

The work programme includes the following actions:

- development of a detailed action plan for under 65s including patients with complex physical health care needs, mental health and homelessness;
- actions to improve adult mental health Edison recording and improve discharge performance;
- deliver improved performance management for AWI patients delayed due to guardianship applications and correspondingly reduce the number of AWI delays;
- improved hospital interface arrangements including:
 - community team discharges;
 - appropriate completion of specialist multi-disciplinary assessment tool (SMAT);
 - timing of SMAT availability; and,
 - appropriate recording on Edison
- develop palliative care and end of life hospital discharge pathway;
- implement an accommodation-based strategy that seeks to divert demand away from acute care at both admission and discharge ends of the system;
- implement choice protocol for patients refusing to move to intermediate care and ensure appropriately recorded on Edison;
- development of arrangements to facilitate improved discharge to Council managed residential care units;
- agree notification arrangements from homeless liaison team initiated discharges;
- establish focused rehabilitation team input to Intermediate Care units to facilitate patient discharge; and,
- strategically manage care home placement allocations across the three localities to alleviate the areas of greatest pressure and maintain throughput in our intermediate care units.

Other actions to expedite acute hospital discharge include:

- the Marie Curie fast track service which represents a £250k investment via Glasgow's Integrated Care Fund to support people with palliative care needs to get out of hospital as quickly as possible. The service covers the whole city and is projected to support almost 500 patients in 2015/16, equating to around 4,600 visits and almost 15,000 unplanned bed days. In addition, the NHSGGC contract with Marie Curie for Managed Care augments mainstream community nursing services for people with palliative care needs and avoids unscheduled admissions; and,
- EquipU out of hours service for urgent referrals to avoid potential delays as a result of equipment issues. EquipU will communicate information to all partners in early November, advising store closure dates and order cut-off points. This is supported further by partnership discussion at the Operational Development Group which reviews plans and ensures all services have made provision for public holidays.

d) Other actions:

- Community teams will ensure that people are reminded to order and collect their medications, including repeat prescriptions, in advance of the festive period, and link closely with GP practices;
- a predictive stock order of essential supplies e.g. wound dressings, pharmacy, and syringe drivers plus equipment from EQUIPU e.g. walking aids, toileting aids and mattresses will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.
- in adult mental health Out of Hours services receive referrals from the GP OOH service which triages calls from NHS 24. These services will be in place over the festive period. It is not anticipated that there would be an unusual pattern of referrals to psychiatry based on previous year's information.

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

Service managers will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity over the holiday period. Community services such as district nursing will operate as normal over the bank holiday weekends supported by out of hours services. Social work stand by will also be in place.

In mental health inpatients, staff leave is planned for the full festive period to ensure appropriate staff cover. In addition, there is in place review and attendance plans to monitor absence. In the event of staff shortages access is available to the nurse bank. In exceptional circumstances community psychiatric nursing staff may be requested to work in inpatient services.

iii) Whole system activity plans for winter: post-festive surge.

The HSCP will contribute to the whole system activity planning and ensure representation in Board-wide winter planning arrangements. The HSCP Chief Officer links closely with acute and other HSCP Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action. Acute situation reports (SITREPs) will be regularly reviewed at the HDOG, and shared across community services to monitor performance and inform appropriate actions that might be required.

iv) Strategies for additional winter beds and surge capacity.

The HSCP has introduced an intermediate care model and capacity in the city. An intermediate care improvement plan is in place. A commissioning strategy is also being implemented with a view to establishing core and flexible arrangements. Over the winter period there is the potential to spot purchase additional intermediate care placements to relieve any surge in appropriate referrals from the acute system.

In mental health inpatients, the admission and discharge data has been assessed over the past five years, and daily reports on bed occupancy and availability are assessed. These reports also report on any projected ward closures should this be necessary in exceptional circumstances e.g. Norovirus, influenza etc. Annual leave will be managed across the winter and festive period to ensure sufficient staffing to manage demand. The pattern of admissions and discharges over the winter period is similar to the pattern throughout the rest of the year. No special arrangements need to be put in place relating to psychiatric admissions and discharges.

v) The risk of patients being delayed on their pathway is minimised

Arrangements will be put in place to ensure that areas where there is a potential for delays are reduced, particularly in respect of the adults with incapacity. There is also ongoing work at the primary / secondary care interface within rehabilitation services to improve the sharing of information, and reduce the need for reassessment at points of transition that could lead to a delay in the patient's pathway.

vi) Discharges at weekend & bank holiday.

The HSCP will put in place a skeleton integrated response team, with access to home care, over the Sunday and Monday of the two holiday weekends to respond to particular pressures that might arise, and with a view to easing pressure as services get back to normal after the holiday weekends.

The HSCP will work with acute hospitals to anticipate discharges that may require home care services during the two holiday weekends. There are well established arrangements with Cordia for cover over public holidays and this is well communicated to community teams.

Red Cross will be working throughout festive period, supporting admission avoidance from A&E from the main acute hospital sites in Glasgow including supporting transport of patients' discharge to home and to and from Intermediate Care.

Community rehabilitation teams will work every day other than Christmas Day and New Year's Day, and will support A&E admission avoidance, provide a GP rapid response service from GP out of hours and Intermediate care.

In mental health, Liaison Psychiatry Services are provided Monday to Friday to acute hospitals and Psychiatric Liaison Nurse services for deliberate self-harm over weekends and public holidays. The Deliberate Self Harm community psychiatric nursing service will receive referrals directly from acute medical wards over the public holiday and weekend for the festive period. This is in addition to direct referrals to the on-call psychiatry staff in psychiatric hospitals which is available to acute services.

vii) Escalation plans tested with partners.

The HSCP will monitor performance of the health and social care system over the winter period, including the actions in this plan, through a robust set of arrangements that include:

- monitoring of delayed discharges through weekly meetings of the HDOG;
- fortnightly meetings of the winter planning group that produced this plan to ensure its implementation;
- reports on winter planning performance to the weekly HSCP Executive Team;

- regular review of locality performance at Locality Management Team meetings;
- a rota of senior management cover over the winter period to ensure an appropriate management response when required;
- Clinical Director liaison with a network of GP “spotter” practices to monitor levels of flu within primary care; and,
- Care Homes and Intermediate Care Units will identify any issues that require to be escalated.

viii) Business continuity plans tested with partners.

We are currently working on an integrated HSCP emergency plan that will link to the business continuity arrangements in each service. The current business continuity arrangements for each service area will remain in place and will be revised in relation to responsible people and accommodation e.g. the development of the new 120 bedded care homes and the subsequent buddy arrangements.

GP Practices and Pharmacies have business continuity plans in place that include a ‘buddy system’ should there be any failure in their ability to deliver essential services. These are currently being updated to ensure they are robust.

ix) Preparing effectively for norovirus.

The NHSGGC Norovirus Escalation plan will be followed across all HSCP services including inpatient areas and care home settings. Staff will be reminded of the need to remain absent for 48 hours post last symptom of Diarrhoea and vomiting.

x) Delivering Seasonal Flu Vaccination to Public and Staff

All health and social work staff, including home care staff, will be reminded to encourage elderly and vulnerable people to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination

Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided across the city.

Home care staff will be advised as to how they can receive the vaccination if they so choose.

xi) Communication to Staff & Primary Care Colleagues

To ensure that all HSCP staff, primary care and partner agencies are kept informed, the HSCP will:

- ensure information and key messages are available to staff through communication briefs, specific newsletters and communications, team meetings and electronic links;
- circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices;
- collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board;
- Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices; and,

- we will promote use of the community services app to raise awareness of service availability and contact information;
- Other arrangements to provide simple access to services include Social Care Direct for all GCC enquiries and service specific access points for NHS provision. A CHP App is also available which gives smart-phone and desk-top users rapid access to service contact numbers across Glasgow;
- Based on previous work on developing a single point of access to NHS services, it was agreed that many of the systems currently in place provide quick and easy access to services. Examples include the community rehabilitation and mental health duty system. The District Nursing service is currently the subject of a project to develop a single point of access for Glasgow. The infrastructure for this system will be complete by December and will begin operating in early 2016. It is expected this will provide faster access to District Nurses and also free up professional time that will be re-invested in anticipatory care; and,
- Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP and Glasgow City Council.

xii) Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

The HSCP will put in place a robust performance management system to under pin the arrangements described in vii above the key features of which will be to:

- monitor system and service performance / demand across the city and in localities;
- inform our capacity planning and the need for any surge capacity; and,
- Report on performance against agreed targets / KPIs.

Attached at annex A is a draft of the metrics to be used as part of our performance regime.

CONCLUSION

This draft plan outlines the actions the HSCP is taking in preparation for winter 2015/16 in line with national guidance, and guidance from NHSGGC and Glasgow City Council. The HSCP has robust monitoring and performance management arrangements in place to minimise any potential disruption to health and social care services, patients, service users and carers over the winter period. Regular reports and updates will be made to the shadow Integration Joint Board.

PERFORMANCE MANAGEMENT

<u>Glasgow City - Winter Planning - Draft Monitoring Framework</u>				
Draft 2 15/10/2015				
Measure	Data Source	Current Position	Level	Comment
Performance - DELAYED DISCHARGE DETAIL				
Total numbers delayed discharge excluding AWI	Edison	60	City / Locality	Notes reason for delay such as funding or assessment etc as possible trigger for action
Total numbers delayed discharge excluding AWI breaching 72 hours	Edison	54	City / Locality	Reviewed by Locality service Manager / delegated manager and escalated.
Number of delayed discharge patients 65+ years excluding AWI & MH	Edison	30	City / Locality	
Number of delayed discharge patients 65+ years excluding AWI & MH breaching 72 hours	Edison	24	City / Locality	
Number of delayed discharges patients aged under 65 excluding AWI & MH	Edison	13	City / Locality	
Number of delayed discharges patients aged under 65 excluding AWI & MH breaching 72 hours	Edison	13	City / Locality	
Total number of delayed discharge mental health patients over and under 65 years	Edison	17 (13 over 65 / 4 under 65)	City / Locality	
Total number AWI delayed discharge patients (including and excluding MH)	Edison	52 (including MH) 43 (excluding MH)	City / Locality	
Measure	Data Source	Current Position	Level	Comment
Capacity - INTERMEDIATE CARE				
Step Down				

Percentage occupancy	GCC Data	89%	City / Locality / Care Home	Would also need to include reporting of any loss of capacity such as closure of beds for norovirus / repairs etc
Number of Admissions	GCC Data	12	City / Locality / Care Home	
Number of discharges	GCC Data	3	City / Locality / Care Home	
Length of stay - average / min / max	GCC Data	Weekly	City / Locality / Care Home	
Vacancies	Care Homes	Daily	City / Locality / Care Home	Reviewed by Locality service Manager / delegated manager and escalated.
System Demand Indicators - UNSCHEDULED CARE ACTIVITY				
Service Demand - HOME CARE				
Referrals to Cordia	Cordia	Weekly	Hospital / Locality	To include weekend and public holiday monitoring

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

INTEGRATION JOINT BOARD

2015

Report by Julie Murray, Chief Officer

WINTER PLAN

PURPOSE OF REPORT

1. To inform the Integration Joint Board about unscheduled care planning and preparations for winter.

RECOMMENDATION

2. The IJB is asked to note the unscheduled care planning arrangements in place to support the wider health system over the winter period.

BACKGROUND

3. Health and Social Care Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHSGG&C whole system planning group that each Health and Social Care Partnership will produce a local unscheduled care plan with a particular focus on the winter period. Partnerships have been asked to cover:
 - The community service aspects of the 6 essential actions (Appendix 1)
 - Delayed discharge
 - Measures to reduce admissions and attendances
 - Delivery of key service features including single point of access, Care Home support and Anticipatory Care
 - Continuity and resilience
 - Developing an agreed set of indicators to monitor performance
 - Planning with GPs for the two long bank holidays
 - Local Improvement
 - Local Communications
4. The report section sets out local planning arrangements and planned actions under the twelve key themes set out in the Scottish Government guidance

National Unscheduled Care Programme: Preparing for Winter 2015/16 (DL (2015) 20). The relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance* (Appendix1) are covered within the twelve themes.

REPORT

Planning Activity

5. The HSCP management team reviewed national and NHSGGC guidance: reflected on performance and issues from last winter; and have put in place a number of actions to strengthen the HSCP unscheduled care performance.
6. In addition, planning for delayed discharge and unscheduled care had already been identified as a priority area by Strategic Planning Group. It approved the establishment of four distinct task and finish 'Safe and Supported' work groups using improvement methodology.
 - a) Prevention and Anticipatory Care
 - b) Point of Possible Admission
 - c) During Admission
 - d) Discharge from Hospital
7. Partners in the task and finish groups, in line with integration legislation, include third sector, independent sector, carers, health and social care staff and managers, GPs and acute clinicians. The tasks and finish groups will report back at the beginning of December on a range of additional improvement opportunities they have identified. Prioritised actions will be tested over the winter period and learning captured and incorporated in the Implementation Plan for 2015-18.

Planned Actions

- i. Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January***

Admission Avoidance

8. A series of measures are in place to avoid admissions:
 - Home care managers are authorised to increase care packages in and out of hours to avoid admission.

- Third sector partners have been directed to triage and fast track urgent referrals to single point of access or direct to RES team.
- Information of services and supports have been developed and shared with in house out of hours and partner services.
- Single point of access team receive urgent referrals and rapidly refer to multidisciplinary Rehabilitation and Enablement clusters who identify the most appropriate professionals to undertake rapid assessment and immediate access to preventative supports and care packages. This includes access to step up care home respite with rehabilitation support.

Anticipatory Care Planning

9. There are a number of anticipatory actions established across all health and social care teams. In particular,
 - Rehabilitation and Enablement Cluster Teams have systems in place to predict or identify vulnerable patients at risk of admission so that the necessary support can be given to avoid unnecessary admissions and help people remain in their own homes.
 - Advanced Nurse Practitioners lead anticipatory care planning for patients with long term conditions this work has been successful in avoiding unnecessary admissions. ANPS and District Nurses will update ACPs and optimise just in case prescribing.
 - All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with acute and the Scottish Ambulance Service.
 - Community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period.
 - A predictive stock order of essential equipment from EQUIPU, wound dressings, pharmacy, and syringe drivers will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.
 - Homecare services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users. Council staff from less priority areas can be redirected to support this service and ensuring essential staff can get to and from work.
 - Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP, East Renfrewshire Council, and relevant Third Sector websites. This will include “Know who to turn to” and NHSGG&C winter website link.

Expediting Discharge from Hospital

10. Tested measures and additional capacity have been put in place to expedite safe discharge from hospital and avoid re-admission.

- Inreach social work capacity has been increased from 1 to 2 workers reaching into the new Queen Elizabeth hospital. The role of the workers is to identify people as early as possible (prior to fit for discharge) and commence planning for discharge.
- A re-ablement home care worker is in place to identify people who would benefit from our re-ablement services and arranging home care cover.
- A similar model of in reach into the RAH which has been very successful at bringing down delays and supporting people home will continue.
- For the few people who might benefit from an extended period of assessment or rehabilitation care home beds with inreach from Rehabilitation and Enablement teams are available. This is a real step down model that enables us to do home visits and phased returns home – minimising the risk of readmission and maximising the success of returning home.

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

11. Health and Community Care Service Managers will ensure that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods. This will be monitored via the Health and Community Care Managers meeting and reported to the HSCP Management Team.

iii. Whole system activity plans for winter: post-festive surge

12. The HSCP will continue to contribute to the whole system activity planning and ensure representation at winter planning groups. The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.

13. Situation reports (SITREPs) will be shared between the Community and Acute services to inform escalation pressures.

iv. Strategies for additional winter beds and surge capacity

14. The HSCP will respond where possible to support Acute services in managing surge capacity. There is additional capacity in the local care home market due to speculative development that could be utilised if required.

v. The risk of patients being delayed on their pathway is minimised

15. HSCP in reach services will continue to pro-actively plan discharge, indentifying and tackling any potential issues and barriers in advance of discharge.

vi. Discharges at weekend & bank holiday

16. The Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

vii. Escalation plans tested with partners

17. The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments as a result of a particular illness or virus, putting a strain GP services.
18. Regular meetings and phone calls to Care Homes from the commissioning team will be used to share information and identify any issues that require to be escalated.

viii. Business continuity plans tested with partner

19. HSCP staff have participated in a Council wide winter planning exercise to test plan locally. Lessons learned have been incorporated into the HSCP Business Continuity Plan and East Renfrewshire Council Severe Weather/Winter Plan.
20. GP Practices and Pharmacies have Business Continuity Plans in place that include a 'buddy system' should there be any failure in their ability to deliver essential services.

ix. Preparing effectively for norovirus

21. Information for Care Homes will be shared by the Independent Sector Integration Lead and

x. Delivering Seasonal Flu Vaccination to Public and Staff

22. All health and Homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions.
23. The HSCP is undertaking peer immunisation for nursing staff and offering immunisation to home care staff.

xi. Communication to Staff & Primary Care colleagues

24. To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;

- Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
- Circulate updates on services available over festive period, including pharmacy open times, to GP practices
- Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xii. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

25. The actions set out in this Winter Plan will be monitored and analysed on a fortnightly basis by the HSPC management team. If pressures increase this will increase to weekly or daily meetings as required.

Particular measures that will be monitored include;

- Bed days lost to delayed discharge
- Bed days lost to delayed discharge for AWIs
- Emergency admissions age 75yrs+
- Percentage uptake of flu vaccinations by staff
- Percentage uptake of flu vaccinations by GP population
- Referrals to Re-ablement Services
- Referrals to Hospital Inreach Team
- Referrals to Single Point of Access
- Demand and capacity (including GP practices)

26. A report analysing the activity, performance and pressures will be produced and reviewed at the end of the winter planning period.

East Dunbartonshire Health & Social Care Partnership

Winter Plan

2015/16

4.0 MAIN REPORT

4.1 Introduction

Health and Social Care Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHSGG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period. These plans will cover:

- The community service aspects of the 6 essential actions (Appendix 1)
- Delayed discharge
- Measures to reduce admissions and attendances
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care
- Continuity and resilience
- Developing an agreed set of indicators to monitor performance
- Planning with GPs for the two long bank holidays

This Winter Plan identifies and addresses the local issues across the primary care and community services for which East Dunbartonshire Health and Social Care Partnership is responsible, to support the NHSGG&C whole system planning as detailed above.

4.2 Winter Planning Arrangements

A Winter Planning Group has been established and meetings have been arranged to take place on a monthly basis. The purpose of the meeting is to discuss the delivery of the Winter Plan and identify any issues that require to be addressed, or escalated, to enable appropriate actions to be put in place and ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges throughout the winter, and in particular, the festive period.

The membership of this group includes representation from planning and operational teams as follows;

- Planning Manager (**Chair**)
- Fieldwork Manager Older People (**Vice Chair**)
- Fieldwork Manager Older People
- Planning Information Officer
- Team Lead Mental Health Services
- Clinical Director
- Head of Planning, Acute Services
- Head of Administration
- Senior Nurse, Adult Services
- Interim Senior Nurse, Children & Families

- Team Manager Community Rehabilitation / Older Peoples Mental Health
- Health Improvement Lead

4.3 Key Themes

The local planning arrangements are described under the twelve key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20).

In addition, the planning arrangements described have integrated the relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance* (Appendix1).

xiii. **Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January.**

(b) Admission Avoidance

Teams have systems in place to predict or identify vulnerable patients at risk of admission so that the necessary support can be given to avoid unnecessary admissions and help people remain in their own homes:

- The Community Nursing teams have introduced *Patient Status at a Glance* Boards that are updated daily. The board displays details of vulnerable patients as well as patients with changing needs. The nursing teams have daily meetings to identify vulnerable patients and those at risk of admission. The nurses will link with GPs to identify patients who may potentially be vulnerable during the long bank holidays.
- The Social Work team maintain a register of vulnerable people known to them living in the community. The Social work out of hours Standby Services have a copy of the information regarding these individuals to ensure appropriate supports can be provided if required outwith office hours, including weekends and Public Holidays.
- The Community Rehabilitation team and Older Adults Mental Health team maintain a list of patients at risk of admission to assist in daily scheduling of visits during adverse weather periods.
- The Rapid Assessment Link within the rehabilitation team offer same day access to service for patients referred by the GP before 4pm who are at risk of admission.
- Community and Acute Services will be asked to predict service users who will be discharged and require Homecare services during the two long weekends as Homecare will stop accepting referrals 48 hours prior to each Public Holiday.

- The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team
- Social Work Occupational Therapy is staffed daily and can respond to prevent escalation leading to potential admission. This provision is maintained across the holiday period with the exception of the public holidays.
- Contacts with private providers of Homecare services include monitoring their capacity for delivering services as commissioned.
- The HSCP Older People's Programme Board will continue to work in partnership, with GPs, Acute services, Independent Sector including links with Care Homes, and Third Sector organisations including Older People's Access Line, Carers Link, Ceartas, Marie Curie, Befriending Plus and the Red Cross, to help people remain in their own homes, or homely setting, when it is safe to do so.

(c) Anticipatory Planning and Care

There are a number of anticipatory actions established across all health and social care teams. In particular,

- Local intelligence and SPARRA information is used to identify patients at risk of admission. These patients are offered assessment and support from the Community Nursing service. Complete anticipatory care plans are uploaded by GP practices onto their electronic information system, eKIS. Work is underway with local GP colleagues to extend this over the winter period to include specific long term conditions.
- Anticipatory structures within Social Work Older People's services seek to identify those considered to be potentially most at risk across this time and information provided to Social Work Standby Services is regularly updated by social work staff.
- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with acute and the Scottish Ambulance Service.
- Community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period.
- A predictive stock order of essential equipment from EQUIPU, wound dressings, pharmacy, and syringe drivers will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.

- Homecare services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users.
- The East Dunbartonshire Council Roads Department has agreed that an HSCP service manager can inform them of remote vulnerable service users who cannot be reached by car or foot during severe weather and actions will be taken to clear the road and enable access, thereby preventing a potential avoidable hospital admission.
- Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP, East Dunbartonshire Council, and relevant Third Sector websites. This will include “Know who to turn to” and NHSGG&C winter website link.

(d) Expediting Discharge from Hospital

A weekly operational discharge meeting has been established to review all individual hospital delayed discharge cases and ensure that the collective resources are appropriately directed to create improved joined up working that will minimise and reduce future delays. The group membership includes:

- Manager of Adult and Community Care Resources;
- Team Manager – Older People’s Team;
- Team Leader – Hospital Assessment Team;
- Team Manager – Care at Home Services;
- Team Leader – Care at Home Services;
- A representative from the Mental Health Team;
- Adults and Community Care Support Worker;
- Community Rehab Team Manager
- A representative from the Community Nursing Team

There are a number of activities that the group will explore and enact including:

- Promotion of legal powers in relation to adults with incapacity;
- Further exploration of the use of 13ZA under ‘deprivation and liberty’ Mental Health (Scotland) Act;
- Weekly discussions regarding those people currently in hospital and the issues that require to be resolved;
- Access to Trakcare;

- Anticipatory AWI meetings;
- A dedicated process for allied health professionals and home care organisers to identify and highlight issues to the Team Manager, Older People's Team, regarding individuals, living in the community, who lack capacity and legal powers.
- The use of delayed discharge monies to employ a Resource Worker role that will support the Joint Delayed Discharges group by arranging meetings; gathering and comparing information across various systems (Trakcare, Carefirst etc); analysing case notes and highlighting issues that could prevent discharge;
- The use of delayed discharge monies to fund care placements in the short term while financial disputes are settled;
- The use of delayed discharge monies to fund the services of a solicitor (via Citizens Advice Bureau) to undertake a short term episode of processing power of attorney applications

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

Service leads will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods. This will be confirmed by an assurance memo in October.

xv. Whole system activity plans for winter: post-festive surge.

The HSCP will contribute to the whole system activity planning and ensure representation at winter planning groups.

The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.

The HSCP Planning Manager attends the North Sector UCC Winter Planning Group meetings to share planning arrangements and discuss issues with the North Sector Acute Services and East Dunbartonshire HSCP.

Situation reports (SITREPs) will be shared between the Community and Acute services to inform escalation pressures.

xvi. Strategies for additional winter beds and surge capacity.

The HSCP will respond where possible to support Acute services in managing surge capacity. The Hospital Assessment Team will provide a reduced staff rota the week between the public holidays with a minimum of two staff on duty to support surge activity. Additional capacity to respond to particular increases in service demand can be resourced from the wider local social work teams if required.

xvii. The risk of patients being delayed on their pathway is minimised.

Anticipatory structures have been supported to ensure that potential areas of need, particularly in respect of the adults with incapacity (AWI) are best met and AWI delays minimised. The Integrated Care Fund has supported additional capacity, including Mental Health Officers and a part time Solicitor, to facilitate the process around Power of Attorney and Guardianship orders to minimise delays for AWIs.

There is ongoing work at the primary secondary care interface within rehabilitation services to improve the sharing of information and reduce need for reassessment at points of transition that could lead to a delay in the patient's pathway.

xviii. Discharges at weekend & bank holiday.

The Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

xix. Escalation plans tested with partners.

Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues.

The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments as a result of a particular illness or virus, putting a strain GP services.

The Hospital Discharge team will provide a reduced staff rota the week between the public holidays where a minimum of two staff are on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required.

Commissioned services have emergency arrangements are in place and the Independent Sector Integration Lead has agreed to act as a link between the HSCP, the commissioning team, and Care Homes to share information and identify any issues that require to be escalated.

xx. Business continuity plans tested with partners.

Business Continuity Plans (BCP) for both Health and Social Services will be harmonised into a single BCP by March 2016. Until this process is complete and tested, each organisation will continue to work within the remit of their own business continuity arrangements.

As part of the Winter Planning process, service leads have been asked to review their individual BCP service plans by November 2015.

Links have been established with East Dunbartonshire Council's winter planning arrangements to support the continuity of all partnership services throughout the winter period.

GP Practices and Pharmacies have BCPs in place that include a 'buddy system' should there be any failure in their ability to deliver essential services.

xxi. Preparing effectively for norovirus.

Information distributed to Care Homes will be shared by the Independent Sector Integration Lead

xxii. Delivering Seasonal Flu Vaccination to Public and Staff

All health and Homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination

Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided in KHCC, Milngavie Clinic and Stobhill.

Homecare staff will be advised as to how they can receive the vaccination if they so choose.

xxiii. Communication to Staff & Primary Care Colleagues

To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;

- Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
- Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices
- Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board.
- Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xxiv. *Effective analysis to plan for and monitor winter capacity, activity, pressures and performance*

The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning.

Particular measures that will be monitored include;

- Bed days lost to delayed discharge
- Bed days lost to delayed discharge for AWIs
- Emergency admissions age 75yrs+
- Percentage uptake of flu vaccinations by staff
- Percentage uptake of flu vaccinations by GP population

- Referrals to Rapid Response and Rapid Assessment Link team
- Referrals to Hospital Assessment Team
- Demand and capacity (including GP practices)

A detailed rolling action log will be maintained and updated at each Winter Planning Group meeting. This will be submitted monthly to the HSCP Senior Management Team meetings.

A report analysing the activity, performance and pressures will be provided at the end of the winter planning period.

HSCP Winter Planning Work Plan v.6
 Alan Brown Service Manager
 October 2015

Theme	Task	Status & Key Issues	Action	Lead	Target Date	Progress	
<u>Continuity Resilience</u>	Ensure community services are available when required	Clear Service Pathways are in Place Process of referral and response is timely Out Of Hours pathway to be finalised	Establish Direct Access Point for community Services in particular out of hours 2 main contact numbers Office Hours (ACM) Out with Office Hours (DN OOH)	EC	30/09		
		Ensure up to date information re access to service is available	Prepare info sheet with 2 main contact numbers Office Hours (ACM) Out with Office Hours (DN OOH)			To be passed to PA/MB	
		Operational Discharge Meeting is attended by key operational individuals including community Leads who assist in planning discharge of complex cases	Maintain ODM attendance & planning function Report into WPDP (Winter Plan Data Pack)	AB			
			Include discussion of HC packages including restarts				
		Homecare has a fast flexible service to respond to referrals and discharge on a enablement model	Identify potential pressure on service	JA	31/10		
	The Community Nursing service					In place	

and Homecare service provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

Focussed recovery from periods limited cover

CACM duty rota to cover peak holiday period and January 16 (Dec15 -Jan 16)

CACM/ Duty cover IRH in terms of back up & support

AB

15/10

Based on previous years arrangements

Arrange Annual Leave for period to ensure sufficient cover

Flu immunisation programme for staff

To be confirmed by email end of Oct 2015 confirmed

HSCP Rotas over winter period to be confirmed

Home Care Reablement RES District Nurses Liaison Nurses

AB (to collate)

15/10

Advice First District Nurses

Peer immunisation clinic

The usual uptake is around 300, last year we increased venues and accessibility however the numbers remained static. Consider how to increase uptake for vital services

organised peer immunisation for Monday 26th October at Podiatry Department PGHC

between
11am and
1pm.
Tuesday 27th
November
Wing G Room
88 GNK H/C
between
2pm until
4pm.
Monday 2nd
November
Podiatry
Department
PGHC
between
2pm and
4Pm
Tuesday 3rd
November
Wing G Room
88 GNK H/C
between 11
am and 1pm.

If agreeable can the dates
times and venues be
published across the
HSCP communication
circuit.

Passed to
communication
teams

Planning GPs cover for 2 bank holiday periods	GP practices will put in contingency arrangements for winter period	AB to liaise with Pauline for arrangements by GP's over Dec/Jan	PA	tbc	Raised with practice managers and GP forum Oct 2015
		PA to link with Practice Managers			
		Production of clear information around services and how to access them – to go to partners including GP's			
Service Capacity	Home Care capacity tracked through CM200	Create weekly reports		In Place	Winter Plan Data Pack
	Care Home Capacity is monitored daily with pressures identified	Link with care home providers to maintain daily reports around pressure	AB	In place	
Prioritising emergency patients	Currently have early identification in IRH	Managed through ODM early identification of discharge	AH	In place	

	Identify discharge/restart of homecare through cm200	JA	To be set up		
	Identify discharge of New Home care packages	JA	tbd		
	Early identification process of vulnerable people at risk of admission to IRH in community	Criteria for identification of most vulnerable adults	AB	30/10	Mental Wellbeing II health/elderly carer Complex cases
		OD supporting development around localities to focus on this issue Links between; Homecare ACM District Nurses RES Rapid Response	AB	30/11	Winter Plan Data Pack 1 st Session 2/10/15
		Development of Friday Allocation Meetings to identify capacity issues complex cases	TB/HM/ ML		
	The Community Nursing teams introduce <i>Patient Status at a Glance Team have daily meetings update.</i> details of vulnerable patients as				

		<p>well as patients with changing needs. to identify those at risk of admission. The nurses will link with GPs and HCC to identify patients who may potentially be vulnerable during the winter period</p>	
		<p>The Home Care/ Social Work team maintain a register of vulnerable people known to them living in the community. Link with OPMHT to ensure list is updated</p>	
		<p>Contacts with private providers of Homecare services include monitoring their capacity for delivering services as commissioned.</p>	<p>JA</p>
		<p>Base action on outcome of Chronic Disease Management Review</p>	<p>EC 31/10</p>
<p>Advise to Patients with chronic conditions on source of help</p>	<p>Public Health information to be circulated Local Contacts to be included</p>	<p>Link to communication Plan Link to CR Plan on preparing for Winter</p>	<p>AB/M H Comms plan is in place require to focus on</p>

		Health Improvement	Link to GCC generic information and add local focus		winter issues
<u>Delayed Discharge</u>	Reducing Numbers Delivering 72 hours	See attached Home First Action Plan			
Reduce admissions and Attendances	Reduce Admissions		Link to one contact for service OOH	EC	
		Step Up Beds – Plan to have 6 beds available in from 2015.	Procurement Process underway Project Group established	EC	
		Through the Night care teams in place and functioning	Link with OOH DN service	JA/AB	
		Review of Specialist Nurses with a remit for discharge within IRH	Link with CH and MB to discuss	CH	30/09
		Role of ECAN nurse Early geriatric assessment	Link with Catriona Glen	AB	
	Continue development of Home First Approach	Older People's Service Development workshop 29/10 to include Pathways, risk enablement, comprehensive geriatric assessment		EC/ CG	
<u>Delivery Key Services</u>	Single Point of Access	Discharge Team/CACM now have single point of access based at GHC	Ensure contact information is circulated Generic email to be created for CACM Ensure telephone contact is available	AB	30/09
	Nursing Home support	HSCP Governance arrangements with Care Homes established. Care Home Providers Forum in	Liaison Nurses/ AHP link group agreed to support work with care homes	AB	31/10

	place Enablement input to Nursing Homes	identification of residents at risk of admission Explore fast track discharge for existing residents liaison between ward and home	
	Leadership development programme completed by half of local care home managers.	Link with Scottish Care support worker funded through integration fund.	EC
Anticipatory Care	ACP in place for residents in care homes	ACP to be further developed in community Link to identification of emergency admissions	CH/ EC
		Reviewing use of SPAR in care homes	
		Access to ACP	
Capacity for AWI Patients	MHO rota in place and increased capacity of MHO service	Monitor the impact of AWI on IRH	CG
	Early identification of AWI issues on wards with TL CMHT attending ODEM		
Equipment	Fast Track in place for discharge Joint Store single access in place	DM to add information	DM
In reach to Hospitals	Home First Action Plan	EC to add	
Rehabilitation	Home First Action Plan	Establish the principle of assessment at home	Longer term plan?
		Older Peoples Development Group	
		RES team specialist input around COPD	

			Falls pathway in place and linked to initial referral to HSCP to take preventative approach.	JA	21/09	In place
Performance	Develop agreed indicators to monitor performance	keep current PI so to compare performance on DD bed days lost 72 target	Staffing numbers capacity	EC	31/10	
			Outcomes for step up to be determined			
			Identify escalation point and triggers- agree when and how huddle information should be escalated			
			Contingency plan for weekly meeting over winter period to evaluate performance and risk management	AB		
	Analysis of demand & capacity	Develop key information brief for winter period <ul style="list-style-type: none"> LTC beds and vacancies Admissions to Hospital from care homes Delayed discharges Ava fit list which identifies potential referrals to discharge team Cm 200 data on usage we could look at hours available and hours used Referral to services waiting list with priority and weighting of need We could collate staff numbers annual leave absence etc.include HSCP & GP 	OP Data Pack recently reviewed to inform process work	DP		
Develop Data Capture Tool			DP			
Produce weekly data pack			RM			
Link this date to IRH daily Huddle information						
			Easy reference to information			

		<ul style="list-style-type: none"> Homecare discharge restart 			
Local Communication	Develop local communications plan	HSCP communications group in place to coordinate communication	Winter Planning to be on agenda at HSCP communication group	EC	30/09
			Write up discharge guidance and pathway	EC/A H	
		Twice daily huddle established in IRH	Direct link to IRH Huddle from community during winter period	EC	31/10
			Identify how HSCP can input to Huddle during this time as well ODM		

West Dunbartonshire Health & Social Care Partnership

Draft Winter Plan

2015/16

Introduction

Health and Social Care Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHSGG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period. These plans will cover:

- The community service aspects of the 6 essential actions (Appendix 1)
- Delayed discharge
- Measures to reduce admissions and attendances
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care
- Continuity and resilience
- Developing an agreed set of indicators to monitor performance
- Planning with GPs for the two long bank holidays

This Winter Plan identifies and addresses the local issues across the primary care and community services for which West Dunbartonshire Health and Social Care Partnership is responsible, to support the NHSGG&C whole system planning as detailed above.

Winter Planning Arrangements

A Winter Planning Group has been established and meetings are taking place regularly and report to the HSCP Senior Management Team. The purpose of the meeting is to discuss the delivery of the Winter Plan and identify any issues that require to be addressed, or escalated, to enable appropriate actions to be put in place and ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges throughout the winter, and in particular, the festive period. The detailed plan is attached.

CORE TASKS	ACTIONS
<p>1. Safe & effective admission / discharge continue in the lead-up to and over the festive period and also into January.</p>	<p>1 Admission Avoidance</p> <p>Teams have systems in place to predict or identify vulnerable patients at risk of admission so that the necessary support can be given to avoid unnecessary admissions and help people remain in their own homes:</p> <ul style="list-style-type: none"> • The Community Nursing teams have introduced <i>Patient Status at a Glance</i> Boards that are updated daily. The board displays details of vulnerable patients as well as patients with changing needs. The nursing teams have daily meetings to identify vulnerable patients and those at risk of admission. The nurses will link with GPs to identify patients who may potentially be vulnerable during the long bank holidays. • Our Integrated Teams maintain a register of vulnerable people known to them living in the community. The Social work out of hours Standby Services have a copy of the information regarding these individuals to ensure appropriate supports can be provided if required outwith office hours, including weekends and Public Holidays. • Our Integrated Rehabilitation and Older Adults teams maintain a list of patients at risk of admission to assist in daily scheduling of visits during adverse weather periods. • Teams can access rapid day care assessment and community bases assessment within the rehabilitation team which offers same day access to service for patients referred by the GP before 4pm who are at risk of admission. • Our early assessor service identifies patients who will be discharged and require Homecare services which we provide rapidly and will continue to provide including until close of play prior to public holidays. • The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team • Contacts with private providers of Homecare services include monitoring their capacity for delivering services as commissioned. • Locality Groups will continue to work in partnership with GPs, Acute services, Independent Sector

including links with Care Homes, and Third Sector organisations including Link Up, Marie Curie, and the Red Cross, to help people remain in their own homes, or homely setting, when it is safe to do so and to return them home safely on discharge.

2 Anticipatory Planning and Care

There are a number of anticipatory actions established across all health and social care teams. In particular,

- Local intelligence and SPARRA information is used to identify patients at risk of admission. These patients are offered assessment and support from the Community Nursing service. Complete anticipatory care plans are uploaded by GP practices onto their electronic information system, eKIS. Additional nursing and social care support has been recruited to identify high risk patients, undertake single shared assessment and put in place supports which will maintain people at home.
- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with acute and the Scottish Ambulance Service and our extended Palliative Care Team (Nursing, Homecare and Pharmacy) provide additional support.
- Community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period. These include additional homecare, respite, nurse led beds in local care homes and step up/down placements.
- Additional equipment and supplies are ordered and available for clinical staff.
- Homecare services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users.
- The West Dunbartonshire Council Roads Department has agreed that an HSCP service manager can inform them of remote vulnerable service users who cannot be reached by car or foot during severe weather and actions will be taken to clear the road and enable access, thereby preventing a potential avoidable hospital admission. In addition, they will clear and grit access roads and parking areas around health facilities as a priority.

	<ul style="list-style-type: none"> • Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP, West Dunbartonshire Council, and relevant Third Sector websites. This will include “Know who to turn to” and NHSGG&C winter website link. <p>3 Expediting Discharge from Hospital</p> <ul style="list-style-type: none"> • Our services are available via a single point of access and provide direct referral for OT, physiotherapy, nursing, social work, home care and care at home, pharmacy team and step up/down beds. • Our hospital discharge team has an early assessor function to allow identification where possible prior to fit for discharge status and speedy assessment. Dedicated MHO staff provide support for adults with incapacity and we provide multi-disciplinary post-discharge support. • Routine daily review of 13Za cases to ensure discharge is fast-tracked where the legal framework allows. • West Dunbartonshire HSCP has commissioned 10 NHS beds for access by Acute for patients delayed whilst awaiting legal powers and these will be active when RMO cover is advised by Acute.
<p>2. Workforce capacity plans & rotas for winter / festive period agreed by October.</p>	<p>Service managers are responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity throughout the winter and during the festive period, and immediately following the four day holiday periods.</p>
<p>3. Whole system activity plans for winter: post-</p>	<ul style="list-style-type: none"> • The HSCP will contribute to the whole system activity planning and ensure representation at winter planning groups.

<p>festive surge.</p>	<ul style="list-style-type: none"> • The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action. • Situation reports (SITREPs) will be shared between the Community and Acute services to inform escalation pressures.
<p>4. Strategies for additional winter beds and surge capacity.</p>	<ul style="list-style-type: none"> • The HSCP will respond where possible to support Acute services in managing surge capacity. • Our Hospital Discharge Team will provide services between the public holidays to support surge activity. • Additional capacity to respond to particular increases in service demand can be resourced from the wider local teams if required. • Additional care at home respite and nurse-led beds will be available over the period.
<p>5. The risk of patients being delayed on their pathway is minimised.</p>	<ul style="list-style-type: none"> • Our SPOA will be fully resourced to accept referrals. • All referrals are assessed and allocated daily. • Patients identified by our early assessor team will have care packages in place timeously. • Access to rehabilitation and nursing services will be available throughout the period. • Home care services are managed alongside district nursing services and home based pharmacy support to ensure continuity of care post discharge.
<p>6. Discharges at weekend & bank holiday.</p>	<ul style="list-style-type: none"> • The Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.
<p>7. Escalation plans tested</p>	<ul style="list-style-type: none"> • Escalation plans will be prepared and shared across services to ensure a whole system approach to

<p>with partners.</p>	<p>implementing actions that minimise potential issues.</p> <ul style="list-style-type: none"> • The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments as a result of a particular illness or virus, putting a strain GP services. • The Hospital Discharge team will provide staff during the weeks between the public holidays where a minimum of two staff are on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required. • Commissioned services have emergency arrangements are in place and the Independent Sector Integration Lead has agreed to act as a link between the HSCP, the commissioning team , and Care Homes to share information and identify any issues that require to be escalated.
<p>8. Business continuity plans tested with partners.</p>	<ul style="list-style-type: none"> • Business Continuity Plans are in place across HSCP services and shared with locality representatives. • Managers have been asked to review their individual BCP service plans by November 2015. • Links with West Dunbartonshire Council’s winter planning arrangements to support the continuity of all partnership services throughout the winter period are well tested with support from the Council’s Emergency Planning Team. • GP Practices and Pharmacies have BCPs in place that include a ‘buddy system’ should there be any failure in their ability to deliver essential services and alternative premises have been identified. •
<p>9. Preparing effectively for Norovirus</p>	<p>All care homes have participated in action learning sets and have plans and processes in place to manage these. In emergencies, there will be additional capacity available. Information distributed to Care Homes will be shared by the Independent Sector Integration Lead</p>

10. Delivering Seasonal Flu Vaccination to Public and Staff

- All health and homecare staff have been offered vaccination.
- All health and homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. Information has been provided to community groups on the benefits of vaccination.
- The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination
- Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided in all Health Centres.

<p>11. Communication to Staff & Primary Care Colleagues</p>	<p>To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will:</p> <ul style="list-style-type: none"> • Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links • Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices • Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board. • Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet and on the HSCP and Council websites. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.
<p>12. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance</p>	<p>The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning.</p> <p>Particular measures that will be monitored include;</p> <ul style="list-style-type: none"> • Bed days lost to delayed discharge • Bed days lost to delayed discharge for AWIs • A&E attendances • Emergency admissions all ages • Emergency Admission age 65yrs+ • Emergency admissions age 75yrs+ • Percentage uptake of flu vaccinations by staff • Percentage uptake of flu vaccinations by GP population

	<ul style="list-style-type: none">• Referrals to Rapid Response and Rapid Assessment Link team• Referrals to Hospital Discharge Team and time to assessment and provided care.• Demand and capacity on community services, including GP practices, and community health services. <p>A detailed rolling action log will be maintained and updated and reviewed monthly by the HSCP Senior Management Team.</p> <p>A report analysing the activity, performance and pressures will be provided at the end of the winter planning period.</p>
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