Midlothian Health & Social Care Partnership Winter Plan 2021/22

INTRODUCTION

This document forms the Midlothian Health & Social Care Partnership's (HSCP) overarching Winter Plan for 2021/22. The overall aim of winter planning is to ensure that the partnership is prepared for winter pressures, alongside ongoing pressures due to COVID-19, so that we can continue to deliver high quality care. It is recognised that demand for services is likely to be at its highest level during the winter period. This plan builds on lessons learned from Winter 2020/21.

The required outcomes of winter planning are to ensure:

- That comprehensive, joined-up plans are in place in Midlothian Health and Social Care Partnership with established monitoring and escalation processes.
- The provision of high-quality services is maintained through periods of pressure.
- The impact of pressures on the levels of service, national targets and finance are effectively managed.

The Winter Plan will be a standing agenda item on the Senior Management Team (SMT) Business meeting. Levels of pressure in the system, progress against plans, and other issues will be monitored and escalated as necessary by a Winter Oversight Group, with a tactical Winter SMT group convening where necessary for any emergencies or when risk has been escalated.

REVIEW OF PREVIOUS WINTERS

Managers noted several key lessons from reviewing previous winters. Key themes are summarised below:

- Recruiting to vacancies as early as possible to account for delays in recruitment
- Planning for severe weather – arranging 4x4 access, preparing staff to work remotely, and changing work bases where possible
- Planning service cover/annual leave as early as possible
- Ensuring services are maintained throughout the festive period
- Recognition that additional workforce from last winter may not be available this winter – specifically, those staff who were redeployed during lockdown and were able to help other areas. Community/volunteer responses may be reduced also due to easing of Scottish Government Covid restrictions, but also workforce fatigue.

These lessons, paired with lessons from the pandemic, highlight the need to plan ahead and prepare for the worst to ensure that staff are safe and service delivery is maintained.

A review of progress against the winter 2020/21 plan showed positive performance during the winter period. Extra capacity was agreed in intermediate care teams as part of the winter funding allocation process; this provided extra Allied Health Professional (AHP) and Clinical Support Worker (CSW) staff, and the teams were able to facilitate more discharges and prevent more admissions than their averages before the winter period.

Staff sickness absence levels were lower in Midlothian HSCP compared to the overall rate for NHS Lothian for winter 2020/21, and to Midlothian's absence levels in the previous winter (2019/20). Informal staff feedback at the winter workshop felt that this could be a benefit of the increased flexibility in working patterns that have developed from the pandemic and could partially be due to staff feeling a 'need to be there' due to the importance of their work. This also raised the necessity to focus on staff wellbeing and the longer-term impacts on working throughout the pandemic on staff.

KEY PRIORITIES FOR ACTION IN 2021/2

Our key priorities for Winter 2021/22 are summarised below:

- Resilience – We will ensure our services are prepared for increased winter pressures, both in increased demand and reduced capacity due to staff absences, severe weather, etc.

- Patient Flow – We will maximise patient flow by increasing capacity in and streamlining intermediate care services, to reduce delayed discharges and hospital length of stay, and provide care as close to home as possible.

- Infection Control – We will ensure services are delivered safely and encourage maximum vaccination uptake in staff and patients.

- Impact & Inequalities – We will recognise and mitigate the negative impacts of winter and ongoing Covid on more vulnerable groups

- Communications – We will put a robust communications plan in place for both the public and staff so important and urgent messaging is shared with the right people at the right time.

- Workforce Mental Health & Wellbeing – We will support the mental health and wellbeing of our workforce.

- Monitoring and Escalation – We will put robust monitoring and escalation systems in place to review progress against the winter plans.

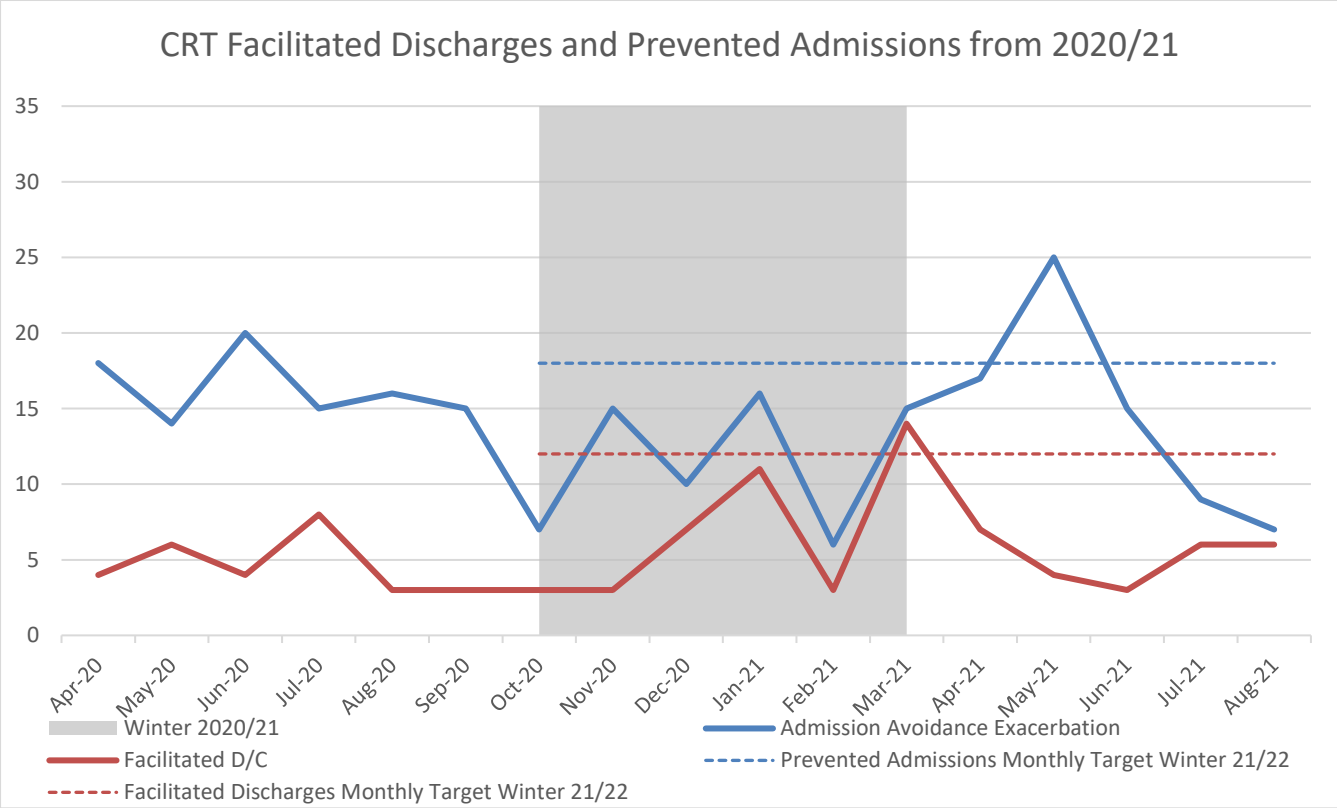
The table in **Appendix I** shows our high-level against these priorities. A detailed action plan will sit behind this with timescales and key performance indicators. This will be used to monitor progress against the winter plan and will be a live document. The below is only an indication of actions to prepare for winter.

For the purposes of this plan, the entire winter period is considered October 2021 – March 2022, to account for planning and preparation timescales and an increase in winter pressures before January.

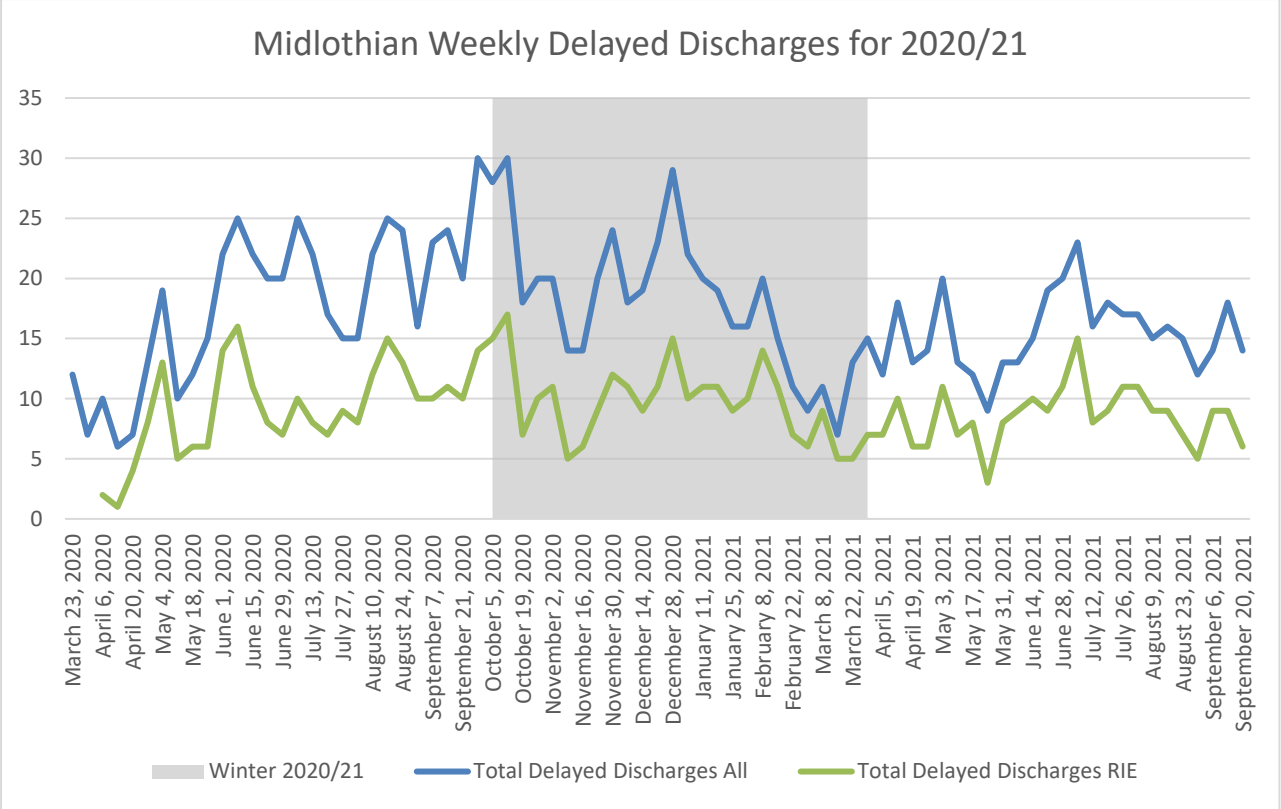
RESOURCED WINTER INITIATIVES

To support these key priorities, Midlothian HSCP is undertaking several winter initiatives, as outlined in **Appendix II** and summarised below:

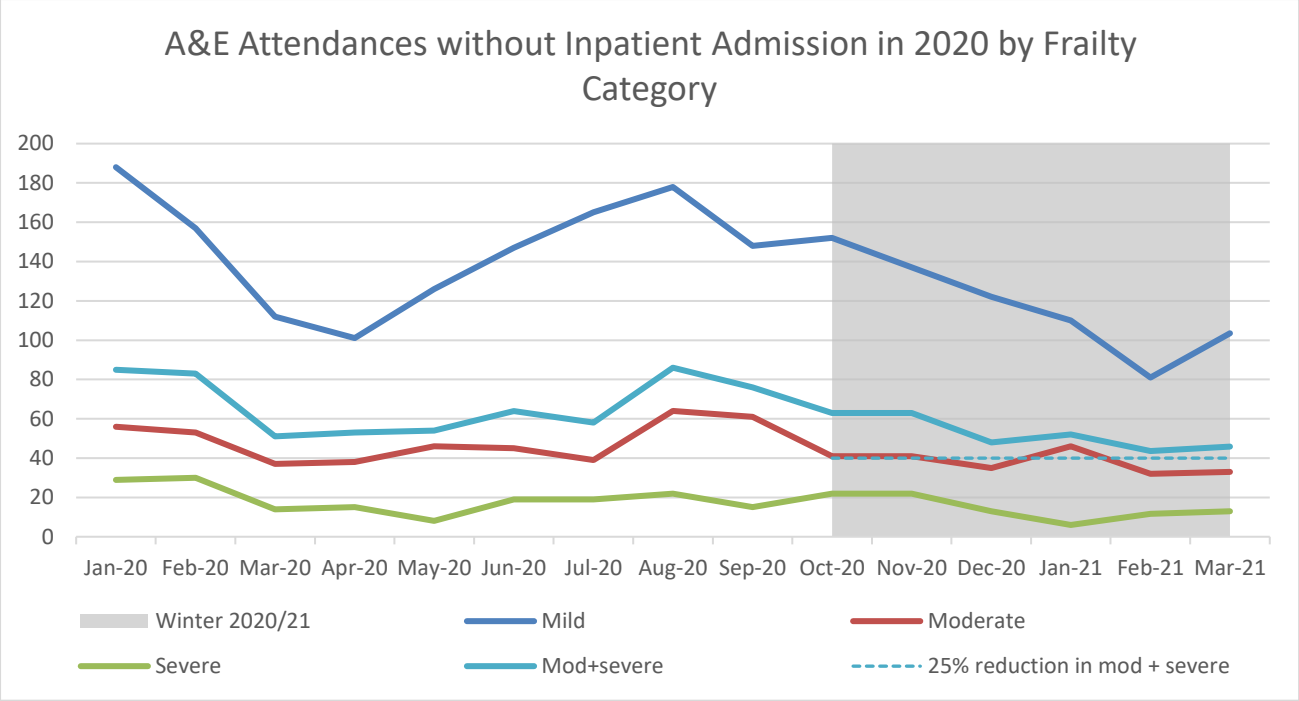
- NHS Lothian's winter funding process changed to provide a proportionate 12-month recurring funding award as opposed to the previous bidding process in place. Midlothian's allocation was £74,000, based on historical winter funding. This resource was prioritised for the Community Respiratory Team (CRT) to increase capacity to prevent admissions and facilitate earlier discharges for patients with respiratory conditions (excluding asthma). The chart below shows recorded facilitated discharges and prevented admissions by CRT from 2020/21.More information on this initiative and intended impact is in **Appendix II.**



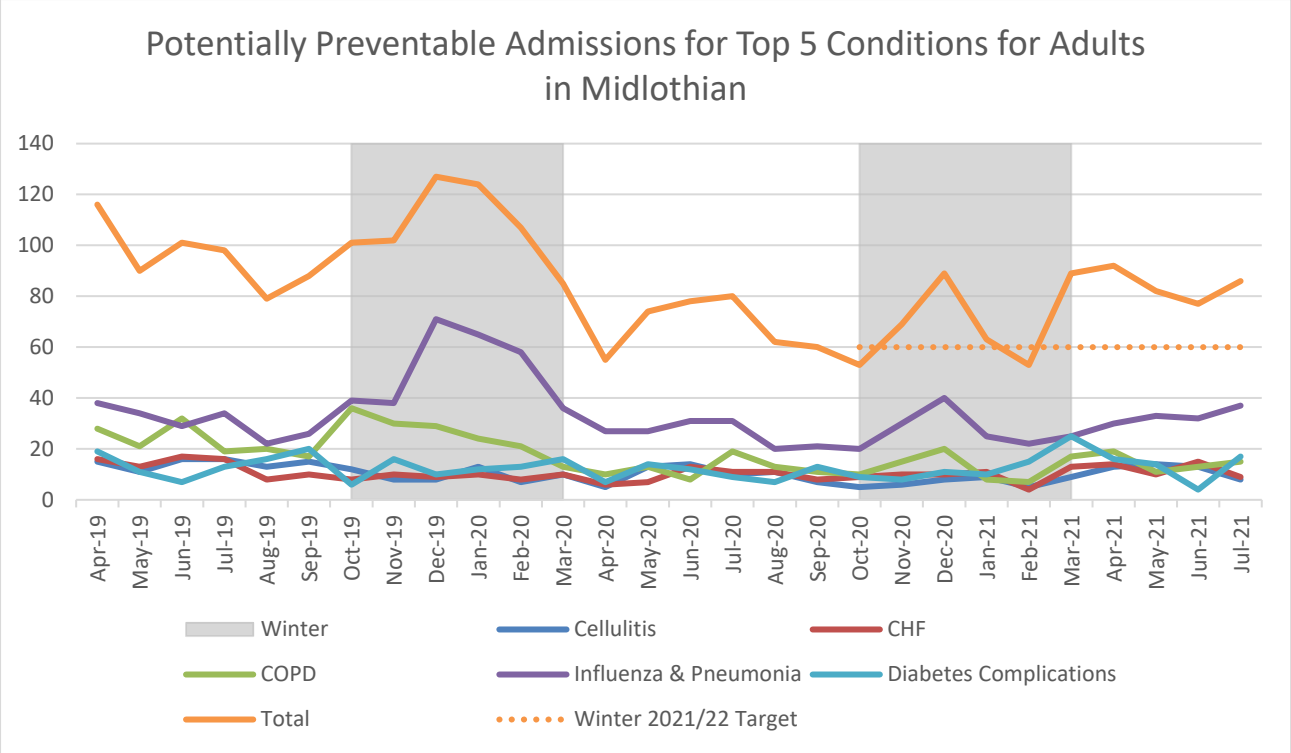
- The Integration Joint Board (IJB) and NHS Lothian Gold Command were supportive of funding an additional 20 Healthcare Support Workers (£756,000) to increase carer capacity in the Home First teams to reduce delayed discharges and length of stay in hospital for patients, providing more care to patients at home.
    - Additional funding (£40,000) is available from the British Red Cross for a Local Area Coordinator (LAC) who would work with the Home First team, and the Frailty LAC, to provide support for patients upon discharge from hospital to free up carer capacity and also provide crisis prevention in the form of aids and adaptations, falls alarm, transport, regular check-ins, and reducing social isolation.
- The graph below shows weekly Midlothian from 2020/21. The lighter green line represents delays from the Royal Infirmary of Edinburgh. More information on the intended impact of this initiative is in **Appendix II**.



- Plans are in place to re-assign internal resources to second an Occupational Therapist (OT) to work alongside the Frailty GP with a Winter Frailty Team approach in one practice population, extending the review to all patients with severe or moderate frailty attending A&E or discharged from an unplanned admission of under 24 hours. This will reduce A&E attendances and hospital admissions and readmissions. The chart below shows A&E attendance by frailty cohort for the 2020 calendar year where there was no inpatient admission. More information on the intended impact of this initiative is in **Appendix II**.

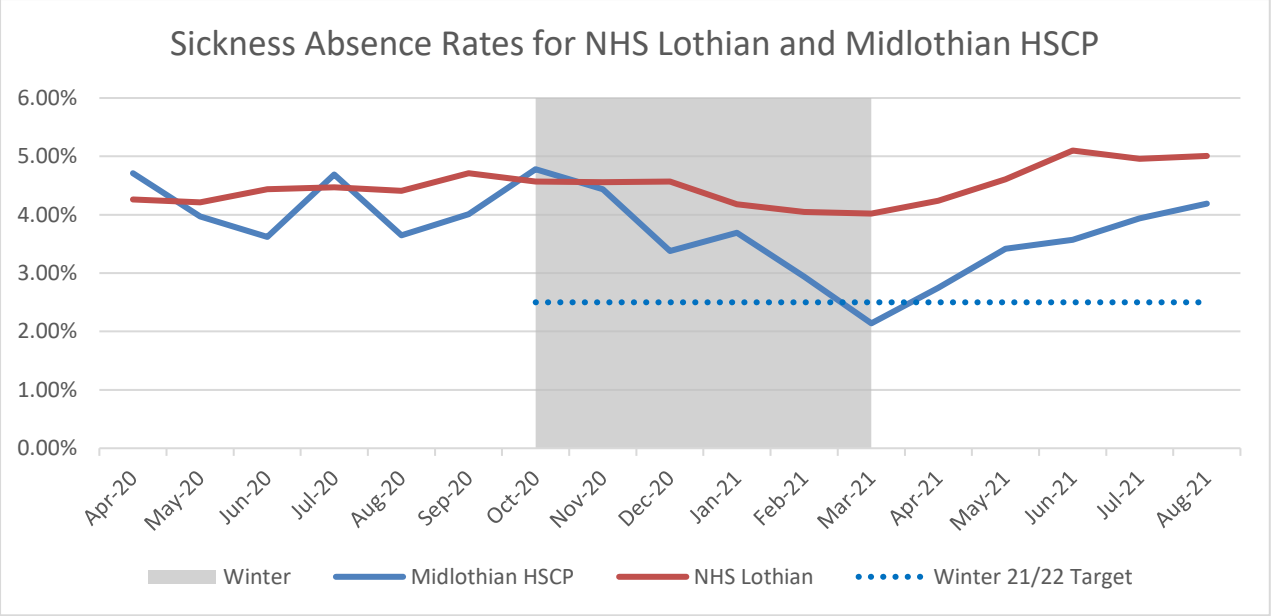


- The HSCP is undertaking a review of the top five potentially preventable admissions to the Royal Infirmary of Edinburgh, working with clinical and operational staff to put plans in place to reduce these admissions where clinically appropriate and offer local alternatives to care. The top 5 potentially preventable admission conditions for Midlothian are Cellulitis, Diabetes Complications, Influenza & Pneumonia, Congestive Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD). The graph below shows the number of potentially preventable admissions for adults in Midlothian for these conditions. More information on this initiative and its intended impact are in **Appendix II.**



- In addition to the above, the HSCP will deliver a comprehensive flu and Covid booster vaccination programme; this year, all vaccinations will be administered by the HSCP, with none will be delivered by General Practice. This was a requirement from the 2018 GP Contract and associated Memorandums of Understanding (MOU) that vaccination activity will transfer from General Practice from October 2021 (this has been revised in the recently published MOU which delays this transfer until April 2022). A synergistic approach to the delivery of Covid-19 and Flu vaccination will be pursued where appropriate to maximise uptake of both vaccines. Data will be used to determine any pockets of lower uptake in vaccination rates for targeted communication and pop-up clinics to encourage uptake. The programme aims to meet vaccination rate targets set by Scottish Government and reduce the number of potentially preventable flu and Covid-related hospital admissions, as well as community infection spread

- Finally, all services have submitted winter resilience and capacity maximisation plans. These are also summarised in **Appendix II.** Sickness absence rates for Midlothian HSCP were consistently lower than NHS Lothian's overall rates last winter. This lower level of sickness absence should be maintained due to service resilience planning in tandem with the focus on staff wellbeing. The graph below shows these figures in more detail.



MONITORING AND REVIEWING WINTER PLANS

Senior managers will hold a weekly winter meeting to monitor and assess progress against the winter plans. This will be used to escalate issues that arise during the peak winter period. This will feed into the fortnightly Senior Management Team meetings as a standing agenda item. The priority will be to monitor the levels of pressure in the system and the effectiveness of the winter plan, and identify further action as required.

Performance management and data will be a key part of these meetings. Agreed key performance indicators (KPIs) will be shared and monitored to pre-empt issues and track progress against service winter plans. It is expected that winter plans will impact Midlothian's hospital activity and therefore KPIs are focused on patient flow through hospitals. The aim is to reduce time spent in hospital or attending A&E by improving access to community services, providing care in the community where possible, and ensuring out community services are resilient through winter to provide the necessary capacity. These KPIs are summarised in **Appendix III** with previous figures for comparison against this winter.

Winter EMT membership is detailed in **Appendix IV**.

A winter readiness self-assessment checklist was completed for NHS Lothian and this is attached in **Appendix V**.

Appendix I: High-Level Action Plan

	Action Plan	Lead
1.0	***Resilience:*** *We will ensure our services are prepared for winter by:*	
1.1	Business continuity plans for all services will be reviewed and updated by 15/09/2021, which detail escalation processes and essential service provision in response to critical incidents such as another lockdown, major staff absence, or severe weather. This includes assurance on resilience planning from GP Practices.	L Friedman R King
1.2	Services will have resilience plans in place for their workforce by providing robust plans to account for staff absence and/or staff inability to travel due to severe weather	L Friedman R King
1.3	All services will have contingency plans for severe weather by providing robust plans for issues such as transporting staff, traveling to patients in the community, and delivering care to vulnerable patients. These will also link to Midlothian Council plans for accessing 4x4 vehicles when required to transport staff in severe weather.	L Friedman R King
1.4	Resilience plans for travelling in severe weather will also link with Midlothian Council for gritting roads and footways and clearing car parks for our identified priority areas through close working between council and health & social care colleagues. This includes prioritising the two mass vaccination sites at the Community Hospital and Gorebridge Leisure Centre.	L Friedman R King
1.5	All services will ensure sufficient capacity is in place over the festive period and to cover 7-day working where appropriate by agreeing staff cover and rotas and ensuring resilience plans are in place to deal with lockdown, severe weather, and/or unexpected staff absence during this period.	G Cowan N Clater
1.6	Clear communication and escalation channels will be put in place by instating a Winter Executive Management Group, with the ability to step this up in frequency and mobilise other channels of communication where required.	L Friedman R King
1.7	Individual services will prepare for major incidents by Red-Amber-Green (RAG) rating caseloads and prioritising per their resilience plans and updating this regularly	G Cowan N Clater
1.8	All staff will ensure individual resilience plans are in place that take into consideration risks such as car preparation, school closures, travel plans in severe weather, health & wellbeing, and general winter safety. These will be promoted by managers and team leads and through normal staff communication channels such as the Council website, social media, and all-staff emails.	G Cowan N Clater
1.9	Building upon the contribution of the third sector during the pandemic and working through the Care for People group to build resilience for service delivery, such as access to 4x4 vehicles and assistance with medicine and food delivery	N Clater
1.10	Developing HSCP workforce planning for redeployment and rapid induction training for carers to mitigate risks to staffing levels	A Fraser
2.0	***Patient Flow:*** *We will prevent admissions, reduce hospital length of stay, avoid delayed discharges, support patient flow, and build on the Home First approach as far as possible by:*	
2.1	Strengthening our intermediate care model and reducing delayed discharges, with continued rollout of Home First and proactive flow hub arrangements	G Cowan
2.2	Recruiting additional Healthcare Support Workers into the Discharge to Assess team	G Cowan
2.3	Continue to progress with increasing the bed capacity of Glenlee Ward in Midlothian Community Hospital	K Jack
2.4	Expanding the capacity of the Community Respiratory Team to account for increased respiratory-related hospital activity during winter	D Crerar
2.5	Implementing a Falls Prevention Plan through the Strategic Falls Group	G Chapman

2.6	Linking in with Royal Infirmary of Edinburgh winter plans and discharge planning	G Cowan
2.7	Strengthening the Hospital at Home service and bringing paramedics into the model to support clinical decision-making	G Cowan
2.8	Working alongside the national redesign of urgent care to redirect patients from acute hospital settings where appropriate to deliver care at home or in a community setting, including mental health pathways	G Cowan N Clater
2.9	Providing robust support to care homes through our Care Home Support Team	F Stratton M Reid
2.10	Undertaking intensive review and case management of patients over 75 years who frequently attend A&E	J Megaw
2.11	Continued investment in the frailty GP Mid-Med model for proactively supporting patients with frailty	J Megaw
3.0	***Infection Prevention and Control:*** *We will ensure our services are delivered safely by:*	
3.1	Standard infection control measures will be taken to address the requirements of the most common infections, for example, Norovirus, Clostridium difficile, Influenza, MRSA	F Stratton
3.2	Contingency plans are in place to minimise the impact of outbreaks of infection by complying with infection control audits and completing associated infection control action plans	F Stratton
3.3	PPE stock and supplies are managed with contingency plans in place should demand greatly increase to ensure supplies are available to safely deliver services	L Swadel
3.4	COVID-19 Health Protection Scotland and Scottish Government guidance is followed ensuring defined patient pathways	F Stratton
3.5	Accessible and timely COVID-19 testing pathways should be available to all who require a test in line with the national Testing Strategy	R King
3.6	Implement an effective immunisation programme against seasonal influenza and follow Scottish Government guidance for the continued rollout of the Covid-19 vaccination programme. This includes encouragement of high staff uptake across the HSCP.	J Megaw
4.0	***Impact & Inequalities:*** *We will mitigate the impact of winter on vulnerable groups by:*	
4.1	Recognising that COVID-19 and winter has and will continue to detrimentally impact certain groups of people – not only older people and those with underlying health conditions but also those who are vulnerable simply because they do not have the resources and opportunities to stay well	All
4.2	Services will carry out integrated impact assessments where necessary	G Cowan N Clater
4.3	Investigate options to support older people through winter to regain confidence, combat social isolation, and increase activity.	G Cowan C Evans
4.4	Midlothian's Public Health team will contribute to the winter plan, focusing on the things that keep people well during winter. For example, reducing fuel poverty and financial and food insecurity, increasing good physical and mental health, reducing loneliness, increasing community resilience, and increasing the number of people vaccinated for Covid-19 from population groups who face unjust, unfair, and avoidable differences.	R Hilton
4.5	Piloting green prescribing to promote physical and mental health as forms of prevention and alternatives to care in acute and primary care settings	T McLeod
4.6	Promote community resources and services available to support staff and the people they care for regularly via communication channels	W Fleming
4.7	Working through the Care for People group to mobilise support for people in the community through volunteers, the third sector, and other partners	N Clater

5.0	***Communications:*** *We will ensure a robust staff and public communications plan by:*	
5.1	A clear communications plan with the public will be established by sharing timely and relevant information through channels such as social media, the Council website, general practice websites, and a winter Older People's newsletter. This will require close working between and contributions from the communications team, planning groups, the Strategic Falls Lead, and all other services.	W Fleming
5.2	A clear communications plan with staff will also be established by utilising various staff communication channels to share important updates, good news stories, promotion of staff wellbeing activities and initiatives, and other winter-specific information around falls, travel, car safety, etc.	W Fleming
5.3	The all-staff distribution list for the HSCP will be kept up to date to ensure people receive communications.	L Friedman
5.4	Publishing the Midlothian HSCP public website	C Shilton
5.5	A major vaccination campaign and communications plan will be undertaken to promote vaccination uptake	W Fleming J Megaw
6.0	***Wellbeing:*** *We will support the mental health and wellbeing of our workforce by:*	
6.1	Appointing a staff wellbeing lead (due to commence in September 2021) who will engage and consult with front line services to ensure a range of options and opportunities are available for staff to access support and development to enable them to continue with their role	A Fraser W Armitage
6.2	Ensuring the staff wellbeing group meets the actions and directions from the evaluation of the staff wellbeing survey	A Fraser W Armitage
7.0	***Monitoring & Escalation:*** *We will monitor progress against the winter plan by:*	
7.1	Risks will be escalated, and progress monitored through reporting by exception via an established Winter Executive Management Group.	L Friedman R King
7.2	Progress against the plan will be monitored and reported via the Senior Management Team fortnightly meetings	L Friedman R King
7.3	Develop a winter dashboard with agreed key performance indicators, metrics, and targets for tracking progress against plans	J Megaw

APPENDIX II: RESOURCED WINTER INITIATIVES & SERVICE-LEVEL PLANS

Service	**1. COMMUNITY RESPIRATORY TEAM (CRT)**		
The Midlothian Community Respiratory Team was initially funded to provide respiratory support to patients with a diagnosis of COPD only. The aim of the team being to prevent unnecessary hospital admission, facilitate earlier appropriate discharge from hospital where an admission was unavoidable and provide community respiratory support to reduce the burden of COPD on Primary and Secondary care. Throughout Covid 19, with additional funding, the team have expanded where possible to include a CRT+ service and take on patients with additional respiratory diagnoses where capacity allows. There is still a cohort of patients not known to CRT in the community, so referrals continue to increase and in turn this increases the number of patients who can self-refer back into the service over time. There is a concern that without additional funding, the team will not be in a position to meet the anticipated respiratory demand beyond COPD over the winter period. This is a particular priority over a period where the prevalence of respiratory conditions increases and the likelihood of another Covid 19 winter remains high. Confidence in the vaccine will allow for more socialisation and a return to more normal activities, which may result in increased exacerbation rates.			
Additional Capacity	Cost	Funding Source	Risk
1 WTE B7 APP 0.2 WTE B5 Dietitian	*£63468* *£8656* *Total £72,124*	*NHS Lothian Winter Funding*	**MED** Risk of delay in recruitment which will reduce the ability to meet projected impact. Risk of internal recruitment may further delay intended impact.
Intended Impact			
Reduction in Midlothian Scottish Ambulance Service call outs, A&E attendances, hospital admissions and length of stay for respiratory conditions (excluding asthma). Increase in patient confidence and self-efficacy with managing respiratory symptoms in the patients' own home. This additional capacity increases the existing capacity by 50%. Therefore we expect a 50% increase in facilitated discharges and prevented admissions over the 6-month winter period compared to last winter's baseline capacity. During Winter 2020/21, between October-March, the CRT team facilitated 49 discharges and prevented 71 admissions to hospital. A 50% increase for Winter 2021/22 equates to 73 facilitated discharges/294 bed days saved, and 106 admissions prevented/639 bed days saved over the 6-month period. We will continue to monitor caseload numbers and bed days saved for both admission prevention and facilitated discharge work. We will also monitor the impact on primary care, by measuring GP hours saved.			
Key Performance Indicators for monitoring			
Prevented Admissions Facilitated Discharges Bed Days Saved CRT Contacts Respiratory-related admissions and A&E attendances GP Hours Saved			

Service	2. OLDER PEOPLE'S SERVICES		
Frailty drives unscheduled hospital activity. ED attendance by the severely frail cohort is a predicter for future ED attendance and/or admission (50% of ED attendance from cohort will have a further ED attendance in following 6/12). The health and care system does not reliably assess an ED attendance or short admission associated with frailty with intention of preventing future hospital activity. The focus of this investment would be prevention of frailty presentations and unscheduled frailty admissions along with reducing the length of stay by having a Mid Care Model to address unmet clinical and social needs			
Additional Capacity	Cost	Funding Source	Risk
1 Frailty GP 1 B7 OT	None – Existing Resource	*Existing HSCP resource*	**LOW** Capacity already resourced and agreed
Intended Impact			
We plan to use the Mid Med Model for intensive assessment and support within the community for one practice population. Further investment of an additional Band 7 Occupational Therapist will allow multidisciplinary proactive review of all ED attendance in cohort prioritised using SPARRA (Scottish Patients at Risk of Readmission and Admission) The value this post will add is proactively following-up all moderately and severely frail patients who either attended ED but were not admitted or were discharge with an unplanned admission of under 24 hours. These patients are likely to be known to practice GPs, who the team will work closely with to identify those patients who would most benefit from review. This model can also be extended to the severe cohort with high SPARRA. A combination of clinical-note review and patient assessment using the Winter Frailty Team approach will identify and address unmet clinical and social needs. This will be used to inform pathway development and relationships between services. Reduction in A&E attendances by frequent attenders Reducing in hospital admissions and A&E attendances by those with severe frailty. 50% of ED attendance from frailty cohort will have a further ED attendance in following 6 months. Aim to reduce this to 25%. Currently weekly average of: 22 severely frail unscheduled admissions, 5 severely frail 28-day readmissions, 7 A&E attendances. Aim to reduce these by 25%.			
Key Performance Indicators for monitoring			
A&E attendances, including for frequent attender cohort and those with frailty Hospital admissions, including those with frailty Readmission rate for those with frailty Anticipatory Care Plan Quality			

Service	3. HOME FIRST		
Despite the significant amount of development work under Home First, care capacity issues remain the main reason for blockage in flow for Midlothian patients delayed in hospital beds. Delays for packages of care from our Internal service and External providers, over the summer period, have prevented the improvements expected. Whilst the delays performance in Midlothian remains improved on previous years, the additional demand anticipated on the system over winter, remains a concern. Recruiting additional Healthcare Support Workers (HCSWs) will increase carer capacity in the Home First team. Additional funding is available from the British Red Cross for a Local Area Coordinator (LAC) who could be embedded within the Home First team, and provide support to patients upon discharge from hospital in the form of aids and adaptations, falls alarms, transport, and reducing social isolation – all forms of crisis prevention. They would work closely with the frailty local area coordinator to support those living with frailty who may already be known to the service.			
Additional Capacity	Cost	Funding Source	Risk
20 WTE HCSWs 1 Local Area Coordinator	£756,000 £40,000	*MIJB and NHS Lothian Gold Command* *British Red Cross*	**MED** Risk of delay in recruitment which will reduce the ability to meet projected impact. Risk of bottlenecks in system waiting on longer packages of care in the community.
Intended Impact			
Reduction in delayed discharges Currently Discharge to Assess team consistently bridging in 14-22 packages of care per week. 13 census delayed discharges in August 2021. Intent to move all hospital discharges through Discharge to Assess. This increased carer capacity will allow for more throughput out of hospital. The additional HCSWs should be able to provide care for 32 more patients per week at home, reducing social delays The local area coordinator would have capacity for a caseload of 30 patients. This should lead to a reduction in waiting times for aids and adaptations (driven by local area coordinator), and a reduction in social admissions and re-admissions (crisis prevention from support local area coordinator)			
Key Performance Indicators for monitoring			
Delayed Discharges Hospital Length of Stay Packages of care Waiting times Hospital admissions and re-admissions			

Service	4. POTENTIALL PREVENTABLE ADMISSIONS		
Public Health Scotland publishes data on Potentially Preventable Admissions (PPAs) which are 19 identified conditions which result from medical problems that may be avoidable with the application of public health measures and/or timely and effective treatment, usually delivered in the community. A working group was established in Midlothian HSCP to undertake an intensive review of these admissions and progress a targeted action plan. The identified top 5 PPAs for Midlothian residents in 2020/21 were Cellulitis, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Diabetes Complications, and Influenza & Pneumonia.			
Additional Capacity	Cost	Funding Source	Risk
None	None	*Existing HSCP Resource*	**MED** Risk of delays in making any service changes or improvements Interdependencies with acute teams who may be under other pressures
Intended Impact			
Reduction in potentially preventable admissions for top 5 identified conditions. Monthly average of 69 PPAs for top 5 conditions in winter 2020/21; aim to reduce this by 10% for average of 60 PPAs per month. Reduction in occupied bed days for conditions. These are wide ranging as monthly bed days for Influenza/Pneumonia are close to 500 while closer to 75 for Cellulitis. A 25% reduction in overall averages would take bed days down from 200 monthly to 125 monthly. Increased local options for care and chronic disease management.			
Key Performance Indicators for monitoring			
Admissions for top 5 conditions A&E attendances and other related episodes of care Length of stay for top 5 conditions Access to community treatment and support			

Service	5. ALL HSCP SERVICES

All HSCP services are considering their resilience planning and looking at different ways of working for winter to maximise capacity and maintain service delivery. This includes:

- Workforce resilience for staff absence
- Festive Period and 7-day cover
- Severe weather resilience planning
- Staff transport, getting to patients, travel time, staff and patient safety, Red-Amber-Green rating patients, changing work bases, etc.
- Flu and Covid vaccination staff uptake
- Reduced face-to-face/use of telephone and Near Me
- Recruiting to establishment/vacancies
- Remobilisation of services previously closed or reduced during lockdown

Additional Capacity	Cost	Funding Source	Risk
See details below	None – Existing Resource	*Existing HSCP resource*	**MED** All services will complete their resilience plans Risk of significantly severe weather or significantly high sickness absence levels Risk with recruitment delays for recruiting to vacancies

Intended Impact

All services to have resilience plans in place to maximise capacity and maintain service delivery throughout winter and festive period where required
Services will be prepared to deliver services remotely where possible
Services will move staff bases around where possible in severe weather
Reduction in staff sickness absence levels. Maintain 2.5% levels of sickness absence (lowest levels in Winter 2020/21).

Key Performance Indicators for monitoring

Staff sickness absences
Establishment/vacancy gaps
Activity over weekends and festive periods
Hospital activity impacted by capacity in community

Service-specific plans (in addition to the above resilience planning which applies to ALL)

Service	***Initiatives (additional to resilience planning)***
Community Respiratory Team	- Upskilling Band 3 and 4s for managing anxious patients and encouraging self-management - Increased capacity (see appendix I) will increase prevented admissions and facilitated discharges - Optimisation work to reduce GP time - Improving quality of anticipatory care planning - Take on patients with other respiratory conditions beyond COPD
Home First and Single Point of Access	- Additional HCSWs to support Discharge to Assess Team (D2A) (see appendix I) - All hospital discharges to go to D2A - Reablement OTs to move to Home First - British Red Cross local area coordinator supporting people after discharge - aids and adaptations, etc.

	- Upskilling Band 3, Band 4s, and Community Care Assistants to see more routine return patients - Daily huddles to discuss capacity; second huddle if required - Work with MCPRT (Midlothian Community Physical Rehabilitation Team) to maximise capacity, reduce waits for slow stream rehab, and prevent deterioration - Increased focus on discharging direct from ED and AMU and strengthening these links - Admission prevention work with Rapid Response team having access to packages of care - SPOA return to 7/7 working when staffing in place
Older People and Frailty	- Intensive review of those with frailty attending A&E or discharged from hospital within 24 hours (see appendix I) - Review and management of top 10 frequent attenders to A&E over 75 years - Local Area Coordinator from British Red Cross supporting people in the community with frailty
Care at Home	- Streamlining of roles and responsibilities to free up capacity - Dedicated schedulers to focus on efficiency of service - Use of CM2000 for accurate and live data - Review of referral process into the service to reduce delays
Hospital at Home	- Looking at adding paramedics to model for clinical decision-making and 7-day working - Move to dependency-level capacity - Change of TRAK structure to increase maximum bed capacity - Working with pan-Lothian review of Hospital at Home model
MCH	- Daily monitoring of staffing levels - Review of admission criteria to support flow hub - SOP for escalation of shifts to Agency - Increasing capacity to manage increased demand and complexity
District Nursing	- Increasing capacity to manage increased demand and complexity - Agreement to add Advanced Nurse Practitioners into District Nursing service to facilitate faster access to treatment and release workload from GPs
Care Home Support Team	- Daily calls to all care homes and minimum weekly support visits - Increased capacity since team was established from 5 WTE to 10 WTE and to include Occupational Therapist for referrals - Quality Improvement Projects - Restore2, Anticipatory Care Planning - to increase timely assessment and care - Nurse Practitioner secondment to review and support post-hospital discharged residents and those with soft signs of deterioration
Mental Health & Substance Misuse	- Redesign of Urgent Care pathways - Midlothian Intensive Home Treatment Team redesign for same day access for crisis/distress - Delivering Distress Brief Intervention - Substance Misuse has recommenced drop-in clinic - Outreach nurse to Homeless accommodation for high-risk, hard to reach cohorts
Primary Care & Vaccinations	- CTAC (Community Treatment and Care) model still in pathfinder stage and looking at models of service delivery to be established by April 2022

	- Vaccination programme following Scottish Government guidelines for both flu and Covid boosters. Expanded flu cohorts this year. Synergistic approach where applicable to deliver both vaccines at once. Two mass vaccination sites plus Penicuik clinics to account for geographical challenges. - Monitoring weekly vaccination uptake to identify pockets of lower uptake for targeted communications and pop-ups - GP practices updating business continuity and resilience plans
Pharmacy	- Band 5 Pharmacy Hub Technicians - Flexible workload planning in spring/summer in preparation for winter pressures - Recruiting additional 7.2 WTE Pharmacists
Falls	- Integrated Falls Pathway Development - Improved onward referrals from Scottish Ambulance Service callouts - Joint working with Midlothian Council Roads Team for gritting/clearing of key HSCP facilities - Winter falls prevention communication campaign
Community Justice	- Route Map phased plan - New Unpaid Work Supervisor to assist with backlog in Unpaid Work Hours - Considering 0 hours contracts for unpaid work to increase flexibility - Spring and Stride groups restarted in space with extra capacity - 3 temporary contract social workers to assist with workload
Sport & Leisure	- In-house qualification courses and casual staff recruitment to deliver operations - Remobilisation of leisure centres closed previously - Flexible staff working e.g., when Snowsports Centre closes due to adverse weather
Disabilities	- Working with commissioned services for continuity planning - Working from home protocols for fieldwork staff - Flexible redeployment of staff when services are cancelled/reduced
MSK	- Upskilling Band 4 staff to support routine orthopaedic patients, freeing up capacity in the team - Improving patient journey/process from booking to first appointment
Dietetics	- Digitalised group services now in place - Over establish within budget for acute inpatient priority - Create ‘Lothian Flexible Crew’ by orientating and upskilling staff - Working with home Enteral nutrition supplier for resilience planning
PPE Hub	- Buffer stock to be ordered
Workforce Planning	- Wellbeing Lead appointed - Progressing actions from staff wellbeing survey - Directions for services with identified 'hard to fill' posts - Additional SVQ assessor posts to meet demand - Additional Learning & Development Asst. to improve access to training - Rapid induction training for care at home staff to mitigate risks of winter pressures

APPENDIX III: KEY PERFORMANCE INDICATORS

Key Performance Indicator	Previous figures (Winter Oct 2020-Mar 2021)
A&E Attendances (Incl. falls and frailty)	8443 A&E arrivals to RIE (1407 monthly, 351 weekly) 395 A&E attendances for falls (66 monthly, 16 weekly) 28 severely frail people attending A&E monthly 20 severely frail people discharged following unplanned admission within 24 hours 50% of frailty cohort attending A&E will have a further A&E attendance in following 6 months
Hospital admissions	22742 Unplanned TRAK Admissions (3790 monthly, 947 weekly) 129,026 OBDs (21504 monthly, 5376 weekly) 354 falls-related admissions (59 monthly, 15 weekly)
Delayed discharges	Average Daily Census Delays from RIE: Dec 2020: 12 Jan 2021: 13 Feb 2021: 8 Mar 2021: 8
MCH Ward and Hospital at Home - admissions, discharges, length of stay	MCH Average 25 admissions per month Hospital at Home average 39.5 admissions per month
Care at Home requested hours*	**Ongoing work within the service to streamline performance reporting. These figures may change.* 1075.8 total hours requested as of 23/08/21. Average 13 referrals per week in previous winter
CRT activity - prevented admissions, facilitated discharges, exacerbation management	71 prevented admissions 49 discharges 139 self-managed exacerbations
Staff sickness absence rates	3.56% average

APPENDIX IV: Winter EMT Membership

Name	Role
Morag Barrow	*Director*
Grace Cowan	*Head of Older People's Services & Primary Care*
Nick Clater	*Head of Adult Services*
Fiona Stratton	*Chief Nurse*
Hamish Reid	*Clinical Director*
Mairi Simpson	*Integration Manager*
Jamie Megaw	*Strategic Programme Manager*
Roxanne King	*Business Manager*
Leah Friedman	*Business Manager*

APPENDIX V: WINTER READINESS SELF-ASSESSMENT FOR NHS LOTHIAN

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

Priorities

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

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

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

The checklists also include other areas of relevance but are not exhaustive. Local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

NHS National Boards should support local health and social care systems to develop their winter plans as appropriate.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups can use these checklists to self-assess the quality of overall winter preparations and to identify where further action may be required. This should link to the guidance available for continual provision of service available on the associated web links highlighted on the accompanying paper.

- The following RAG status definitions are offered as a guide to help you evaluate the status of your overall winter preparedness.

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

1	Resilience Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action /Comments
1	NHS Board and Health and Social Care Partnerships (HSCPs) have clearly identified all potential disruptive risks to service delivery and have developed robust Business Continuity (BC) plans to mitigate these risks. Specific risks include the impact of Respiratory Infections (e.g. Covid, RSV, Seasonal Flu) on service capacity, severe weather and staff absence. Business continuity arrangements have built on lessons identified from previous events, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter preparedness to ensure that business continuity management principles are embedded in Remobilisation / Annual Operating Plans as part of all-year-round capacity and service continuity planning *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details.* This guidance Preparing for Emergencies Guidance*sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☒ ☒		All services updating service resilience plans and additional winter-specific resilience planning by 13/09. Winter operational briefing with services was held on 30/08 to review previous winter experiences and go over resilience planning requirements. Baseline capacity will be monitored to evaluate services' resilience planning.
2	BC plans take into account all critical activities across the NHS Board / HSCPs spectrum of activity and include analysis of the risks of disruption and their actual effects and demonstrate that planning has been based upon the likelihood and impact of worst case scenarios. Risk assessments take into account staff absences including those likely to be caused by a range of scenarios and are linked to a business impact analysis to ensure that essential staff are in place to maintain key services. All critical activities and actions required to maintain them are included on the corporate risk register and are actively monitored by the risk owner. The Health Board and HSC partnership have robust arrangements in place to support mutual aid between local / regional partners in respect of the risks and impacts identified	☒ ☒ ☒		As above All services completing resilience plans to maintain baseline capacity, taking into account staff sickness absence. Planning for annual leave to ensure service deliver is maintained over winter period.
3	The NHS Board and HSCPs have appropriate policies in place to cover issues such as : • what staff should do in the event of severe weather or other issues hindering access to work, and • arrangements to effectively communicate information on appropriate travel and other advice to staff and patients	☒		Working with Midlothian Council teams and local voluntary groups for access to transport in severe weather. Service level agreement

	• how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*			has been updated and SOP for accessing 4x4s is being produced. Individual services are maintaining lists of staff who can drive other staff. Services also prepared for staff to work from home or change work base as required.
4	NHS Board/HSCPs websites will be used to advise patients on any changes to service access arrangements or cancellations of clinics / outpatient services due to severe weather, reduced staffing levels etc,	☒		Communications via social media and website. All staff communication mechanisms for the HSCP are in place. Process for any emergency/urgent comms in place and draft scheduled comms plan including holiday closures being developed.
6	The NHS Board, HSCPs and relevant local authorities have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☒		Midlothian Council have developed plans for this

2	Unscheduled / Elective Care Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity and visibility of other key performance indicators *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☒		Winter EMT established and meeting weekly w/c 13/09 as avenue for escalation and dissemination of information; performance monitoring is a key part of this Daily huddles for intermediate care services and delayed discharges All staff communication channels established Monthly IJB Brief commencing 07/10 to include winter information
1.2	Effective communication protocols are in place between clinical departments and senior managers across the whole system, to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked with key actions and timescales assigned to individuals.	☒		As above Involved with NHS Lothian Gold Command and local authority Gold when initiatied
1.3	A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU.	☐		N/A

	This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact. *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care, with PDDs (planned dates of discharge) visible and worked towards, to ensure patients are discharged withouth delay.*			
1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☒		Full HSCP strategic winter plan by 18/09 to cover capacity and workforce, substantiated by robust action plan. Going to IJB in October.
2	**Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID-19 activity (both short and medium-term) based on forecast emergency and elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *Weekly projections for COVID demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity.* *Plans in place for the delivery of safe and segregated COVID-19 care at all times.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This*	☒		Building performance monitoring and KPIs to be regularly reported to weekly winter EMT, looking for risks/bottlenecks in delays, beds, capacity, demand, etc. relating to HSCP community performance

	requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period. *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID-19 surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*			
2.2	Pre-planning created pathways which provide an alternative to admission, and optimised the use of inpatient capacity for the delivery of emergency and elective treatment, including identification of winter / COVID-19 surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work. *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution.* *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.* *Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical prioritisation and planning assumptions*	☐		N/A
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.**			

3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☒	■	Winter operational briefing with service managers on 30/08 as reminder for holiday cover. Resilience planning templates to be completed by 13/09. All services to have holiday cover plans by 01/10.
3.2	Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services.	☒	■	As above Services planning/approving annual leave currently for winter period.
3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*	☐		Working with NHS Lothian within their Cat. 1 responder responsibilities
3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*	☒	■	Communications plan in place to disseminate information and emergency comms process in place.
	Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of hospital associated infection and crowded Emergency Departments.	☒	■	Representation on NHS Lothian Unscheduled Care Programme Board Local planning in place to support key pathways

	Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.			Continued development of Home First models and pathways
	To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate. Referrals to the flow centre will come from: • NHS 24 • GPs and Primary and community care • SAS • A range of other community healthcare professionals. If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide viable appointments / timeslots at A&E services. The impact on health-inequalities and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.	☒	■	As above Representation on RUC Project Board Working with acute, primary care, and flow centre colleagues to build professional to professional pathways to Midlothian's Single Point of Access
	Professional to professional advice and onward referral services should be optimised where required Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission.	☒	■	As above. Single Point of Access now in place CRT/SAS pathway established to avoid admissions

				Funding secured to develop pathway with paramedics within Hospital at Home
4	**Optimise patient flow by proactively managing Discharge Process utilising PDD (Planned Date of Discharge) and associated discharge planning tools such as – Daily Dynamic Discharge, to shift the discharge curve to the left and optimise in day capacity,and ensure same rates of discharge over the weekend and public holiday as weekday.**			
4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☒	■	Daily delayed discharge calls to discuss plans Enhancement of Home First Model 7-day operation of Single Point of Access and Flow Hub Recruitment of additional HCSWs into D2A to move delays out of RIE Investment in Frailty GP project from HSCP Additional OT working with frailty GP to review A&E attendances of those with severe/moderate frailty Intensive assessment of top 10 frequent attenders to A&E over 75

				Enhanced services from British Red Cross to support discharge Improving anticipatory care planning Plans in development for top 5 potentially preventable admissions Delays part of performance monitoring system built into weekly EMT tracking
4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate. *Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.*	☒		Home First, Flow Hub, and SPOA now covering 7 days per week.
4.3	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*	☐		N/A
4.4	Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services	☒		As above

	should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre-Christmas discharge *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*			HSCP Pharmacy recruiting to vacancies to increase capacity for winter surge Recruitment for additional D2A capacity commencing (risk in any recruitment delays)
5	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			
5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.* *Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☒	🟨	Workforce issues relating to Covid currently impacting significantly on availability of packages of care across the system. Plans in place to review current processes and systems to free up additional capacity. Use of RAG risk assessment for all clients when required. Recruitment of additional 20 HCSWs to support care for our Home First team. Working within Scottish Government guidance. Regular status communication to local authority and NHS Lothian Gold Command in line with other partnerships.
5.2	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible. *Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*	☒	🟩	These processes are in place

	All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible			
5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*	☒		Process in place for SAS/acute services to view this information if developed by the practices
5.4	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.*	☒		ACPs in place for care homes. Specific focus on frail patients who have them as part of innovation models currently in place.
5.5	COVID-19 Regional Hubs fully operational by end November. Additional lab capacity in place through partner nodes and commercial partners by November. Turnaround times for processing tests results within 24/48 hours.			**N/A**
6.0	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
6.1	Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector and into the Scottish Government. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.*	☒		Work with communications teams in NHS Lothian and Midlothian Council around key messaging

	Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.			
6.2	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around direction to the appropriate service are effectively communicated to the public.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*	☒		Working with NHS Lothian and Midlothian Council communications team that uses all available media to communicate with staff and public HSCP Public website will be launched 09/09/21 Winter communication plan in place to disseminate information

3	**Out of Hours Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays. *This should include an agreed escalation process.* *Have you considered local processes with NHS 24 on providing pre-prioritised calls during OOH periods?*	☐		Assumption that this section relates to Lothian Unscheduled Care Services, not Midlothian HSCP. Midlothian HSCP will ensure key services are working over the festive period and will work with LUCS for OOH pathways.

2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☐		N/A
3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☐		N/A
4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*	☐		N/A
5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☐		N/A
6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa	☐		N/A
7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☐		N/A
8	Ensure there is reference to provision of dental services, that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☐		N/A
9	The plan displays a confidence that staff will be available to work the planned rotas.	☐		N/A

	While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.			
10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☐		N/A
11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☐		N/A
12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☐		N/A
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☐		N/A
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☐		N/A
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic flu and other emergency plans, including provision for an escalation plan.	☐		N/A

	The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.			

4	Prepare for & Implement Norovirus Outbreak Control Measures *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☒		In place
2	IPCTs and HPTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their IPCTs and Health Protection Teams (HPTs) are supported to undertake the advance planning to ensure that Norovirus outbreaks in hospitals and care homes are identified and acted upon swiftly. Boards should ensure that there are sufficient resources to provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*	☐		N/A
3	PHS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff	☒		In place
4	How are NHS Board communications regarding bed pressures, ward closures, kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☒		Communication in real time via flow hubs regarding bed capacity.

5	Debriefs will be provided following significant outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☒	■	Business as usual within clinical areas
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker.	☐		N/A
7	Are there systems in place that would ensure appropriate patient placement, patient admission and environmental decontamination post discharge in ED and assessment areas	☐		N/A
8	NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.*	☐		N/A
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple bays / wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☐		N/A
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.	☐		N/A

11	Are there systems in place to deploy norovirus publicity materials information internally and locally as appropriate,	☒	■	In Place
12	Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of COVID-19.	☒	■	Will communicate any NHS Lothian communications from the Directorate through all available channels to our community

5	**COVID -19, RSV, Seasonal Flu, Staff Protection & Outbreak Resourcing** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	Staff, particularly those working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients and other staff, as recommended in the CMOs seasonal flu vaccination letter published on Adult flu immunisation programme 2021/22 (scot.nhs.uk) and Scottish childhood and school flu immunisation programme 2021/22 . Further CMO letters will be issued before the flu season begins to provide further details on aspects of the programme, including the marketing campaign and details of education resources for staff administering vaccinations.	☒		Planning assumptions in place but awaiting final guidance form Scottish Government to finalise plans for flu and Covid-19 vaccination programmes for staff and patient cohorts.
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake. Vaccine uptake will be monitored weekly by performance & delivery division*	☒		Planning assumptions to tun two mass vaccination sites operating 6 days a week with extended hours for staff to attend, but awaiting final Scottish Government guidance Care home staff will be vaccinated in care homes

3	The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. SG procures additional stocks of flu vaccine which is added to the stocks that Health Boards receive throughout the season, which they can draw down, if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals co-ordinated and issued by the Vaccinations Strategy Division.)*	☒		Midlothian HSCP Winter Plan to be finalised and agreed by Senior Management Team 15/09
4	PHS weekly updates, showing the current epidemiological picture on COVID-19, RSV and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Public Health Scotland and the Vaccinations Strategy Division within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.*	☒		Weekly Winter EMT will monitor PHS updates Midlothian Public Health Team involvement
5	Adequate resources are in place to manage potential outbreaks of COVID-19, RSV and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☒		Outbreaks managed under Public Health processes

6	Ensure that sufficient numbers of staff from high risk areas where aerosol generating procedures are likely to be undertaken such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) are fully aware of all IPC policies and guidance, FFP3 fit-tested and trained in the use of PPE for the safe management of suspected COVID-19, RSV and flu cases and that this training is up-to-date. ***Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's 'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013). https://www.hse.gov.uk/pUbns/priced/hsg53.pdf***	☒	■	HPS guidance in place at all times Local PPE Hub established with processes in place Staff communications of guidance continue to be in place
7	Staff in specialist cancer & treatment wards, long stay care of the elderly and mental health (long stay) will also will be required to continue to undertake asymptomatic weekly testing for COVID-19 throughout this period. We are actively reviewing the current asymptomatic Healthcare Worker testing Operational Definitions to ensure they are still fit for purpose.	☒	■	Staff testing in place at Midlothian Community Hospital and monitored

8	Ensure continued support for care home staff asymptomatic LFD and PCR testing and wider social services staff testing. This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results. *Enhanced care home staff testing introduced from 23 December 2020 . This involves twice weekly LFD in addition to weekly PCR testing review of enhanced staff testing underway. PCR testing - transition to NHS lab complete. Good level of staff participation in PCR testing.* *Testing has been rolled out to a wide range of other social care services including care at home, sheltered housing services.*	☒	■	Staff testing in line with national guidance with support for asymptomatic care home testing
9	NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows: • Adults aged over 65 • Those under 65 at risk • Healthcare workers • Unpaid and young carers • Pregnant women (no additional risk factors) • Pregnant women (additional risk factors) • Children aged 2-5 • Primary School aged children • Frontline social care workers • 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household • Eligible shielding households The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This	☒	■	Performance monitoring in place and will be tracked via winter EMT

	will include regular reporting that will commence from day 1 of the programme utilising automated data collection methods for performance monitoring. Public Health Scotland will report weekly.			
10	**Low risk** – Any care facility where: a) triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact who have isolated/shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the test date OR b) Individuals who have recovered from COVID-19 and have had at least 3 consecutive days without fever or respiratory symptoms and a negative COVID-19 test OR c) patients or individuals are regularly tested (remain negative) **Medium risk** Any care facility where: a) triaged/clinically assessed individuals are asymptomatic and are waiting a SARSCoV-2 (COVID-19) test result with no known recent COVID-19 contact OR b) testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR c) asymptomatic individuals decline testing **High risk** Any care facility where: a) untriaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who	☐		

	have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals who decline testing So all emergency admissions where COVID-19 status is unknown/awaited will fall into the medium risk pathways until testing can be undertaken to allow them to transition into green.			
11	All NHS Scotland Health Boards have provided assurance that all emergency and all elective patients are offered testing prior to admission. *Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster.*	☐		N/A
12	Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf *In mid-February 2021, the scope of the LFD testing pathway was expanded further to include patient facing primary care staff (general practice, pharmacy, dentistry, optometry), hospice staff, and NHS24 and SAS call handlers. Some hospice staff had been included in the original scope where staff worked between hospitals and hospices, so this addition brought all patient facing hospice staff into the testing programme.* *On the 17 March Scottish Government announced that the scope of the HCW testing pathway would be further expanded to include all NHS workers. The roll out is currently underway and we expect that all Boards across Scotland will have fully implemented the roll-out of twice weekly lateral flow testing to eligible staff by the end of June 2021. This will include staff who may have been shielding or working from home and is in line with national guidance.*	☒		In Place

	Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-COVID-19-healthcare-worker-testing/			

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*		RAG	**Further Action/Comments**
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☒		Community Respiratory Team remain operational within Midlothian
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☒		Additional investment in Community Respiratory Team which may support 7-day working, dependent on recruitment
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*	☒		In place
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☒		Fact-sheet for patients specific to winter time Working with NHS Lothian and Council communications team around key messaging
2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation.	☒		In place

	Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).			
2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.	☒	■	Pathway in place from hospital to home. Expanded Community Respiratory Team in place (MCRT+) for discharge planning for any respiratory patient.
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☒	■	In place
4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			

4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☒ ☒ ☒ ☒		This is managed by our Hospital at Home team. CRT have developed COVID oxygen weaning pathway. Staff have access to community respiratory team and the team is available over the festive period.
5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*	☒		In Place

7	Key Roles / Services		RAG	Further Action/Comments
	Heads of Service	☒		
	Nursing / Medical Consultants	☒		Inability to recruit to some trained nursing roles within HSCP has and will continue to impact on ability to safely maintain and maximise bed numbers. Mitigation plans in place but recruitment challenges remain a risk.
	Consultants in Dental Public Health	☐		
	AHP Leads	☒		
	Infection Control Managers	☒		
	Managers Responsible for Capacity & Flow	☒		
	Pharmacy Leads	☒		
	Mental Health Leads	☒		
	Business Continuity / Resilience Leads, Emergency Planning Managers	☒		
	OOH Service Managers	☒		
	GP's	☒		
	NHS 24	☐		
	SAS	☐		
	Other Territorial NHS Boards, eg mutual aid	☐		

	Independent Sector	☒	■	
	Local Authorities, incLRPs & RRPs	☒	■	
	Integration Joint Boards	☒	■	
	Strategic Co-ordination Group	☒	■	
	Third Sector	☒	■	
	SG Health & Social Care Directorate	☐		

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

		Baseline ICU Capacity	Double Capacity and Commitment to deliver in one week	'Triple plus' Capacity Commitment to deliver in two weeks	ICU Max Surge Beds	Y - Correct / N Incorrect with comment	Please list assumptions & consequences to other service provision to meeting these requirements
PART A: ICU	Please confirm that your NHS Board can deliver the stated level of ICU Capacity in the time periods set out						

PART B: CPAP	Please set out the maximum number of COVID-19 patients (at any one time) that could be provided CPAP in your NHS Board, should it be required		
PART C: Acute	Please set out the maximum number of acute beds that your NHS Board would re-provision for COVID-19 patients (share of 3,000 nationally), should it be required		

Annex B

Infection Prevention and Control COVID-19 Outbreak Checklist

(Refer to the National Infection Prevention and Control Manual (NIPCM) for further information http://www.nipcm.hps.scot.nhs.uk/)

This COVID-19 tool is designed for the control of incidents and outbreak in healthcare settings.

Definitions: 2 or more confirmed or suspected cases of COVID-19 within the same area within 14 days where cross transmission has been identified.
Confirmed case: anyone testing positive for COVID-19
Suspected case: anyone experiencing symptoms indicative of COVID (not yet confirmed by virology)

This tool can be used within a COVID-19 ward or when there is an individual case or multiple cases.

Standard Infection Control Precautions;
Apply to all staff, in all care settings, at all times, for all patients when blood, body fluids or recognised/unrecognised source of infection are present.

Patient Placement/Assessment of risk/Cohort area	**Date**				
Patient placement is prioritised in a suitable area pending investigation such as for a single case i.e. single room with clinical wash hand basin and en-suite facilities					
Cohort areas are established for multiple cases of **confirmed** COVID-19 (if single rooms are unavailable). Suspected cases should be cohorted separately until confirmed. Patients should be separated by at least 2 metres if cohorted.					
Doors to isolation/cohort rooms/areas are closed and signage is clear (undertake a patient safety risk assessment for door closure).					
If failure to isolate, inform IPCT. **Ensure all patient placement decisions and assessment of infection risk (including isolation requirements) is clearly documented in the patient notes and reviewed throughout patient stay.**					
Patient placement is reviewed as the care pathway changes. NB: Patients may be moved into suspected or confirmed COVID-19 cohorts or wards to support bed management.					
Personal Protective Clothing (PPE)					

1. PPE requirements: PPE should be worn in accordance with the **COVID 19 IPC addendum** for the relevant sector: • **Acute settings** • **Care home** • **Community health and care settings** 2. All staff should wear a FRSM in accordance with the updated guidance on face coverings, which can be found **here**.					
Safe Management of Care Equipment					
Single-use items are in use where possible.					
Dedicated reusable non-invasive care equipment is in use and decontaminated between uses. Where it cannot be dedicated ensure equipment is decontaminated following removal from the COVID-19 room/cohort area and prior to use on another patient.					
Safe Management of the Care Environment					
All areas are free from non-essential items and equipment.					
At least twice daily decontamination of the patient isolation room/cohort rooms/areas is in place using a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl.).					
Increased frequency of decontamination (at least twice daily)is incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g. "frequently touched" surfaces such as door/toilet handles and locker tops, over bed tables and bed rails.					
Terminal decontamination is undertaken following patient transfer, discharge, or once the patient is no longer considered infectious.					
Hand Hygiene					
Staff undertake hand hygiene as per WHO 5 moments: using either ABHR or soap and water					
Movement Restrictions/Transfer/Discharge					
Patients with suspected/confirmed COVID should not be moved to other wards or departments unless this is for essential care such as escalation to critical care or essential investigations. Discharge home/care facility: Follow the latest advice in COVID-19 - guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.					
Respiratory Hygiene					
Patients are supported with hand hygiene and provided with disposable tissues and a waste bag					
Information and Treatment					
Patient/Carer informed of all screening/investigation result(s).					
Patient Information Leaflet if available or advice provided?					

Education given at ward level by a member of the IPCT on the IPC COVID guidance?					
Staff are provided with information on testing if required					