East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 31 October 2019

BY: Chief Officer

SUBJECT: Winter Planning

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1 PURPOSE

1.1 This report explains East Lothian HSCP's plans to ensure all possible steps are taken to assist in controlling the pressures on Lothian's acute hospitals during the winter months through effective planning and provision of additional capacity in key services.

1.2 It should be noted that this report does not cover the ongoing resilience work being undertaken across partners to plan for business continuity across the county.

2 RECOMMENDATIONS

2.1 The IJB is asked to note the work being taken forward to cope with additional pressures which are likely to arise in the Lothian acute hospitals during the winter months.

3 BACKGROUND

3.1 Each year NHS Boards are required to draw up plans to ensure resilience over winter. This is in response to well-documented additional pressures experienced in hospitals during the winter e.g. resulting from flu and adverse weather. The Draft NHS Lothian Winter Plan is attached as appendix 1.

3.2 The winter planning process is managed through a partnership approach involving the 4 local IJBs and NHS Lothian. The need for this whole system approach has been reinforced by the Scottish Government's decision to place NHS Lothian at Level 3 on the NHS Board Performance Escalation Framework. Unscheduled Care and Delayed Discharge were identified as areas that required improvement.

3.3 Proposals to augment local services through short-term financial investment have been developed by the East Lothian HSCP team and subsequently subjected to peer review on a Lothian-wide basis.

3.3.1 **Enhanced Discharge to Assess**

- The intensive rehabilitation model has been very successfully implemented within the central cluster of East Lothian; it has been one of the initiatives that has successfully enabled a reduction in bed utilisation. This has been very successfully applied to those patients within the stroke unit. East Lothian patients are being discharged out of hospital by the team utilising the agreed stroke pathway up to 10 days earlier than before. This means patients receive active rehabilitation in the community within the confines of their own home.

- Patients with Chronic Obstructive Pulmonary Disease who would be admitted to Royal Infirmary of Edinburgh are managed collectively with the Advanced Physiotherapy Practitioner and Hospital at Home Team to keep them within the community Support includes including administering IV antibiotics at home.

3.3.2 **7 Day Working Patient Flow Team**

- This initiative includes both social work and health teams and will support weekend and extended week day hours within the Partnership to work with discharge teams in the two Edinburgh acute sites. This will allow the commencement of speedier needs assessment and allow the relevant information to support discharge across seven days rather than five.

- This will enable discharge paperwork and arrangements to be prepared and reduce length of stay in hospital

3.3.3 **Increase Hospital to Home Capacity**

- The Hospital to Home team within East Lothian has been in place for several years. The service has increased year upon year from one team to six including a ‘double up’ team. Over the last year they have successfully supported a total of 448 patients to return home.

- Increasing the capacity within the hospital to home team to provide packages of care within the community will ensure that patients can be allocated a package of care at the point of discharge.

- The further expansion of this service will reduce the number of patients waiting on packages within acute beds and will ensure that patient return to the community when medically fit.

3.3.4 **Increase the Emergency Social Care Service**

- The Emergency Care Service (ECS) is geared for rapid response to those in the community. It is currently a daytime service, augmenting it to run overnight will enhance the service's ability to maintain more people at home, avoiding a hospital admission.

- Increasing capacity within the ECS will ensure that those requiring care within the community during a crisis are provided with this rather than being admitted to hospital beds or care home beds overnight, this service will be implemented from 10 pm to 8 am.

3.4 These proposals have been considered alongside a range of proposals by other Lothian HSCPs and the Acute Services Division. These have now been approved by the NHS Lothian Unscheduled Care Committee and submitted to Scottish Government.

4 ENGAGEMENT

4.1 East Lothian HSCP Management Team discussed and agreed submissions based on evidence from current practice within a challenging timeframe for submissions and with experience of previous winter actions.

5 POLICY IMPLICATIONS

5.1 Reducing hospital admissions and avoid unnecessary delays in hospital discharge are key targets for IJBs. While there is a need to redesign services on a sustainable basis over the longer term to reduce pressures in hospitals, it is also necessary to be able to take short term measures to introduce both capacity and flexibility into our system and to ensure that East Lothian benefits from any additional resource made available to support our population.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy.

7 DIRECTIONS

7.1 This proposal supports Directions:

D11b – Occupied Bed Days and D11c – Delayed Discharge

8 RESOURCE IMPLICATIONS

8.1 Financial - The allocation of winter funding from Scottish Government has also been supported with the commitment of a further £2M from NHS Lothian to support the Winter Plan. East Lothian HSCP has received its requested funding of £196,524.

8.2 Personnel – Recruitment is underway for all positions required to support the plan.

8.3 Other – None

9 BACKGROUND PAPERS

9.1 NHS Lothian Draft Winter Plan.

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NHS Lothian: Winter Plan 2019/20

Date Approved: 4th October

Reducing Attendances Wherever possible by managing care closer to home, preferably at home with services focussed on assessment and care closer to home.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
Midlothian Health & Social Care Partnership		
ED Redirection/Support for < 65	November 2019	• On average, 6626 Midlothian residents attend ED each year. • During June 2019 there were 1197 Royal Infirmary of Edinburgh ED attendances by Midlothian residents aged under 65. This is the highest monthly figure this year • On average, about 29 people were frequent attenders each year (attending ED 10 or more times within that year). • Top reasons for attendance included non-specific chest or abdominal pain, cellulitis, asthma, and lower respiratory tract infection. For the 18-44 age group, overdoses, wounds, and alcohol intoxication were unique top reasons. For ages 45-65, COPD, UTI, deep vein thrombosis, vasovagal syncope, and pulmonary embolism were unique top reasons. • 76% self-referrers to ED took not advice prior to attendance. Funding will support a reduction to repeat attendance by signposting and redirecting.
East Lothian Health & Social Care Partnership		
Enhanced Discharge to Assess	December 2019	• The intensive rehabilitation model has been very successfully implemented within the central cluster of East Lothian; it has been one of the initiatives that has successfully enabled a reduction in bed utilisation. This has been very successfully applied to those patients within the stroke unit. East Lothian patients are being pulled out of hospital by the team utilising the agreed stroke pathway up to 10 days earlier than before. They now have active rehabilitation in the community within the confines of their own home. • The COPD patients who would be admitted to Royal Infirmary of Edinburgh would be managed collectively with the advanced physiotherapy practitioner and hospital at home to team keep them within the community including administering IV antibiotics at home.
Edinburgh Health & Social Care Partnership		
CRT+	December 2019	• Number of referrals. • Source of referral. • Average time to contact. • Average home visits and telephone calls per patient. • Number of patients at risk of admission. • % of 'at risk' patients remaining at home at 48 hours and 1 week. • Number of 'supported discharge patients' • Number of supported discharge patients remaining at home at 48 hrs and 1 week

		• **This scheme will also support Admission Avoidance and Focus on Flow through Acute Care. Metrics include:**
		  o Number of 'supported discharge patients'
		  o Number of supported discharge patients remaining at home at 48hrs and 1 week

Festive Practice	20th December 2019	• Reduced number of attendances at A&E, LUCS, and Mental Health Services on public holidays • Reduce need for DN home visits for dressings
Winter Support Team	December 2019	• Reduction in attendances at acute hospitals • **This scheme will also support Admission Avoidance and Reducing Length of Stay.** • Metrics for Reduced Length of Stay include reduction in Delayed Discharges.

Open House (Stafford Centre)	December 2019	• Providing an alternative to A&E for those in mental health crisis
		  o Numbers of people supported during a crisis
		  o Numbers of people reporting increased resilience
		  o Numbers of carers supported

Lothian Unscheduled Care Service (LUCS) and Flow Centre		
Weekend cover for Care Homes	December 2019	• For practices which are recognised as the lead practice for a care home or care homes to provide additional cover over winter weekends to improve continuity of care for patients, avoid hospital admissions, and reduce pressure on LUCS and A&E. • Between 10 and 14 practices participated over the dates covered last year and 18 to 21 care homes received cover from their lead practice. • 179 patients were visited at a total cost of £50,400 giving a cost per visit of £103 over the festive holidays and £142 on the other Saturdays • There was a positive impact on LUCS demand for care home visits. If all Lothian practices had participated and had the same impact as the practices that did participate the LUCS visits to care homes could have reduced from 153 in 2017/18 to 55 in 2018/19. A home visit for LUCS is estimated to cost £200-£250/visit (based on volume of work and cost of supporting the service (GPs/drivers/equipment/drugs/other) over the course of a year)
Increase number of alternatives to admission including access to these in evenings and at weekends.	December 2019	• % alternatives booked through Flow Centre • Increase availability of alternative pathways
Communications		
Winter Communications Plan	November 2019	• Last year, the campaign reach was 105,022 across social media, and 931 likes, shares, retweets and 46,722 impressions overall. • It is estimated that Bus advertising reached 89 per cent of adults visually and the aim is

		to replicate this again. • Radio advertising on Radio Forth reaches an audience of 405,000 and the target will be aimed to improve this reach 19/20. • The Plan will also support recruitment of flu champions and peer vaccinators via internal communications campaign using all channels: Intranet, staff magazine, social media and direct email cascade. Last year this tactic resulted in the recruitment of more flu champions and more peer vaccinators. • Roll out seasonal flu campaign Be Incredible 2 – the sequel to last year's effective promotion. We ask staff to "Be Incredible" and fight flu by being vaccinated.
Managing / Avoiding Admission Wherever possible with services developed to provide care at home across 7 days.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
Midlothian Health & Social Care Partnership		
Rapid Extended MDT Frailty Intervention	November 2019	• People identified with severe frailty are 4 times more likely to be admitted into hospital within 12 months than the non-frail population. • 716 frail people in Midlothian accounted for 20,000 unplanned OBD in 2018. • 190 were from two practices that will be supported in this project. • When someone with severe frailty presents to ED in 75% of presentations they will be admitted. For moderately frail patients the likelihood of admission is 60% (Midlothian analysis). • Access and Relational continuity of care in general practice is associated with a significant number of benefits to individuals and wider health systems, including: better clinical outcomes for an array of conditions; reduced mortality; better uptake of preventative services; better adherence to medication; reduced avoidable hospital admissions (Nuffield trust 2018). • A reduction of 20% hospital activity is achieved by this cohort, would equate to cost avoidance over £600K. This does not include the impact of the third practice.
West Lothian Health & Social Care Partnership		
REACT Care Home	January 2019	• Reduction in admissions from care homes at weekends
Edinburgh Health & Social Care Partnership		
Open House (Phone link & Befriending)	December 2019	• Providing an alternative to (for example) emergency Primary Care attendances for repeat medications • Providing support to augment existing community-based care (e.g. D2A, H@H) • Providing a link back to Locality Hub to intervene earlier in the event of a decline ○ Numbers of crisis appointments reduced in (for example) PC

		○ Numbers supported ○ Numbers reporting increased resilience ○ Number of carers supported
St. John's Hospital		
Acute Respiratory Nurse Specialist (RNS) in reaching into ED and MAU	January 2020	• Patients presenting with Respiratory illness increases over winter period. By providing a RNS into front door, will allow a treatment plan identified for those who can be discharged and supported in the community, rather than being admitted, therefore reducing admissions. This links also with the Flu campaign • Monitoring impact will be through RNS activity : ○ Number of patients reviewed ○ Number of patients who were discharged ○ Length of Stay ○ Site admission profile ○ Reduction in overcrowding in ED
Cardiology Nurse Practitioner (NP) in reaching into ED	January 2020	• This would be a test of change for the site, where there would be a NP at front door. Troponin waits are the second largest reason accounting for clinical exception breaches. Buy having a NP at front door would allow them to assess patients and discharge all appropriate patients, with a view of moving into a planned clinic slot Monitoring impact will be evidenced through NP activity : ○ Number of patients reviewed ○ Number of patients who were discharged ○ Length of Stay ○ Site admission profile ○ Reduction in overcrowding in ED
Royal Infirmary of Edinburgh		
ED Hogmanay	December 2019	• Enhanced staffing model to ensure we can deliver safe and effective patient care throughout the Hogmanay period.
ED Resilience	December 2019	• The scheme will help reduce time to first assessment during the holiday period.
Therapy Services		
Adult Physiotherapy – Respiratory (APP) Royal Infirmary of Edinburgh /Community	December 2019	• Collecting data on the impact of APP working across acute and community managing acute respiratory patients. • Reducing Length of Stay, aided by clinical decision making from experienced, well-established community respiratory physiotherapy colleagues and knowledge of community capacity to support discharge. • Increased discharges on a Friday/later in week when confidence may previously be low

		for discharge over/towards the weekend, thereby a more consistent spread of discharges over the week. • Increased weekend discharge as improved knowledge of CRT
Paediatric Physiotherapy	December 2019	• Collecting data on the increased number of respiratory patients receiving physiotherapy in hospital and supporting hospital to home for immediate discharge from A&E and/or earlier supported discharge from wards will allow us to quantify the impact increased physiotherapy intervention has in contributing to decreased LOS and admission avoidance. • Collecting data on the those patients receiving physiotherapy in the community with chronic complex respiratory conditions and the long term ventilated patients who are often in hospital for extended periods will allow us to quantify the impact increased physiotherapy intervention has in contributing to avoiding admissions.
Lothian Unscheduled Care Service (LUCS) and Flow Centre		
LUCS winter (inc festive) provision	January 2020	• Patient capacity / avoidance of redirection to EDs due to inability to provide timely OOH service / turnaround of festive patients (Christmas and NY) / increased home visiting and base capacity, supportive of admission avoidance to hospitals
Increase number of Alternatives to Admission including Hospital @ Home including evenings and weekends	December 2019	• % H@H referrals booked through Flow Centre • Increase availability of alternative pathways
Reducing Length of Stay Through reduction in delayed discharges, discharge to assess, access to intermediate care services and provision of rehabilitation services at home or a community setting.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
Midlothian Health and Social care Partnership		
Seven day working for Discharge to Assess Team	December 2019	• To date the service has delivered: o 110 Patients supported home earlier from Royal Infirmary of Edinburgh o Saving 542 bed days o Financial savings of £135 000 o Provides ability for 7 days a week discharging
East Lothian Health & Social Care Partnership		
7 Day Working Patient Flow Team	December 2019	• This initiative will allow weekend and extended week day hours within the Partnership to work with discharge teams in the two Edinburgh acute sites. This will allow the commencement of needs assessment quicker and allow the relevant information to support discharge across seven days rather than 5.

		• Weekday working till 8.00pm and Saturday and Sunday working. • Enable discharge paper work and arrangements to be prepared and reduce length of time patients/clients are in the acute sector.
Increasing Hospital to Home Capacity	December 2019	• The Hospital to Home team within East Lothian has been in existence for several years. The service has increased year upon year from one team to six including a double up team. Over the last year they have successfully supported a total of 448 patients to return home. • The Emergency Care Service (ECS) is geared for rapid response to those in the community. It is currently a day time service and augmenting the service to run overnight will enhance their ability to maintain more people at home, avoiding a hospital admission. • Increasing the capacity within the hospital to home team to provide packages of care within the community will ensure that patients can be allocated a package of care at the point of discharge. • The further expansion of this service will reduce the number of patients waiting on packages within acute beds and will ensure that patient return to the community when medically fit. • To increase capacity within the Emergency Care Service (ECS) to ensure that those requiring care within the community during a crisis are provided with this rather than being admitted to hospital beds or care home beds overnight, this service will be implemented from 10 pm to 8 am.
West Lothian Health & Social Care Partnership		
7 Day Equipment Delivery	January 2020	• Reducing length of stay • Facilitating weekend discharges • Impact will be determined by demand • Earlier discharges on Mondays with planning over the weekend
Edinburgh Health & Social Care Partnership		
AWI (Adults with Incapacity)	December 2019	• Reduced length of stay for patients in hospital whose discharge is being impacted by issues of capacity to make welfare and/or financial decisions • Reduction in delayed discharges for this cohort of patients. Impact will be evidenced through Tableau and local systems to monitor capacity such as delays coding. All delays due to issues of capacity are coded 51X and are reported weekly.
Social Work to Support the Home First Model	December 2019	• Reduction in delayed discharges due to earlier intervention of social workers • Reduction in number of people waiting for an assessment
St. John's Hospital		

Managing patient flow 4- additional nurse practitioner at weekends	January 2020	• This will improve decision making at weekends, assisting in improving weekend discharges to meet demand on unscheduled care. • Monitoring impact will be evidenced through: o Discharges at weekends o Time of discharge o Length of Stay o Boarding numbers o Breaches associated with bed waits
Managing patient flow 6- Acute Consultant increase on Ward rounds	January 2020	• This initiative was trialled last year and was evaluated well. Essentially job planned clinic activity in January is converted to ward rounds, to maximise the number of decision makers on ward rounds, to expedite patient treatment and decision to discharge. To offset the closed clinics in January, patients are booked into extra clinic slots generally within their TTG. • Monitoring impact will be evidenced through: o Length of Stay o Time of Discharge o Breaches associated with bed waits o Out-patient TTG performance
REACH	January 2020	• This will allow service to expand into back door and Sundays. Frail patients can befollowed through their pathway, with early interventions and identification as to where they could be discharged to home or other facility, which would be more appropriate with their care requirements. Close working with the discharge hub will integral and having a Sunday service, will allow better planning for week ahead • Monitoring impact will be evidenced through: o Activity by REACH o Reduced Length of Stay o Reduction in delays o Earlier in day discharge
Royal Infirmary of Edinburgh		
Boarding Team: Acute & General Medicine	December 2019	• Reduced length of stay • Weekend senior medical cover to facilitate discharge decisions
Boarding Team: MOE & Stroke	December 2019	• Earlier reviews for patients that are boarded out with their specialities.
Orthopaedic Supported Discharge	December 2019	• Enhanced support with ambulatory care pathways • Earlier access to services in the community

		• Earlier engagement with community teams • Prevents delays as patients are able to have ongoing rehab in the community and reduce the amount of inpatient rehab that is required.
Orthogeriatric Pathways Coordinator	December 2019	• Orthopaedic supported discharge has reduced 11,337 occupied bed days since commencing in feb 2017. This service supports on average 20-30 patients a day at home depending on their level of care/rehab dependency. Evidence supports that an additional 3 HCSWs would support a further 12 patients a day with OSD taking the service up to 32-42 a day.
Western General Hospital		
Optimising length of stay in patients with diabetes	January 2019	• Data analysis has demonstrated an increased length of stay for patients with diabetes. Evidence has also demonstrated that a focused **proactive** inpatient diabetes services (utilising e-health initiatives –which NHS Lothian are embedding) reduces length of stay. • CHI linkage of information will allow length of stay analysis. Focused MAU pick up in the morning will reduce length of stay for appropriate patients and will facilitate early review rather than wait for post take ward round review and time to subsequent referral. • QI work to data has focused 3 keys areas for intervention to improves length of stay / flow (based on tableau dashboard data) – inpatients on surgical wards, patients with type 1 diabetes and acute admissions which will be the targeted focused of this winter plan to facilitate timely discharge and improve flow.
Pharmacy		
Royal Infirmary of Edinburgh Weekend Working (1) Winter weekend clinical pharmacy service on the three anticipated busiest months Royal Infirmary of Edinburgh Clinical (2) Clinical pharmacy prioritising areas that did not have a pre-existing clinical pharmacy service	January 2020	• Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives: o Number of medicines reconciliation with error rate o Volume of patients assessed/reviewed by clinical pharmacists o No of IDLs & IPSs reviewed and error rate o Number of Interventions o Number of High Risk Patients o Increase in capacity of over labelling service o Time of receipt of requests to pharmacy o Turnaround time of prescriptions from pharmacy performance
Therapies		
Adult Physiotherapy - Royal Infirmary of Edinburgh /Western General Hospital MMOET	December 2019	• Reduction in average length of stay for physiotherapy patients • Patients being discharged faster from physiotherapy services • A clinically meaningful improvement in patient function in more than 80% of caseload • Patient flow was directed to a high degree of accuracy

		• Patients being discharged less frail and more independent
Physiotherapy - Activity Support Workers Royal Victoria Building/ Western General Hospital Royal Infirmary of Edinburgh	January 2020	• Reduction in average length of stay for physiotherapy patients • Patients being discharged faster from physiotherapy services • A clinically meaningful improvement in patient function in more than 80% of caseload • Patient flow was directed to a high degree of accuracy • Patients being discharged less frail and more independent
Occupational Therapy - Roving - Western General	December 2019	The target of increased Roving winter resource at Western General Hospital would be to decrease the length of stay of medical boarders and increase flow of patients to point of discharge. Medical boarding patients are predominantly: over 65yrs; fall under frailty groups; sit on medical wards outwith their specialities; and wait for assessment from under capacity teams. By improving links to OTs at the 'front door' and tracking patients from there who are boarded directly, roving team members can assist better handover and enable earlier intervention Measurement is aimed at collecting data on: 1. Point of admission to hospital 2. Point of transfer to boarding ward from admissions and when referral received by roving. 3. Response time of OT roving assessment and intervention date and type 4. Date of planned discharge plan 5. Actual discharge date and actions
Occupational Therapy - Roving – Royal Infirmary of Edinburgh	December 2019	The target of increased Roving winter resource at Royal Infirmary of Edinburgh would be aimed at general medical and boarding patients. These patients are currently scoring low on prioritisation parameters and are getting delayed response time from OT. Their average LOS subsequently is higher. Roving will have the specific role to target and screen these patient borders and give them a higher prioritisation status; earlier intervention and improved discharge planning. Measurement is aimed at collecting data on: 1. Point of admission 2. Point of transfer to boarding ward and when referral received. 3. Response time of OT assessment and intervention 4. Date of planned discharge plan 5. Actual discharge
Lothian Unscheduled Care Service (LUCS) and the Flow Centre		
Reduce Length of Stay for patients awaiting repatriation transport to their home board	December 2019	• Bed days saved for repatriations • Utilisation rates – Demand from service/ capacity utilised
Focus on flow through Acute Care Through adherence to discharge trajectories, earlier in the day discharges and improvements through ED flow.		

Winter Initiative	Live Date	Context/Quantifiable Impact
Midlothian Health and Social Care Partnership		
Single Point of Contact Older People Services	November 2019	• Local ownership of patients will reduce length of patient journey as a result of local planning and system knowledge of capacity and options available. • Reduced Length of Stay in Royal Infirmary of Edinburgh, Midlothian Community Hospital and Highbank Intermediate Care • Reduced delays • Easy to navigate system to reduce time to refer for Royal Infirmary of Edinburgh
Edinburgh Health & Social Care Partnership		
Festive Practice	December 2019	• Improvements to ED flow by drawing activity away from the front door during public holidays.
St. John's Hospital		
Efficiency of Discharge Lounge in supporting DDD	January 2020	• This scheme will allow the discharge lounge to increase opening hours, with staff attending huddle, prioritising and pulling patients into lounge. This expands on the work which is a focus for the site, in improving discharges to earlier in day, thus reducing patients waiting for beds • Monitoring impact will be through evidenced through: o Site discharge profile hour by hour o Reduction in breaches associated with bed waits o Improvement in pre 12 discharge
Expansion of discharge hub & DDD	January 2020	• This scheme will allow all back door wards to have support from discharge hub, providing support and focus in discharge planning around complex patients and will link to discharge lounge also. • Monitoring impact will be undertaken by: o Site discharge profile hour by hour o Reduction in breaches associated with bed waits o Reduction in delayed discharges o Length of stay reduction

Managing patient flow 3- PAA	January 2020	• This initiative continues to support GP flow going through Primary Assessment Area (PAA), rather than being diverted to ED. This allows for an expansion of the current model to meet the later demand surge that the site experiences in the evening, allowing patients to be assessed and treated as ambulatory unless identified as need to be admitted. This will continue to reduce admissions into MAU and assist with delays in patients being allocated beds between PAA and ED. • Monitoring impact will be undertaken by: o Breaches associated with bed waits o PAA time to bed allocation o Admission and discharge profile of MAU o Any diverts to ED of PAA flow o Time of discharge
Royal Infirmary of Edinburgh		
Surgical Observation Unit Additional Fellow	December 2019	• Reduced length of stay • Improving time of surgical review on patients in an OOH period to maintain surgical flow throughout the front door areas – this has been recognised as a pressure in the OOH periods previously • Increased patient moves into the inpatient areas • Improved morning discharge profile • More robust staffing profile during winter months to support flow and address the acuity that will present during the winter months
Surgical ANP	December 2019	
AMU Medical Cover	December 2019	
Ward 204: Consultant Cover	December 2019	
Ward 204: Registrar Cover	December 2019	
Ward 204: FY2 Cover	December 2019	
Respiratory Nurse Specialist	December 2019	
Western General Hospital		
Enhanced Nursing Support to OPAT Service	January 2019	• Supporting this bid would reduce patients attending the front door as unscheduled care activity • Additional resource would also provide capacity for nursing staff to attend consultant rounds with ID at the Western General Hospital and Royal Infirmary of Edinburgh to help identify patients who are suitable for the OPAT service in a timely way and improve discharge planning within wards.
Enhanced Medical cover (overnight, weekends and boarding patients)	December 2019	• Increased number of weekend discharges, effective management of boarding patients and average length of stay: further enhancement of weekend medical staffing would help support timely senior review of patients and support discharge.
Radiology		
Radiology Winter Plan - Increased demand for diagnostic imaging	December 2019	• Additional provision is proposed to ensure patient flow is not impacted by any delays to diagnosis for admission and discharge. • Additional reporting capacity is provided for the three month period as WLI sessions

		and some extended days, to keep on top of the additional workload and avoid delays in reporting. • Additional Radiographer cover, CSW/RDA and portering will meet front door additional demand and maintain inpatient flow through CT/MRI/US.
Pharmacy		
Western General Hospital Same as Royal Infirmary of Edinburgh above		• Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives: o Number of medicines reconciliation with error rate o Volume of patients assessed/reviewed by clinical pharmacists o No of IDLs & IPSs reviewed and error rate o Number of Interventions o Number of High Risk Patients o Increase in capacity of over labelling service o Time of receipt of requests to pharmacy Turnaround time of prescriptions from pharmacy performance
Lothian Unscheduled Care Service (LUCS) and the Flow Centre		
Increase number of alternative pathways for patients attending front door areas. Reduce time waiting for repatriation transport. Increase transport for discharges and transfers from acute sites	December 2019	• % alternatives booked through Flow Centre • Increase availability of alternative pathways • Bed days saved for repatriations • Utilisation rates – Demand from service/ capacity utilised • Number of patients transferred or discharged from sites across NHS Lothian
Seasonal Flu, Staff Protection and Outbreak Resourcing Ensure that there are adequate plans in place to manage the outbreak and vaccinations of multiple staff and patient groups as well as contingency planning for Norovirus outbreak control measures.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
Midlothian		
Local Flu Campaign	October 2019	• Midlothian Staff flu uptake was the Partnerships best ever at 59.9% in 18-19 Lothian wide. There have been reports that the additional clinics and clinics running in new areas were well received and attended. • Locally the Partnership built on NHSL 'Be Incredible' social media campaign with regular social media messages that began early October. This included a YouTube and Face Book video of Clinical Director being vaccinated which had over 5000 views and 26 shares. • Uptake amongst Over 65s continues to increase across the board at 74.9%, almost

		reaching the WHO target of 75%. Uptake amongst those at risk remains a challenge across the board at 43% for the year 18/19. • Comparing data from 2017 and 2018 there was a reduction in potentially preventable admissions due to flu. There was a change in the age profile of those that were admitted with an increase in the number of those aged 80+ and an increase in occupied bed days.
Public Health		
Housebound Flu	September 2019	• Last season 6,700 Housebound patients were vaccinated. The aim is to match this uptake for 2019/20 • The effect of not delivering the influenza vaccination to housebound patients could potentially impact on healthcare pressures – this can be evidence by the increase in acute winter admissions in 2017 when influenza virus was more potent and the vaccine less effective • A benefit of the centrally coordinated housebound vaccination programme could free up time for GP and District Nurse teams for other clinical activities • The timely launch of the programme and administration of the vaccine must be taken in to account as the immune response to vaccination takes about 2 weeks to fully develop • The programme is delivered by NHS L Bank staff vaccinators and this group of staff maintain their competencies and can be utilised to deal with flu outbreaks eg Nursing Home
Staff Flu Programme	September 2019	• Last season 17,200 staff were vaccinated. 15,800 NHS L staff (59% uptake) and 1400 of staff from social care partners • The NHS Lothian uptake for 2018/19 increased from the 51% achieved during 2017/18 season. For this coming season the aim is to improve uptake of clinical staff • The main benefit of delivering the staff flu programme is to maximise reduction of flu transmission in addition to providing individual protection. This will potentially reduce staff sickness rates and minimise local disruption/impact on local service delivery • This service also assists with the data collection and reporting process – could potentially enhance response rates should there be an outbreak
Point of care testing for influenza in emergency medical patients (children and adults) attending A/E and MAU at the 4 hospital sites across Lothian.	October 2019	• Rapid diagnosis, in this case POCT has been shown to reduce length of stay by 1 day. In NHS Lothian length of stay has been compared in periods where POCT is available to time periods where it is not and has found that length of stay is reduced overall in periods where POCT is available by 1 day. • Additionally the following impacts will be evidenced following funding of POCT Flu Testing: o Reduced bed closures o Improved patient flow o less patient moves

		○ correct and appropriate use of antivirals ○ reduced spend of antivirals for prophylaxis owing to ward patients being exposed to flu Reduced nosocomial cases
Preparedness for Additional Surge Capacity across Health and Social Care services Planned dates for the introduction of additional acute, OOH and Social care services is agreed and operational before the anticipated surge period.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
St. John's Hospital		
1. Managing acute patient flow 1- ward 18 staffing	January 2020	• All 3 of these schemes are interlinked and relate to medicine taking capacity from ward 18 and cohorting medical patients into this area. To reduce impact on Head &Neck activity, DOSA will be used to supplement capacity and will move to a 7 day service between January- March, thus requiring additional staff. • To ensure that this is safe for patients and staff enhanced staffing is required in ward 18, to supplement the required care needs of this group of patients. Additionally medical staffing will be required to be increased to support this group of patients and any other patients that are boarding outside of medicine on the site. • Metrics which will be used: ○ Number of breaches associated with bed waits ○ Length of Stay ○ Time of discharge ○ Complaints/ compliments ○ Boarding numbers
2. Managing acute patient flow 2- medical staffing	January 2020	
3. Managing patient safety and dependency- DOSA	January2020	
Supporting Acute ORS flow over Winter	January 2020	• Historically the demand for Orthopaedic rehabilitation increases over winter months. This would allow for the addition 6 unfunded beds in ward 14 to open, to allow pull of West Lothian Orthopaedic patients requiring rehabilitation to be pulled over onto site, instead of being delayed at Royal Infirmary Edinburgh or other Orthopaedic centres and allow access to rehabilitation earlier in their journey. • Metrics which will be used: ○ Time to repatriation on site ○ Reduced length of stay
Royal Infirmary of Edinburgh		
DSU Winter Capacity	December 2019	• Enhanced site resilience in anticipation of increased attendances and admissions.
Western General Hospital		
Enhanced Medical cover (overnight, weekends and	January 2020	• Support system wide patient flow and the reduction of the number of delayed discharges in acute beds, optimising hospital capacity for acute admissions.

boarding patients) This proposal is to open 21 beds flexibly in Ward 15 to support delayed discharge patients		• To mitigate the risk associated with the reduction of 26 beds following ward 71 closure
Additional MDT Support for Medicine of the Elderly Team	January 2020	• Reduction in length of stay and number of delayed discharges • Improvement in Planned Discharge Dates in collaboration with MDTs • Support MDTs in the early initiation of realistic conversations with families to manage expectations • Support the reduction - to support length of stay post 71 ward closure
Workforce It is essential that the appropriate levels of staffing are in place across the whole system to facilitate efficient and effective patient care, to ensure consistent discharge during weekends and the holiday periods.		
Pharmacy		
St. Johns Extending hours would support safe supply of discharge medicines and manage staff welfare which requires additional manpower NOT additional hours to existing staff.	December 2019	• Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives: o Number of medicines reconciliation with error rate o Volume of patients assessed/reviewed by clinical pharmacists o No of IDLs & IPSs reviewed and error rate o Number of Interventions o Number of High Risk Patients o Increase in capacity of over labelling service o Time of receipt of requests to pharmacy o Turnaround time of prescriptions from pharmacy performance
Therapy Services		
Occupational Therapy - Ward 15 - Western General	December 2019	Impact is aimed at providing maintenance therapy to those who are awaiting NH or POC. The aim is to prevent de-conditioning / deterioration whilst continuing to work on improving function and reducing package of care requirements or requirements for complex discharge planning. Measurement will be aimed at: 1. Scoring functional capacity using pre and post measures of function to assess incremental gains or deterioration during length of stay 2. Improved patient experience
Adult Physiotherapy - Western General Hospital Ward 15	December 2019	Collecting data on those patients awaiting a Package of Care or Nursing Home placement. Physiotherapy to maintain/progress patients functional and mobility status and prevent de-conditioning whilst in hospital and increase patients' resilience at point of discharge. Collate impact of physiotherapy on: 1. reduction in falls. 2. reduced requirement for analgesia. 3. reduction in re-admission rates