Winter Plan 2018/19
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1. Executive Summary

Introduction

The Winter Plan is the Health and Social Care response to unscheduled care over the winter to supplement existing year round plans. It is a whole system business continuity plan developed in collaboration between NHS Ayrshire & Arran, East Ayrshire Health & Social Care Partnership (HSCP), North Ayrshire HSCP, South Ayrshire HSCP and key partners from Scottish Ambulance Service and the Third Sector.

To develop our Winter Plan for 2018-19, partners have reflected on learning from previous years with a particular focus on ensuring that we have the ability to meet variation in demand. We know through our modelling approach that there is a significant degree of predictability in patterns of demand throughout the winter period and, indeed, across the year. Acknowledging this has afforded us an opportunity to plan, rather than react to the challenges that this variation brings. Our plan sets out in section 2 our current approach to managing unscheduled care and describes in section 3 the additionality in the winter period that will be created through use of existing resources and investment of winter monies.

Mr John G Burns              Dr Martin Cheyne  
Chief Executive Chairman

Summary of Actions

Section 3 of this document sets out a number of projects already at implementation stage which will support our work to reduce unnecessary admissions, improve flow within the hospital and facilitate smoother transfer or discharge of patients on the health and care pathway. The projects include:

- Intermediate Care and Rehab
- Pulmonary Rehab
- Discharge to Assess
- Supported End of Life Care

Acknowledging the outputs from our predictive analysis and the expected impacts from our interventions at both implementation and additional stages, we will also invest in 15 beds to support the transition to full implementation over this winter period.

Our predictive analysis affords us the opportunity to plan for unscheduled care but to also understand where this may impact on planned care capacity and mitigate accordingly. This approach permits our commitment to maximising elective theatre capacity over the winter period.

Our focussed investment from additional resources is intended to further support improvement priorities for unscheduled care. Projects to support Daily Dynamic Discharge and the Discharge Lounge are already evidencing improving performance in ‘earlier in the day’ discharge and weekend discharge. Our improvement trajectories will continue to be maintained and evidenced through the Acute Performance Dashboard.
Additional Capacity & Resource

In addition to these projects, the following resources will be purchase using the winter allocation. Further detail is also provided in section 3.

- Weekend and Evening Discharge - the purpose of these investments is to support patient flow through enhanced 7 day working and extended hours to evening.
  - Additional Senior Decision Maker Capacity. Cost for 5 months inc extended Jan opening £0.110m per site = £0.220m
  - Discharge Lounge – extended hours. Cost for 5 months £0.0205m per site = £0.041m
  - Additional Capacity in Ambulance, AHPs and Pharmacy - extended hours working. Cost for 5 months £0.051m per site = £0.102m
  - Additional Social Care Capacity - additional Social Care at Home capacity will be made available to directly support evening and weekend discharge. Each Partnership @ 100hrs per week x £20 per hour x 20 weeks = £0.040m (x3) = £0.120m

- Near Patient Influenza Testing - Experience from winter 17/18 demonstrated the positive impact of Near Patient Influenza testing. In response, NHS Ayrshire & Arran have allocated an additional £0.023m in the Acute budget for 2018/19. Our planning for winter seeks to expand this capacity and an additional £0.036m will be allocated from winter funding.

- Right Care for Patients in Complex Discharge - to provide care in a homely environment for patients who no longer need hospital care but their progress to alternative care is being delayed through complexities of discharge.
  - COMMISION CARE HOME PROVISION - Up to 10 NHS funded Care Home Places. 10 placements x £36k per annum x 26/52 weeks = £0.180m
2. Our Approach to Unscheduled Care

In Ayrshire we have established Unscheduled Care Delivery Groups (UCDGs) that have membership from NHS and HSCP teams. There is a group for each acute hospital site. These teams are part of the Unscheduled Care programme that is taking forward work to transform our services on a whole systems basis. The UCDGs have identified priorities for delivery during 2018-19 in support of whole system transformation to achieve our new model of care.

In 2017-18 these groups took a more pro-active approach to the use of performance information. Performance dashboards have been developed to support our unscheduled care priorities that incorporate the MSG indicators and use of local management information. The UCDGs have agreed performance trajectories to support the delivery of our plans and these are monitored every 2 weeks by the leadership teams with corrective action identified and implemented to ensure delivery against plan. The senior responsible Director oversees this work and each group reports back through the Strategic Planning and Operational group.

The priority action to be delivered in 2018/19 is the closure of unfunded beds at both the University Hospital Crosshouse (UHC) and University Hospital Ayr (UHA) sites. This additional bed capacity was created to support demand in previous years due to pressures within the system. Recognising the work underway through the transformation programmes that seeks to increase capacity in the community, reliance on these additional beds has diminished. The Delivery Plan for 2018/19 describes the action to close 42 beds at UHA and 89 at UHC by September 2018. Ahead of schedule, all 42 beds at UHA have been closed. Fifty four beds at UHC have been closed with a plan to secure the remaining bed closures by the end of September underway.

To support this priority action and to further the implementation of the wider programme of transformational change in unscheduled care, actions to deliver against the following objectives have been implemented.

**Reduce emergency admissions by providing accessible community alternatives**

**Ayr Hospital Unscheduled Care Delivery Group**

- Reduce the number of people who are admitted following attendance to the ED, in line with NHS Scotland national average.
- To increase assessment, diagnosis and treatment of people who have medical/surgical conditions under the umbrella of ambulatory emergency care, in a non-inpatient setting, reducing the requirement for inpatient admission.
- Provide an alternative to acute hospital admission or supporting early discharge from acute hospital through a four tier Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation that supports people at different stages of their journey. This will include provision of single point of contact (SPOC) in each HSCP.
- Implement with the Respiratory MCN the delivery of the technology enabled pulmonary rehabilitation service in East Ayrshire and South Ayrshire Health & Social Care Partnerships.
- Provide clinical support for people living in Care Homes targeting in particular, homes with high numbers of hospital admissions in South Ayrshire.
• Further develop and refine East Ayrshire’s response to palliative and end of life care, supporting more people to die at home should they chose to.

**Crosshouse Hospital Unscheduled Care Delivery Group**
• Establish a dedicated acute pathway for people with frailty issues utilising early Frailty Screening, Comprehensive Geriatric Assessment and appropriate resources to achieve early discharge from CAU and reduce in-patient length of stay.
• Provide an alternative to acute hospital admission or supporting early discharge from acute hospital through a four tier Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation that supports people at different stages of their journey. This will include provision of single point of contact (SPOC) in each HSCP.
• Implement with the Respiratory MCN the delivery of the technology enabled pulmonary rehabilitation service in East Ayrshire and South Ayrshire Health & Social Care Partnerships.

**Reduce occupancy and length of stay by improving systems and processes within the Acute Hospital**

**Ayr and Crosshouse Hospital Unscheduled Care Delivery Groups**
• Improving the timeliness and quality of patient care by planning and synchronising the day’s activities through implementing Daily Dynamic Discharge and the Institute of Healthcare Optimisation programme.

**Reduce delays in discharge by providing appropriate community capacity**

**Ayr Hospital Unscheduled Care Delivery Group**
• Supporting early discharge from acute hospital through a four tier Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation that supports people at different stages of their journey. This will include provision of single point of contact (SPOC) in each HSCP.

**Crosshouse Hospital Unscheduled Care Delivery Group**
• Supporting early discharge from acute hospital through a four tier Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation that supports people at different stages of their journey. This will include provision of single point of contact (SPOC) in each HSCP.
• Establish ‘Discharge to Assess’ in North Ayrshire supporting more people in a homely setting.
• Establish a ‘Hospital Social Work Team’ to prevent people being delayed in acute care in North Ayrshire Health & Social Care Partnership
3. Additional Capacity for Winter

As described in Section 2 above, the unscheduled care programme aims to deliver, through a number of actions, transformational change. The graphic below summarises projects and actions that are already operational in the system as part of our ongoing unscheduled care programme. It also describes work that is being implemented this year as part of that unscheduled care programme and goes on to detail areas of additionality that would be implemented in the winter period, using either existing resources or though investment of the winter monies.
3.1 Transformation Interventions at Implementation Stage

As part of the wider unscheduled care programme a number of interventions have been implemented in year to deal with the ongoing challenges in our health and care system relating to demand and current service structure. These are not specifically aligned to dealing with peaks in demand in winter but will, nonetheless, support these periods of increased demand.

**Intermediate Care and Rehabilitation**

The NHS Board through the IJBs has committed an annual investment of £2.5million in Intermediate Care and Rehabilitation with the purpose of enhancing support to people within their own home.

The pan-Ayrshire model for Intermediate Care and Rehabilitation provides enhancements to the existing Intermediate Care services to offer 7 day working and added focus on preventing hospital admission. It will realise efficiencies through Partnership based Intermediate Care and Rehabilitation Hubs working with Acute Care of Elderly (ACE) Practitioners and specialists based in the Acute Hospitals. Together, these changes will improve care quality and people’s experience of care and begin to bring about the whole-system change in the use of local services.

Following a successful recruitment campaign the additional capacity will be available from November 2018.

**Pulmonary Rehab**

Following an implementation period in during 2017/18, of partnership working between the Respiratory Managed Clinical Network and East Ayrshire HSCP, the introduction of Community Pulmonary Rehabilitation has evidenced better outcomes for patients, reduced drug costs and resulted in fewer hospital admissions. For winter 2018/19 this will be expanded in East Ayrshire and also the positive learning adopted and implemented in South Ayrshire.

**Discharge to Assess**

In order to carry out person centred assessments for future needs we will seek where possible to discharge people home or to a homely environment rather than conduct assessment in a ward environment that can be unfamiliar and disorientating to some patients. This is being supported by an increased presence of Social Work staff from North Ayrshire in University Hospital Crosshouse.

**Support End of Life Care at Home**

We have well established partnership arrangements in Primary Care with Marie Curie to support end of life care at home, we will seek to expand capacity and also refine the referral routes to enable easier access to Secondary Care specialist clinicians. In partnership with Scottish Care and Health Improvement Scotland we have developed Models of Palliative Care that support care at or close to home and will expand over winter 18/19.
3.2 Additional Interventions to be Implemented during Winter 2018/19

In Ayrshire, we have developed and used our predictive modelling tools to examine peak times of demand in both health and care services. Planning to meet these peaks has sought to identify resource gaps and ways to mitigate. Using this modelling information and the outcomes from our scenario planning event held on the 5th September we have developed a response that looks to plan rather than react to winter. These inputs have produced a number of proposals that will provide additional capacity to better manage demand.

**Weekend and Evening Discharge**

The purpose of these measures is to support patient flow through enhanced 7 day working and extended hours to evening.

- **ADDITIONAL SENIOR DECISION MAKER CAPACITY**

<table>
<thead>
<tr>
<th>Medical Cover</th>
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<tbody>
<tr>
<td>Saturday and Sunday 9am to 5pm</td>
<td>SHO</td>
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<tr>
<td>Saturday and Sunday 9am to 12 noon</td>
<td>Cons</td>
</tr>
<tr>
<td>Monday, Tuesday &amp; Friday 5pm to 8pm</td>
<td>Cons</td>
</tr>
<tr>
<td>Monday to Friday 5pm to 8pm Jan only</td>
<td>Cons</td>
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</tbody>
</table>

Cost for 5 months inc extended Jan opening £0.110m per site = £0.220m

- **DISCHARGE LOUNGE**

<table>
<thead>
<tr>
<th>Discharge Lounge</th>
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<tbody>
<tr>
<td>Monday to Friday 5-8pm</td>
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<tr>
<td>Monday to Friday 5-8pm</td>
<td></td>
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<tr>
<td>Saturday and Sunday 10am to 4pm</td>
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<tr>
<td>Saturday and Sunday 10am to 4pm</td>
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Cost for 5 months £0.0205m per site = £0.041m

- **ADDITIONAL CAPACITY**

<table>
<thead>
<tr>
<th>Ambulance</th>
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<tr>
<td>Saturday and Sunday 10am to 4pm</td>
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<table>
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<tr>
<th>AHPs</th>
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<tbody>
<tr>
<td>Saturday and Sunday 9am to 5pm</td>
<td></td>
</tr>
<tr>
<td>Band 6 Overtime</td>
<td></td>
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</table>

| Pharmacy                                  |       |
Author: Cost for 5 months £0.051m per site = £0.102m

- ADDITIONAL SOCIAL CARE CAPACITY

In each of the Health and Social Care Partnerships, additional Social Care at Home capacity will be made available to directly support evening and weekend discharge

Each Partnership

100hrs per week x £20 per hour x 20 weeks = £0.040m (x3) = £0.120m

Near Patient Influenza Testing

Experience from winter 17/18 demonstrated the positive impact of Near Patient Influenza testing. In response, NHS Ayrshire & Arran have allocated an additional £0.023m in the Acute budget for 2018/19. Our planning for winter seeks to expand this capacity and an additional £0.036m will be allocated from winter funding.

Right Care for Patients in Complex Discharge

The purpose of this measure is to provide care in a homely environment for patients who no longer need hospital care but their progress to alternative care is being delayed through complexities of discharge

- COMMISSION CARE HOME PROVISION

Up to 10 NHS funded Care Home Places commissioned to support complex discharge, with focus on people delayed within Adults With Incapacity legal processes.

10 placements x £36k per annum x 26/52 weeks = £0.180m

Transition Beds

Acknowledging the outputs from our predictive analysis and the expected impacts from our interventions at both implementation and additional stages outlined above, we will invest in 15 beds and University Hospital Crosshouse to support the transition to full implementation of interventions and protect elective capacity over this winter period. The cost for the winter period is £0.6m1.

1 A proposal for funds to support the investment in transition beds has been made to Scottish Government. These beds will support the transition period as interventions are implemented and protect elective capacity during the winter period.
4. Supporting Resilience in Winter

4.1 Workforce Plan

It is recognised that the delivery of safe and effective Health and Social Care services is dependent on the skills, dedication and availability of our staff.

Each element of the Health and Care system, and particularly the main operating divisions of UHC, UHA and the 3 HSCPs have prepared workforce plans to deploy staff in line with predicted demand. This is supplemented by the additional capacity outlined in section 3 above.

4.2 Additional cross cutting priorities

To support whole system resilience over winter and improve people’s experiences of health and care, additional plans have been reviewed in preparation for this coming winter period. These are:

- Communication plan
- Seasonal Flu Immunisation Plan
- Norovirus Plan
- Respiratory Plan
- Psychiatric Emergency Plan
- Business Continuity Plans
- Resilience plans with Community Planning Partners
- Escalation plans for UHC and UHA, AUCS and each HSCP
- Deployment plans for UHC and UHA and each HSCP

When combined these individual plans provide assurance across Ayrshire and Arran Health and Care services that the whole system has planned to meet the predicted demands of winter.
5. Preparedness Self Assessment
### Resilience and Preparedness

- The Strategic Planning and Operational Group (SPOG) has been established for a number of years. Membership includes the three Health and Social Care Partnership Directors, Director for Acute Services, Director for Transformation and Sustainability and meets on a weekly basis. This weekly planned meeting affords an opportunity to deal with any challenges in the system.
- There is an effective system wide resilience structure in place. This includes NHS Corporate Management Team and an Organisational Resilience Group which takes forward the resilience agenda system wide. In addition, there are Operational Resilience Groups in each of the Health and Social Care Partnerships, Acute Hospitals and Public Health department. These meetings take place regularly with appropriate representation to develop and update resilience and business continuity plans/arrangements.
- Resilience leads are identified and supported across the system and are supported by parent body leads and the NHS Resilience Team.
- Plans are tested in preparation for seasonal pressures.
- Minimum staffing levels have been established and services categorised to support the effective operation of critical and essential services.
- In addition, mutual aid plans are in place at a regional West of Scotland level.
- Supporting human resource policies are in place covering severe weather, adverse conditions and service disruption.
- Communications teams disseminate information on the operation of clinics and ambulance pick-up services and provide signposting to sources of weather and travel advice.

### Unscheduled / Elective Care Preparedness

**Clinically Focussed and Empowered Management**

- There is clarity of hospital site management through Assistant Directors and Associate Medical Directors and Assistant Nurse Directors.
- Twice daily huddles are in place to identify and address system pressures across clinical departments within the hospitals. Health and Social Care Partnerships participate in these huddles and weekly demand and capacity management meetings.
- Escalation plans are in place for each acute hospital sites. Whole-system communication and escalation protocols between partners have been established through multi-disciplinary Unscheduled Care Delivery Groups covering University Hospital Ayr and University Hospital Crosshouse.
- An Ayrshire wide Discharge Group is in place, Chaired by Senior Manager from East Ayrshire Health and Social Care Partnership, with representation from acute and partnership services to facilitate the
identification of opportunities for timely discharge. Detailed planning, analysis and forecasting is in place.
- System Watch predictors are utilised to anticipate the level of emergency admission.
- Elective activity is managed across each acute site and specialty with formal weekly meetings in place to monitor performance.
- Analysis and improvement tools are well established in acute services.
- 95 per cent performance against the 4-hour standard is a top priority for NHS Ayrshire and Arran linked to patient safety outcomes. Where there are waits outwith the 4-hour standard these are reviewed, lessons learned and disseminated. There is regular daily and weekly review of performance.

**Analysis and planning to effectively manage schedule elective and unscheduled activity**
- Monthly performance meetings are in place to monitor both planned care and unscheduled care performance.
- Improvement trajectories are set for each area.
- There is a weekly review of planned care activity to understand the position and deal with any movement from expected trajectory.
- Daily meetings are in place to review unscheduled care performance.
- Daily management debriefs to review and learn from previous day’s performance.

**Staff Rotas**
- Staff rotas are planned in advance to manage predicted activity.
- Health and Social Care Partnerships rotas for supporting services will be set by end of October.
- Pharmacy rotas will be agreed and communicated for an end of October timescale.

**Optimising Flow and Proactively Manage Discharge**
- East, North and South Health and Social Care Partnerships will ensure that discharge planning is coordinated across agencies.
- Proposed changes to working patterns by Scottish Ambulance Service (SAS) teams is planned to support people returning home over extended days and weekends.
- The Red Cross home from hospital service has been rolled-out across NHS Ayrshire and Arran which provides greater flexibility in response for the winter period.
• Daily Huddles between Health and Social Care Partnership teams and acute site management teams take place and focus on ‘no delays’ and discharge.
• E-Whiteboards are in place across acute wards and in most Community Hospital settings. E-Whiteboards also record Estimated Date of Discharge which is fed back into ward teams to support continuous improvement and earlier in the day discharge.

Anticipated home care and intermediate care requirement to facilitate discharge
• Partnership working was enhanced in 2015/16 with the establishment of an Unscheduled Care Network and Unscheduled Care Delivery groups focused on the two main hospital sites. This was further progressed during 2016/17 through establishment of an Unscheduled Care Programme under the pan-Ayrshire programmes for transformational change.
• Significant investment in 2018 in intermediate care and rehabilitation teams will increase support and capacity with a focus on admission prevention, supporting acute flow and facilitating timely discharge.
• The Intermediate Care Teams (ICT) ensure direct access to home care, intermediate care beds and rehabilitation to support discharge.
• There has been a strong focus on Anticipatory Care Planning in NHS Ayrshire and Arran. The identification of ‘at risk’ individuals through SPARRA and other mechanisms are shared and proactively managed by MDTs in primary and community service. Further development of ACPs continues to be progressed.

Effective Communication
• A working communication plan is in place to support key messages and actions Ayrshire partners will take during winter.
• A collaborative leadership event took place on 14th September to develop an engagement plan to take forward workforce engagement both about winter and also the wider unscheduled care priorities. Participants are members of the Unscheduled Care Delivery Groups. The outputs have been added to the working communications plan.
• Communication mechanisms between acute services and Health and Social Care Partnership managers are well established to support the early identification of system pressures. Escalation procedures were established in 2015/16 and have been tested and refined in the years since. Communication has improved greatly with daily information shared to highlight delays in the system and associated pressures.
- A system of daily situation reports is in place where flu incidences increase to enable the monitoring of workforce availability.
- Health Protection Scotland (HPS) population flu incidence reports are made available.
- Lead Partnership arrangements are in place for Mental Health Services covering crisis team and A&E links where acute presentations require support.
- Lead Partnership arrangements are in place for Out of Hours management across Ayrshire for Medical, Nursing and Social Work services.
- Templates with key contacts and service levels are in place with finalisation and sharing across the health and social care system for October 2018.
- Unscheduled Care Delivery Groups have supported the development of whole system escalation plans.
- The local media campaign is planned to dovetail with national ‘Know who to turn to’ campaigns. The campaign is delivered through a mix of traditional and social media. Special emphasis is placed on issues of medicine stock-up, self-care, requesting repeat prescriptions and the closure of GP practices during the festive period.

### Out of Hours Preparedness

- Integration arrangements now provide single management across Out of Hours community Medical, Nursing and Social Work services.
- A contingency/escalation plan is in place for Ayrshire out of hours medical workforce and this will be up-dated pre-winter 2018/19.
- Out of Hours GP rotas will be put in place to ensure cover for the holiday period.
- A pilot utilising ANP’s to support gaps in ADOC shifts has been effective and will continue over the winter period.
- Arrangements are in place with NHS24 regarding pre-prioritised calls.
- Winter activity will be monitored to determine any requirement for additional cover.
- Referral pathways are in place between A&E and Ayrshire out of hours services. This covers Out of Hours Mental Health. The Psychiatric Liaison Team and Crisis Team operate seven days per week and 365 days per year.
- Arrangements for community pharmacy services are made to ensure availability over the festive period and this is communicated widely.
- Emergency Dental Services are covered through NHS 24 for the festive public holiday period. Escalation protocols and on-call arrangements are in place.
- The social work services element of the Ayrshire out of hours service have in place contingency plans and emergency rotas.

| Prepare for & Implement Norovirus Outbreak Control Measures | The Infection Prevention and Control Team (IPCT) have in place Norovirus Control Guidelines.  
Guidelines cover general information, modes of transmission, symptoms, incubation and infection periods and action to be taken in the event of an outbreak or suspected outbreak.  
The IPCT and the Public Health Protection Team (HPT) play a vital role in public and workforce education. National publicity materials are distributed across primary and secondary care and these are reinforced through local media and site visits planned to coincide with Norovirus season. The HPT provide expert infection control advice in the event of any community outbreak and the IPCT for any hospital-related outbreak. |
| Seasonal Flu, Staff Protection & Outbreak Resourcing | Partners in NHS Ayrshire and Arran will work to deliver the seasonal flu vaccination programme in line with the Chief Medical Officer’s letter of 9th August 2018 (SGHG/CMO (2018)(07)).  
Up-take targets at a population level are 75 per cent for over 65s and under 65s in ‘at risk’ groups (including morbid obesity) and cover pregnant women.  
Free seasonal influenza vaccination will be offered to those providing care within Health and Social Care Partnerships. This will be offered in an accessible way to encourage up-take.  
The range of national and local communication resources will used to promote vaccination among residents and staff protection including [www.immunisationscotland.org.uk](http://www.immunisationscotland.org.uk)  
On site flu testing will be implemented by investing winter monies having seen improvements in length of stay in 2017/18 for those testing flu positive. |
| Respiratory Pathway | **There is an effective, co-ordinated respiratory service provided by the NHS board.**  
Partners in NHS Ayrshire and Arran have developed a strong respiratory pathway over recent years.  
Local guidance and information is in place to promote self-management and supported self-management.  
Specialist respiratory service is in place.  
Respiratory conditions are recognised as a significant factor in additional winter pressures.  
East Ayrshire and South Ayrshire have implemented a pulmonary rehabilitation service as part of our whole system technology enabled respiratory care framework. |
NHS Ayrshire and Arran has established specialist nursing respiratory posts in each HSCP from prescribing savings in respiratory drugs, transforming to a treatment based model of care. Increasingly we are using technology/Technology Enabled Care to support people to remain safely at home, for example Home & Mobile Health Monitoring. Intermediate Care & Rehab Teams in conjunction with respiratory specialists provide input to respiratory patients to avoid admission to hospital where appropriate. Teams also support patient discharge from hospital.

There is effective discharge planning in place for people with chronic respiratory disease including COPD:
- This group of patients are managed in a specialist respiratory ward and have access to all support services in order to coordinate a planned discharge in accordance with EDD.
- Care bundles are delivered for people in hospital with an exacerbation of COPD (for information/education/referral, and covers smoking cessation, inhaler technique, pulmonary rehab, telehealth, self-management).
- Medication discussed with patients on discharge and plans for follow up agreed.
- Intermediate Care & Rehab Teams support discharge from hospital.

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:
- Increasing numbers of COPD patients have access to ‘rescue’ medication supported by education and a personalised self management plan.
- Asthma self management plans are also in use.
- Those patients frequently admitted to hospital and patients with complex disease are likely to have ACPs and/or Electronic Care Summaries, including palliative care information.
- Messages about keeping warm, getting flu jab, nutrition and hydration, smoking cessation are visible and promoted in hospitals, General Practices and clinics.
- Ways of enabling clinicians to make easy referral to agencies that can provide advice and support in relation to fuel poverty and other money/debt issues have been introduced.

There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board.
National oxygen service implemented - Patients who require domiciliary oxygen are assessed by the respiratory nursing service and a consultant who then refer the patient to “Dolby” (who provide the national oxygen service) who manage their ongoing needs.

District Nursing teams have access to oxygen concentrators that are held in a number of localities for patients who require short term oxygen use including patients with malignant palliative care needs as per local guideline.

People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.

- All patients with a chronic respiratory disease follow a clearly defined pathway. If, following appropriate assessment, the patient requires access to oxygen therapy and supportive ventilation this will be provided where clinically indicated.
- Pulse oximeters are widely available and used routinely by emergency services (Scottish Ambulance Service, Urgent Care Service, GPs, Emergency Department).
- Patients know to be at risk of CO2 retention are supplied with Oxygen Alert Cards.

Management Information

Dashboards and data sharing developed in previous years continue to be enhanced in order to use real-time information to understand any pressures within the health and social care system and manage demand and capacity accordingly. The system provides data on:

- daily admission and discharge data;
- 4 x daily discharge activity shared to support planning; and
- daily unscheduled care performance data.

Unscheduled Care Delivery Groups have data portals to monitor performance of the ongoing programme. Local indicator and MSG indicator performance data are presented at every Delivery Group with aim to improve performance across the board.
The Winter Plan is the Health and Social Care response to unscheduled care over the winter to supplement existing year round plans. It is a whole system business continuity plan developed in collaboration between NHS Ayrshire & Arran, East Ayrshire Health & Social Care Partnership (HSCP), North Ayrshire HSCP, South Ayrshire HSCP and key partners from Scottish Ambulance Service and the Third Sector.

There are a number of projects already at implementation stage which will support our work to reduce unnecessary admissions, improve flow within the hospital and facilitate smoother transfer or discharge of patients on the health and care pathway. The projects include:

- Intermediate Care and Rehab - an annual investment of £2.5million in Intermediate Care and Rehabilitation services to offer 7 day working with the purpose of enhancing support to people within their own home and added focus on preventing hospital admission.
- Pulmonary Rehab - partnership working between the Respiratory MCN and East Ayrshire HSCP, demonstrated better outcomes for patients, reduced drug costs and resulted in fewer hospital admissions. This project is being expanded in East Ayrshire and implemented in South Ayrshire.
- Discharge to Assess – work to discharge people home or to a homely environment rather than conduct assessment in a ward environment that can be unfamiliar and disorientating to some patients is being supported by an increased presence of Social Work staff from North Ayrshire in University Hospital Crosshouse.
- Supported End of Life Care - Well established partnership arrangements in Primary Care with Marie Curie to support end of life care at home will expand and work to refine the referral routes to enable easier access to Secondary Care specialist clinicians will continue.

In addition to these projects, the following resources will be purchased using the winter allocation.

**Weekend and Evening Discharge**

The purpose of these investments is to support patient flow through enhanced 7 day working and extended hours to evening. It is anticipated that investment in these interventions will reduce length of stay by increasing discharge throughout an extended day and across a seven day week by expanding capacity within the teams across the health and social care pathway.

- Additional Senior Decision Maker Capacity. Cost for 5 months inc extended Jan opening £0.110m per site = £0.220m
- Discharge Lounge – extended hours. Cost for 5 months £0.0205m per site = £0.041m
- Additional Capacity in Ambulance, AHPs and Pharmacy - extended hours working. Cost for 5 months £0.051m per site = £0.102m
- Additional Social Care Capacity - additional Social Care at Home capacity will be made available to directly support evening and weekend discharge. Each Partnership @ 100hrs per week x £20 per hour x 20 weeks = £0.040m (x3) = £0.120m

**Near Patient Influenza Testing**

Experience from winter 17/18 demonstrated the positive impact of Near Patient Influenza testing. In response, NHS Ayrshire & Arran have allocated an additional £0.023m in the Acute budget for 2018/19. Our planning for winter seeks to expand this capacity and an additional £0.036m will be allocated from winter funding.

**Right Care for Patients in Complex Discharge**

To provide care in a homely environment for patients who no longer need hospital care but their progress to alternative care is being delayed through complexities of discharge. It is anticipated that this intervention will provide care for patients in the ‘right’ place and will help to create capacity in the acute environment equivalent to the 10 beds purchased in a care home setting.

- Commission Care Home Provision - Up to 10 NHS funded Care Home Places. 10 placements x £36k per annum x 26/52 weeks = £0.180m

Acknowledging the outputs from our predictive analysis and the expected impacts from our interventions at both implementation and additional stages, we will also invest in 15 transition beds \(^1\) to support the period to full implementation over this winter period. The interventions described above will improve flow within the hospital and facilitate smoother transfer or discharge of patients on the health and care pathway in these transitions beds as they will with all beds in the hospitals. All interventions detailed above will be monitored over the winter period to assess their effectiveness in dealing with peaks in demand with mitigation and remedial action taken where required.

\(^1\) A proposal for funds to support the investment in transition beds has been made to Scottish Government. These beds will support the transition period as interventions are implemented and protect elective capacity during the winter period. The cost for the winter period is £0.6m.