The Scottish Government
Directorate for Health Performance & Delivery

Scottish Government
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Dear Colleague

Preparing for Winter 2017/18

Summary
This guidance will help to ensure that Health & Social Care services are well prepared for this winter. The national report 'Health & Social Care: Winter in Scotland in 2016/17' has been integrated into this year's guidance (Appendix 2). Winter plans should provide safe and effective care for people using services and should ensure effective levels of capacity and funding are in place to meet expected activity levels. This will support service delivery across the wider system of health and social care.

Background
The importance of a collaborative approach to planning across local systems, building OOH capacity, improving delayed discharge and the six essential actions underpin this guidance. The guidance is also focused on planning for the additional pressures and business continuity challenges that are faced in winter.

Action
You are asked to lodge draft winter plan(s) with the Scottish Government by the end of August and final plans by the end of October. Plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Plans should also have senior joint sign-off reflecting local governance arrangements and should be published online. Plans should be sent to Winter_Planning_Team_Mailbox@gov.scot

Yours sincerely

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DL (2017) 19

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Preparing for Winter 2017/18

1. Introduction

1.1 Planning for winter is a particularly important part of all-year-round service delivery, given the additional pressures placed on local systems from seasonal flu, norovirus, severe weather and public holidays. The importance of a collaborative approach to planning, improving delayed discharge, building OOH capacity and a focus on the six essential actions (Annex A) underpin the planning guidance for winter 2017/18. This will help to ensure that Health & Social Care Services are well prepared for the additional pressures that winter brings. Winter plans should ensure that effective levels of capacity and funding are in place to provide safe and effective care and to meet expected service demand.

1. 2. Earlier this year the Scottish Government supported local systems to undertake a local review of service pressures and performance. In June we held a winter planning event to consider winter planning priorities from a collaborative perspective.

1.3 The national report 'Health & Social Care: Winter in Scotland in 2016/17 has been integrated into this year's guidance (Appendix 2).The official statistics show that Health & Social Care Services in Scotland sustained A&E performance throughout the winter of 2016/17 and continued to outperform other UK countries. Local systems also completed reviews of pressures and performance across their health and social care services to help prepare for this winter.

1.4 Over the summer we engaged with local health and social care systems to improve our approach to winter planning. The guidance has been updated to take into account some of the emerging findings from the public holiday review and local systems will want to ensure that their planning processes take full account of the recommendations from this review.

1.5 Unscheduled and elective care performance in Scotland compares favourably with other UK comparators. Robust planning and analysis should facilitate NHS Boards to pursue further sustainable improvement through 95% performance towards the 98% 4 hour Emergency Access Standard. This should also support the Treatment Time Guarantee (TTG) and ensure delayed discharges are kept to an absolute minimum. Health and Social Care Partnerships are expected to increase the percentage of people who are discharged within 72 hours of being ready and reduce the bed days associated with delays.

1.6 A balanced approach to the effective planning and scheduling of elective and unscheduled care and the impact that this is likely to have across the wider system will be needed. This will be particularly important in light of predicted emergency activity over the festive period, when any surge in respiratory and circulatory admissions over the winter can increase pressures, particularly towards the end of December and into January and February. Support to understand the capacity and demand of each site is available through the Unscheduled Care 6 Essential Actions Improvement programme. Developing the Basic Buildings Blocks model (Essential Action 2) will provide a baseline of the whole system and enable robust planning. The focus of the Whole System Patient Flow Programme and Guided Patient Flow Assessment will also contribute to this overall picture.

1.7 Forward planning should ensure that cancer patients who have a MDT, diagnostic or treatment target date occurring over the festive period are not delayed and that 31 day and 62 day cancer waiting times are not adversely impacted. In addition, NHS Boards should

work through Regional Planning Groups to ensure that both local and regional cancer treatment dates are maintained through the winter period.

1.9 Changes in the cohorts of admitted patients and their care requirements over the festive period should be monitored. This will be particularly important within respiratory, circulatory and ICU pathways. Primary care and community services should be engaged in minimising transfers of care through use of anticipatory care planning. A directory of services and alternatives to admissions should be available, covering primary and community services and also third and independent sector social care provision. Any additional capacity in these areas should be highlighted. Consideration should also be given to planning arrangements around end of life care.

1.10 Robust analysis should be undertaken to plan capacity and demand levels for this winter. Data available from ISD, via the Health and Social Care Data Integration and Intelligence Project (Source), can help with such analysis, including system watch. Recent years activity levels and improvements in flow should be taken into account as part of this process. Trends over three to five years should be considered. We also expect winter plans to address variation in demand.

1.11 Local Systems should ensure that NHS 24 and OOH services are supported and that adequate resources are in place across the whole system, including enhanced availability of pharmacy to meet the needs of the service. Plans must be explicit around the additional capacity planned for winter, including staffed medical and intermediate care beds, care packages, home/night sitting services accessible by GPs/NHS 24 and next day GP and hospital appointments. Deliverable plans for workforce capacity over the winter period must be agreed by October and detailed in the winter plan – these are important milestones. Nursing rotas that are made up for the festive period should not include the use of agency staff and should conform to workload planning tool guidance. It is important that this capacity is in place before the risk of boarding medical patients in surgical wards increases and that appropriate indicators of potential surge are monitored on a daily basis. Analysis should include triggers for whole system escalation processes to prevent access block. Local Systems should also ensure that Primary Care Risk Registers are in place.

1.12 Sustainably achieving safe and effective patient flow is critical to maintaining performance as a standard operating model across the winter period. Utilising the improved communication and leadership of the 6 Essential Actions Programme, including Safety Huddles, should focus on a Daily Dynamic Discharge Approach which includes: proactive discharge planning including, pre noon discharges, weekend discharges, utilisation of discharge lounge and criteria led discharge. A review of support services such as portering, cleaning, pharmacy and transport should be undertaken to ensure capacity is aligned to demand, not just within hours, but also across 7 days and out of hours periods.

1.13 The Chief Medical Officers strongly encourage all staff are vaccinated against seasonal flu, particularly front-line staff and those working in areas where patients might be at greater risk (paediatric, oncology, maternity, care of elderly, haematology, ICUs). The aim is to vaccinate 50% of front line staff and efforts should be made to make the vaccine available at times and places that are convenient for staff. Senior clinicians and NHS Managers should ensure their staff understand the benefits of the vaccine to healthcare workers and to patients.

2. Critical Areas, Outcomes and Indicators

2.1 The critical areas identified below remain key to effective winter planning and should be the bedrock on which winter plans are built. The local indicators, which underpin each critical area, should be included in relevant local management processes to achieve the outcomes described. Indicators should also align with the unscheduled care 6 Essential Action Improvement Programme (summarised at Annex A). Winter plans should set out the geographies and frequency of the local indicators being monitored and provide further detail on how these indicators might be developed, where applicable.

1. Business continuity plans tested with partners. *(Appendix 1 - Checklist 1 refers)*
Outcome: • Local health and social care systems have fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather.
Local indicator(s): • progress against any actions from the testing of business continuity plans.

2. Escalation plans tested with partners. *(Appendix 1 - Checklist 2:1 refers)*
Outcome: • Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.
Local indicator(s): • attendance profile by day of week and time of day managed against available capacity • locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over 2, 4 hours • all indicators should be locally agreed and monitored.

3. Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January. *(Appendix 1 - Checklist 2:2 and 2:4 refers)*
Outcomes: • Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period. • The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimised. • Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.
Local indicator(s): • daily and cumulative balance of admissions / discharges over the festive period • levels of boarding medical patients in surgical wards • delayed discharge • community hospital bed occupancy • number of Social Work assessments including variances from planned levels.

4. Strategies for additional surge capacity across Health & Social Care Services
(Appendix 1 - Checklist 2:2 refers)

Outcomes:

- Risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised.
- Staffing plans for additional surge capacity across health and social care services is agreed in October.
- Planned dates for the introduction of additional acute, OOH, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment.

Local indicator(s):

- planned additional capacity and planned dates of introduction
- planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds;
- planned number of additional intermediate beds in the community and the planned date of introduction of these beds;
- levels of boarding.
- planned number of extra care packages
- planned number of extra home night sitting services
- OOH capacity
- planned number of extra next day GP and hospital appointments

5. Whole system activity plans for winter: post-festive surge / respiratory pathway.
(Appendix 1 - Checklists 2:2 and 6 refers)

Outcomes:

- The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.
- Monthly Unscheduled Care Meetings of hospital triumvirate, including IJB Partnerships and SAS (clinical and non-clinical) colleagues.

Local indicator(s):

- daily number of cancelled elective procedures;
- daily number of elective and emergency admissions and discharges;
- number of respiratory admissions and variation from plan.

6. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance
(Appendix 1 - Checklist 2:2 refers)

Outcome:

- NHS Boards have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.

Local indicator(s) :

- Agreed and resourced analytical plans for winter analysis.
- Use of System Watch

7. Workforce capacity plans & rotas for winter / festive period agreed by October.
(Appendix 1 - Checklist 2:3 refers)

Outcomes:

- Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective health and social care. This should encompass all relevant health and social care services.
- Maintain discharges at normal levels over the two 4 day festive holiday periods
- Right level of senior clinical decision makers available over the two 4 day festive holiday periods.

Local indicator(s):

- workforce capacity plans & rotas for winter / festive period agreed by October;
- effective local escalation of any deviation from plan and actions to address these;
- extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements.
- number of discharges on each of the 4 day festive holiday periods compared to number of normal daily discharges

8. Discharges at weekends & bank holidays
(Appendix 1 - Checklists 2:3 and 2:4 refers)

Outcome:

- Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow.
- Robust planning and decision making midweek to support discharges for patients over a public holiday weekend for example Immediate Discharge Letters (IDLs), Pharmacy Scripts, Transport and Equipment to minimise delays

Local indicator(s):

- % of discharges that are criteria led on weekend and bank holidays;
- daily number of elective and emergency admissions and discharges.
- discharge lounge utilisation

9. The risk of patients being delayed on their pathway is minimised.
(Appendix 1 - Checklist 2:4 refers)

Outcomes:

- Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflects the arrival patterns and potential waiting times for assessment and/or transfer/discharge.
- Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer.
- Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance.

Local indicator(s):

- distributions of attendances / admissions;
- distribution of time to assessment;
- distribution of time between decision to transfer/discharge and actual time;
- % of discharges before noon;
- % of discharges through discharge lounge;
- % of discharges that are criteria led;
- levels of boarding medical patients in surgical wards.

10. Communication plans *(Appendix 1 - Checklist 2:7 refers)*
Outcomes: • The public and patients are kept informed of winter pressures, their impact on services and the actions being taken • Effective local and national winter campaigns to support patients over the winter period are in place. • Staff are engaged and have increased awareness of the importance of working to discharge patients over the two 4 day festive holiday periods.
Local indicator(s) : • daily record of communications activity; • early and wide promotion of winter plan

11. Preparing effectively for norovirus. *(Appendix 1 - Checklist 4 refers)*
Outcome: • The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).
Local indicator(s): • number of wards closed to norovirus; • application of HPS norovirus guidance.

12. Delivering seasonal flu vaccination to public and staff. *(Appendix 1 - Checklist 5 refers)*
Outcome: • CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance.
Local indicator(s): • % uptake for those aged 65+ and 'at risk' groups; • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

3. Self-Assessment Checklists

3.1 The self-assessment checklists (Appendix 1) provide further detail to support the development of local winter plans. These checklists should be used by local governance groups to assess the quality of winter preparations and to ascertain where further action might be required. There is no requirement for these checklists to be submitted to the Scottish Government.

3.2 A National Unscheduled Care Event will be held on 14th September at Stirling Management Centre and will include sessions on a range of initiatives designed to support local health and social care systems to effectively prepare for winter.

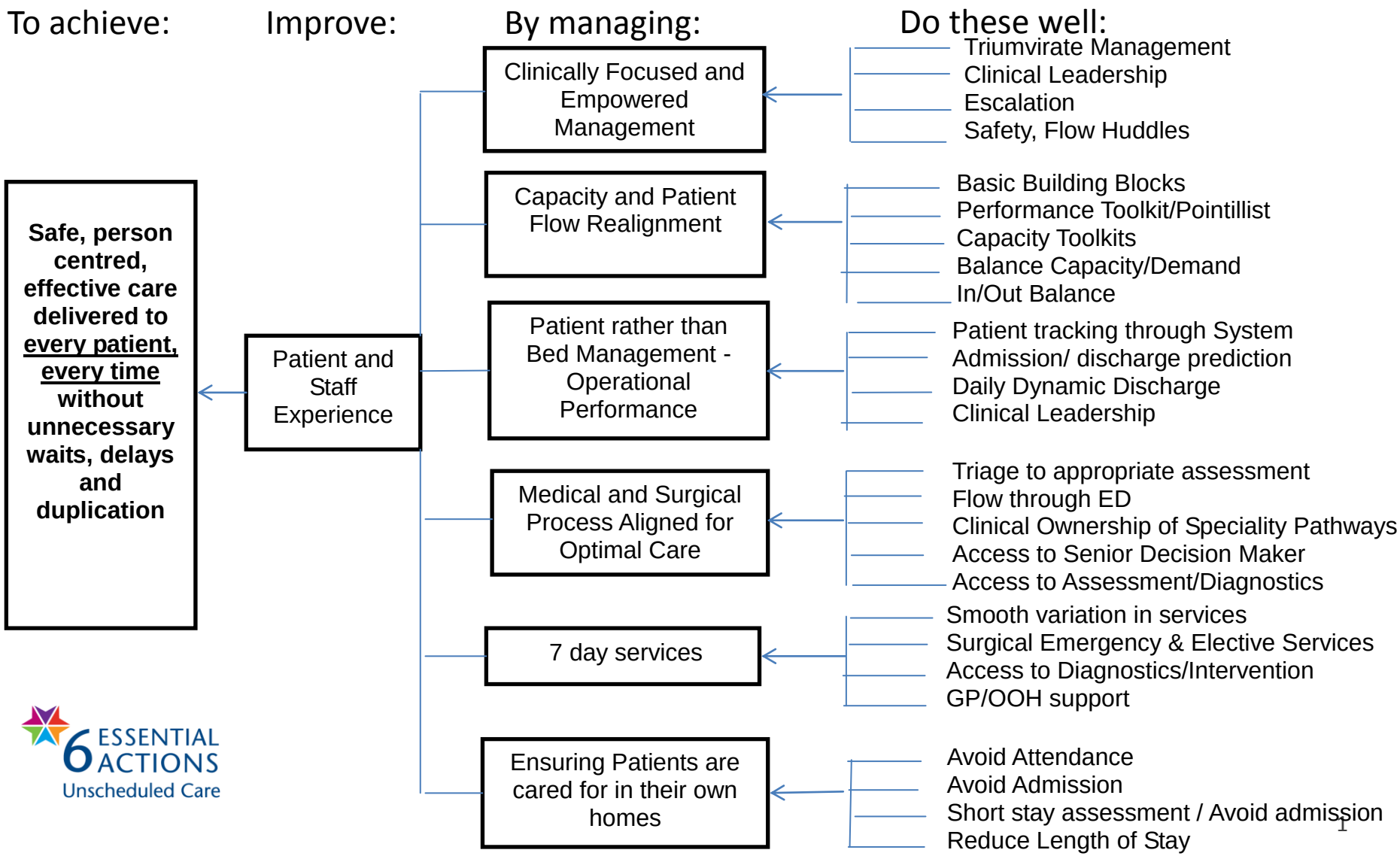
4. Winter Plan Sign-Off

4.1 Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August and final plans by the end of October. Plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Plans should have senior joint sign-off reflecting local governance arrangements and should be published online. Plans should be sent to Winter_Planning_Team_Mailbox@gov.scot .

4.2 I recognise the tremendous commitment made by the workforce across Health and Social Care services in meeting the challenges of winter and I would be grateful if you could pass on my appreciation of their dedication and valued contribution.

Annex A

6 Essential Actions to Improving Unscheduled Care Performance



Appendix 1:

Preparing for Winter 2017/18

Winter Preparedness: Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Seasonal Flu**
6. **Respiratory Pathway**
7. **Management Information**
8. **Sign-Off**
9. **Integration of Key Partners / Services**

These checklists should be read in conjunction with the Preparing for Winter 2017/18 Guidance.

- NHS Territorial Boards and Health & Social Care Partnerships should consider all of these actions, in detail, as part of their winter planning preparations.
- NHS Special Boards should review all of these actions to identify those most applicable to their own area of operations.
- Special Boards should also consider how they can best support Territorial Boards and Health & Social Care Partnerships across the full complement of actions and initiate supportive partnership working where required.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups should use the attached checklists to self-assess the quality of overall winter preparations and to ascertain where further action is required to ensure that winter preparedness priorities are met.

- There is no requirement for these checklists to be submitted to the Scottish Government.

- Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online. Plans / links to plan(s) should be sent to Winter_Planning_Team_Mailbox@gov.scot

- Winter Plans should consider the critical areas highlighted in the Preparing for Winter 2016/17 Guidance and demonstrate effective integration of key partners and services.

- The following RAG status definition table is offered as a guide to help you evaluate the status of your overall winter preparedness against each action.

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	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *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. The NHSScotland Standards for Organisational Resilience (2016) sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☐ ☐		
2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios. Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner. The partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	☐ ☐ ☐		
3	The NHS Board and HSCPs have HR policies in place that cover: • what staff should do in the event of severe weather hindering access to work, and • how the appropriate travel advice will be communicated to staff and patients *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.*	☐		
4	The NHS Board's and HSCPs websites will be used to advise on travel to appointments during severe weather and prospective cancellation of clinics.	☐		
5	The NHS Board, HSCPs and local authority 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.	☐		
6	The effectiveness of winter plans will be tested with all stakeholders by 30 October The final version of the winter plan has been approved by NHS Board and HSCPs	☐		

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 process is in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity. *To manage and monitor outcomes monthly unscheduled care meetings of the hospital triumvirate should invite IJP 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.*	☐		
1.2	Effective communication protocols are in place between clinical departments and senior managers 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.	☐		
1.3	Effective communication protocols are in place between key partners, particularly across local authority housing, social work and homecare services, equipment and adaptation services, Mental Health Services, and the independent sector. *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.*	☐		
1.4	A Target Operating Model has been communicated to all staff. Escalation policies are well defined, clearly understood, and well tested. *Clear thresholds and authorities for triggering, and standing down, escalation plans should be established and clearly communicated across each department and ensure an appropriate whole system response*	☐		
1.5	Escalation policies are in place and consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *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.*	☐		
1.6	Escalation policies are focused around in-patient capacity across the whole system including community beds and care at home services *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 and discharged without further delay*	☐		
1.7	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. *All escalation plans should have clearly identified points of contact and should be comprehensively tested*	☐		

	and adjusted to ensure their effectiveness.			
2	**Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, 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	Demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated. *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *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 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 surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*	☐		
2.2	A range of analysis and management tools to enable effective and related planning and management of scheduled and unscheduled services have been implemented. *e.g. Basic Building Blocks, Performance Toolkit, Statistical Process Control, Queuing Theory, Discreet Event Simulation, Variation Methodology, etc.*	☐		
2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions. *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.*	☐		
2.3	Pre-planning and modelling has been undertaken around elective activity to plan responses, escalation and recovery to minimise the impact of winter peaks in demand on the delivery of routine elective work. *A set of clear actions should be developed based on a firm understanding of demand and capacity, prediction and management of variation.* *In the event of winter pressures impacting significantly on elective capacity, NHS Boards, should contact SGHSCD Access Support Team to advise of any service disruption*	☐		

2.4	NHS Boards review and take stock of their performance against the British Association of Day Surgery (BADS) Directory version 5 to ensure that they have achieved optimum performance against the surgical procedures identified as being suitable for day case surgery" *Achieving optimal performance against BADS version 5 will support NHS Boards to manage bed occupancy, admission and discharge of elective patients.*	☐		
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities such as MDTs, and projected peaks in demand. These rotas should include services that support the management of inpatient pathways, (e.g.) diagnostics, pharmacy, phlebotomy, AHPs, IPCT, portering, cleaning etc.**			
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 (e.g.). Hogmanay Street parties 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*.	☐		
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.	☐		
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*	☐		
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.*	☐		
3.5	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.			
4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge process which includes**			

	determining an Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of simple discharge, ensuring there are no delays in patient pathways.			
4.1	Discharge planning in collaboration with HSCPs 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 ready.*	☐		
4.2	Discharge planning will support all patients and carers to plan required transport arrangements. There will be on-going engagement with SAS, and third sector partners, to effectively plan provision for appropriate patient transport services when it is known, or anticipated, that patients will require transport home or to another care setting. *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.*	☐		
4.3	Multi-disciplinary ward and board rounds will be embedded to proactively manage the patient journey and prepare for discharge detailing the estimated date of discharge. Utilise electronic whiteboards and Criteria Led Discharge where appropriate. *This should be displayed visually for the care team to see and should be the focus of all daily ward rounds and bed meetings and inform daily safety flow huddles. Task lists should be available for all actions leading towards early discharge.*	☐		
4.4	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.*	☐		

4.5	Predictive data will be used to assess the hourly demand for beds allowing for patients to be discharged as soon as fit and as early as possible in the day to optimise flow. *Consider evaluating the accuracy of EDD to help improve the discharge process.* *Develop in/out balance for each ward level to improve speciality receiving and minimise boarding.*	☐		
4.6	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.*	☐		
5	**Ensure that senior clinical decision making capacity is available for assessment, care planning, MDTs and discharge and that AHP rotas are structured, to facilitate the discharging of patients throughout weekends and especially during the fortnight in which the two festive holiday periods occur in order to maximise capacity.**			
5.1	There is adequate medical, nursing and AHP cover across both, the festive holiday period, and over weekends to conduct assessments, plan effective care programmes and perform dedicated discharge rounds. *Criteria-led discharges should be put in place wherever possible to improve discharge process across 7 day.*	☐		
5.2	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. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*	☐		
6	**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.**			
6.1	There is 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.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☐		

6.2	On-going and detailed engagement around the capacity of social care services to accommodate predicted discharge levels will start no later than October.	☐		
6.3	A clear escalation plan is in place to resolve issues that might arise in provision of service. *Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.*	☐		
6.4	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised, where possible. *Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*	☐		
6.5	Host partnerships are taking the discharge requirements of patients who are receiving treatment at the Golden Jubilee Foundation into account. *This will be relevant where patients are likely to be repatriated to their NHS territorial boards after receiving treatment at the Golden Jublilee Foundation.*	☐		
6.6	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.*	☐		
6.7	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.*	☐		
7	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
7.1	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as soon as they occur, and that escalation procedures are invoked at the earliest opportunity. *These should be in place prior to winter and plan tested for effective response. Utilise ED Capacity Management Guidance to develop whole system approach and response to crowding.*	☐		
7.2	Demand, capacity, and activity plans across emergency and elective provision are fully integrated and communicated to all stakeholders *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.*	☐		

7.3	Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector. *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.*	☐		
7.4	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. *NHS 24 are leading on the 2017/18 'Be Healthwise This Winter' media campaign, and SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around repeat prescriptions', respiratory hygiene, and norovirus 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*	☐		

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. *This should include an agreed escalation process.* *Have you considered/discussed local processes with NHS 24 on providing pre-prioritised calls during the OOH period?*	☐		
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.	☐		
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.			
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?*	☐		
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.	☐		
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	☐		
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.	☐		
8	In conjunction with HSCPs, ensure that there is reference to provision of dental services, to ensure 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.*	☐		
9	The plan displays a confidence that staff will be available to work the planned rotas. *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.*	☐		
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.	☐		
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.*	☐		

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.*	☐		
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.*	☐		
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic plan including provision for an escalation plan. *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 guidance provided by the National Infection Prevention and Control Manual. *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☐		
2	IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in care homes.*	☐		

3	HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.	☐		
4	NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be 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.*	☐		
5	Debriefs will be provided following individual 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.*	☐		
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.	☐		
7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.	☐		
8	NHS Boards must ensure arrangements are in place to provide adequate IPCT 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.*	☐		
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple 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.*	☐		
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *This could include the notification of 'tweets', where appropriate, to help spread key message information.*	☐		
11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message.	☐		

	This could include the notification of 'tweets', where appropriate, to help spread key message information.			

5	**Seasonal Flu, Staff Protection & Outbreak Resourcing** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	At least 50% of all staff 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, as recommended in the CMOs seasonal flu vaccination letter due to be published in mid Aug 2017. *This will be evidenced through end of season vaccine uptake submitted to HPS by each NHS board. Local trajectories have been agreed and put in place to support and track progress. Uptake of vaccine in 2016/17 was still significantly below target, at 35.4%.*	☐		
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2017) 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; and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.			
3	The winter plan takes into account the predicted surge of 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. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required and an agreed protocol is in place with NHS Boards on the use of the contingency stock. 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)*	☐		
4	HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Health Protection Scotland and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. HPS produce a weekly influenza bulletin and a distillate of this is included in the HPS Winter Pressures Bulletin.*	☐		
5	Adequate resources are in place to manage potential outbreaks of 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.*	☐		

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.	☐		
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☐		
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).*	☐		
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.*			
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. *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.	☐		
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,* https://www.bo.scot.nhs.uk/. *This release estimates an individual's risk of emergency admission.* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☐		
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.*	☐ ☐		
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.*	☐		

7	**Management Information** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	Admissions data will be input to the System Watch predictive modelling system as close to real time as possible. Local quality assurance of the site and board level data is in place.	☐		
2	Effective reporting lines are in place to provide the Scottish Government with routine weekly management information and any additional information that might be required on an exception / daily basis. *Over the winter period we will be augmenting the weekly management information collected on an all-year-round basis and will share this information across partnerships to help compare and benchmark performance.*	☐ ☐		
3	Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise. *Any exception reporting should be set within the context of planned / actual capacity and demand activity.*	☐		

8	Sign Off *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online.	☐		
2	Arrangements are in place to include governance of winter planning within local Unscheduled Care Management Groups or other relevant management groups as appropriate. *Membership of these groups should include national and local Unscheduled Care Teams where applicable.*	☐		

9	Key Roles / Services Integrated into Planning Process		RAG	Further Action/Comments
	Heads of Service	☐		
	Nursing / Medical Consultants	☐		
	Consultants in Dental Public Health	☐		
	AHP Leads	☐		
	Infection Control Managers	☐		
	Managers Responsible for Capacity & Flow	☐		
	Pharmacy Leads	☐		
	Mental Health Leads	☐		
	Business Continuity / Emergency Planning Managers	☐		
	OOH Service Managers	☐		
	GP's	☐		
	NHS 24	☐		
	SAS	☐		
	Territorial NHS Boards	☐		
	Independent Sector	☐		
	Local Authorities	☐		

	Integration Joint Boards	☐		
	Strategic Co-ordination Group	☐		
	Third Sector	☐		
	SG Health & Social Care Directorate	☐		

Appendix 2

Health & Social Care: Winter in Scotland in 2016/17

Scottish Government
Riaghaltas na h-Alba
gov.scot

Health & Social Care: Winter in Scotland in 2016/17

Summary

1. Health & Social Care systems in Scotland sustained A&E performance in winter 2016/17 and continued to outperform other UK countries.

Purpose

2. Winter disruptions can include increased demand and activity due to seasonal flu, respiratory and circulatory illness; increased numbers of falls and trips; and wards closed to admission due to higher levels of norovirus. There are also business continuity challenges associated with managing workforce rotas during the festive period, to ensure that patients continue to be safely and effectively admitted, diagnosed, treated and discharged.

3. This report draws together the key official statistics on activity, pressures and performance. Unless otherwise stated, within the charts and tables, winter is defined as the two quarters ending December and March.

4. This report should be considered alongside the Preparing for Winter 2017/18 Guidance, which has been issued at the same time as this report.

Planning for Winter 2016/17

5. The Scottish Government and local partnerships reviewed the winter 2015/16 as part of the planning process for 2016/17. The Scottish Government developed winter guidance with NHS Boards and their partners over the summer of 2016. Winter guidance was issued on 12 August 2016. A National Unscheduled Care planning event was held on 08 September 2016. Local plans were published.

Levels of activity in Winter 2016/17

6. The Scottish Ambulance Service introduced a new clinical response model during the 2016/17 winter period on 23 November 2016. The new model is designed to ensure that patients get the right clinical resource first time every time. The model did not have any direct impact on emergency demand during the winter period. Demand since go live, has remained stable and within normal expected levels. The acuity levels within the demand have however changed with significantly less calls being triaged as immediately life threatening. The Service responded to 250,357 Emergency incident during winter 2016/17, 880 incidents less than the previous winter.

7. A&E attendances in winter 2016/17 were at 783,099 similar to winter 2015/16 (788,025). Provisional statistics show emergency inpatient discharges down by over 10,000 or 3.6 per cent this winter.

8. Calls to NHS 24 core services decreased by 16,462 or 2.1 per cent compared to last winter. During the winter 2016/17, 4 of the 6 months reflect this overall reduction, with October and December 2016 however showing an increase. March 2017 shows a significantly lower year on year variance, a decrease of

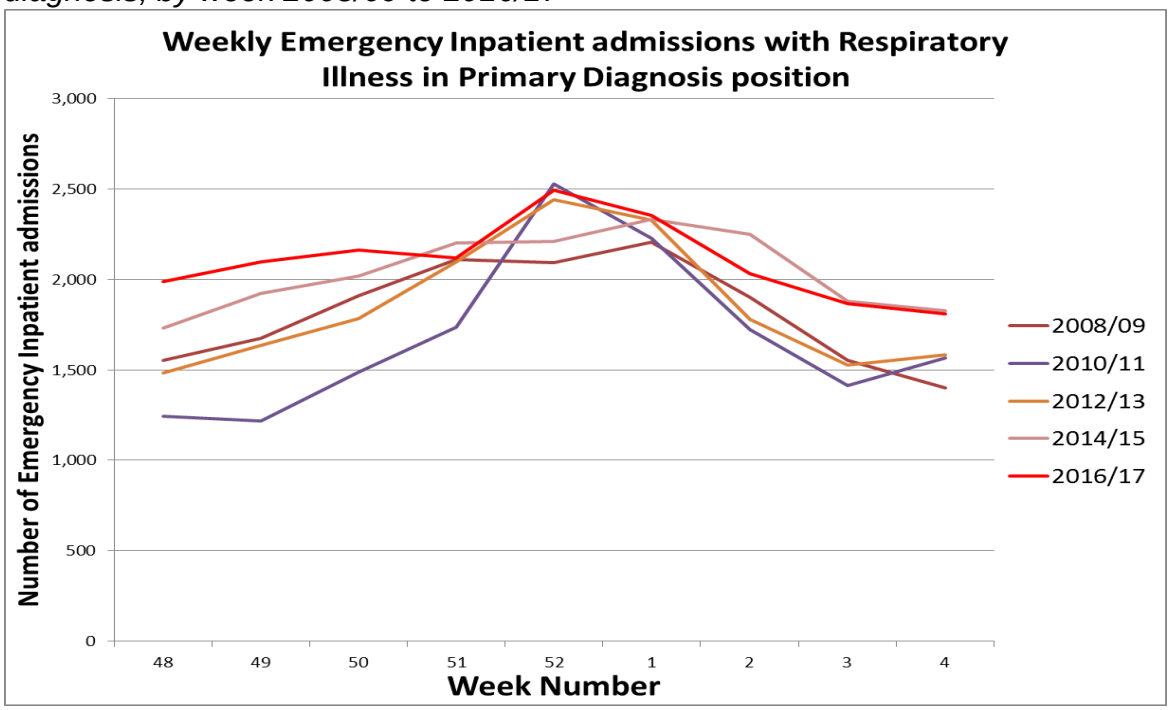
14.2% (20,476 calls) which was heavily influenced by Easter falling in April in 2017, as opposed to March in 2016.

9. GP Out of Hours data will be published in the near future.

Respiratory conditions and influenza

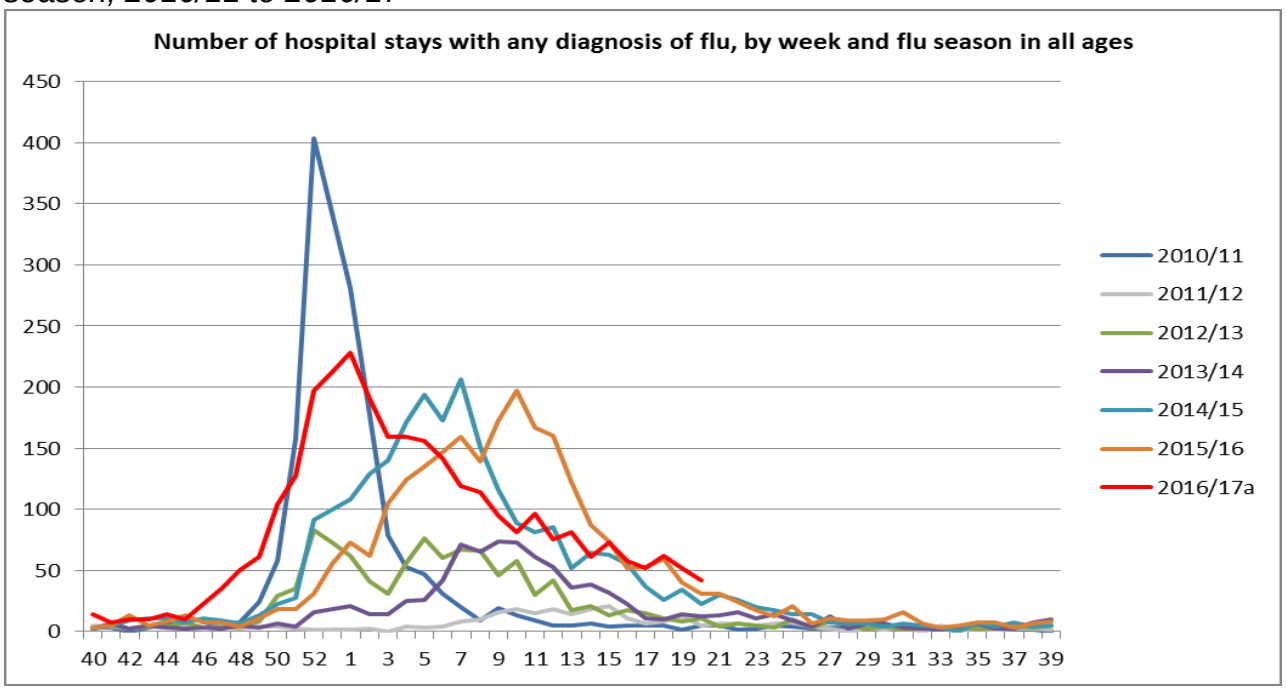
10. Weekly emergency inpatient admissions with respiratory illness are above the recent long term average.

Chart 1: Weekly emergency inpatient admissions with respiratory illness as a primary diagnosis, by week 2008/09 to 2016/17



11. Within the general community, impact on general practice was low and below the levels expected in a normal influenza season across the whole of the 2016/17 season. However, the provisional data on the number of influenza hospital admissions for 2016/17 is similar to 2014/15 and 2015/16, and higher than previous seasons.

Chart 2: The Number of hospital stays with 'any diagnosis' of flu, by week and flu season, 2010/11 to 2016/17

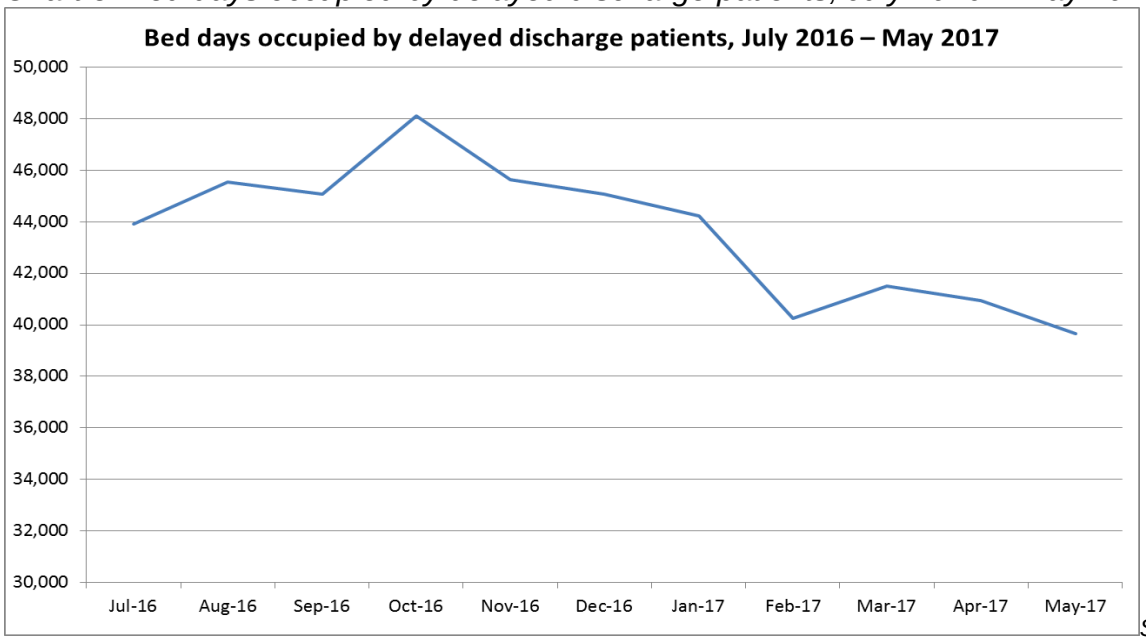


Source: Health Protection Scotland

Delayed discharge

12. During winter 2016/17, the number of bed days occupied by delayed discharge patients have reduced from 48,104 in October 2016 to 41,493 in March 2017.

Chart 3: Bed days occupied by delayed discharge patients, July 2016 – May 2017



Source: ISD Scotland

Norovirus was relatively mild, and the weather was not particularly cold

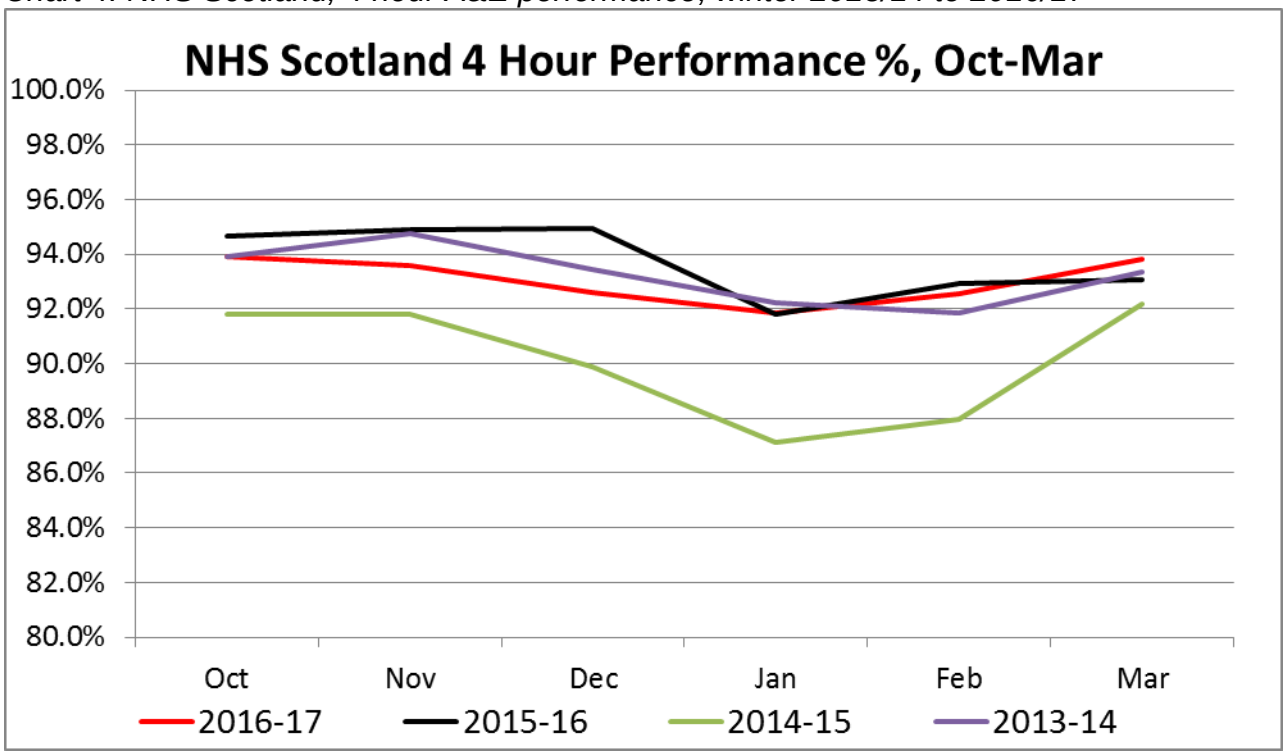
13. The norovirus season 2016-17 was relatively low compared to the 2010-2015 season average.

14. The average temperatures this winter were slightly above the 30 year averages.

A&E waiting times

15. The length of time A&E patients wait to be seen, treated and discharged can be a proxy measure of how the Health and Social Care system is managing the pressures it is facing. Official statistics show 4 hour A&E performance in March 2017 at its highest level since March 2012.

Chart 4: NHS Scotland, 4 hour A&E performance, winter 2013/14 to 2016/17



Source: ISD Scotland, A&E Datamart

Core A&E waiting times performance was higher in Scotland compared to other UK countries in Winter 2016/17

16. Official statistics on waiting times in large Accident & Emergency departments are published by each of the four UK countries. This report does not consider the nature of the pressures faced in other parts of the UK. This winter, performance in Scotland was significantly above that in England, Northern Ireland and Wales.

Table 1: UK A&E "Core" sites 4 Hr Performance, winter 2016/17, percentage

	'Winter'
	Oct-Mar 2016-17
Scotland	92.1%
England	81.6%
Wales	76.4%
Northern Ireland	68.8%

Source: ISD Scotland, NHS England, NHS Wales Informatics and DHSSPSNI

Elective and cancer waiting times

17. Statistics for January to March 2017 show that 82.1% of inpatients and day-case patients were treated within 12 weeks this compares to 89.0% for July to September 2016. Statistics also show 80.7% of patients waiting for a new outpatient appointment at 31 March 2017 had been waiting 12 weeks or less, compared to 79.3% at the end of September 2016. For January to March 2017, 62 day performance for Cancer Waiting times was 88.1%, which was up from the quarter ending September 2016 (87.1%).

Season Flu Vaccination

18. Early (provisional) data on seasonal flu uptake by staff in 2016/17 was 35.3 per cent, a 3.3 percentage point improvement on 2015/16 which saw an uptake figure of 32.0 per cent. The 2016/17 figures are broadly in line with uptake from 2014/15 which reached 35.6 per cent. However, overall recorded uptake remains low and below the 50 per cent target.

19. Last winter more than two million Scots were offered the free flu vaccine. People at greater risk from flu, including those with underlying health conditions, pregnant women and those aged 65 were encouraged to get the vaccine. Provisional uptake rates are shown in the table below.

Table 2: Provisional seasonal flu uptake rates, 2016/17

Eligible Groups	**Uptake**	**Target**
65 and over	72.8%	75%
Under 65 at risk	44.9%	75%
Pregnant Women (without risk factors)	49.3%	75%
Pregnant Women (with risk factor)	58.0%	75%
2-5 year olds (not yet at school) – vaccinated at GP practice	59.0%	65%
Schoolchildren aged 5-11 (P1-P7) – vaccinated at school	73.0%	75%

*Source: HPS (**National Influenza Report - week ending 31 May 2017)***

References

Acute Hospital Activity and NHS Beds Information Quarter ending March 2016
Quarterly trends in available beds
https://www.isdscotland.org/Health-Topics/Hospital-Care/Publications/2017-06-27/Quarterly-Trends-in-Available-Beds-by-Health-Board-of-Treatment-and-Specialty-Jun17.xlsx

Quarterly Inpatient, Day Case and Outpatient Activity
https://www.isdscotland.org/Health-Topics/Hospital-Care/Publications/2017-06-27/Quarterly-Inpatient-Day-Case-Activity-by-Health-Board-of-Treatment-Jun17.xlsx
https://www.isdscotland.org/Health-Topics/Hospital-Care/Publications/2017-06-27/Quarterly-Trends-in-Consultant-Led-Outpatient-Activity-Health-Board-Of-Treatment-Jun17.xlsx

NHS Scotland Workforce Information - Quarterly update of Staff in Post, Vacancies and Turnover at 31 March 2016

Overall Trend
https://www.isdscotland.org/Health-Topics/Workforce/Publications/2017-06-06/Overall_Trend_M2017.xls

Consultant staff in post
https://www.isdscotland.org/Health-Topics/Workforce/Publications/2017-06-06/Consultant_Staff_In_Post_M2017.xls

Nursing and midwifery staff in post
https://www.isdscotland.org/Health-Topics/Workforce/Publications/2017-06-06/Nursing_and_Midwifery_SIP_M2017.xls

Emergency Department Activity and Waiting Times

Emergency Department Activity and Waiting Times data (Excel file)
http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/2017-07-04/AE_activity_waiting_times_Jul17.xlsx

NHS Performs - Weekly Update of Emergency Department Activity and Waiting Times Statistics

2017-07-25 Weekly AE Statistics
http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/2017-07-25/2017-07-25-ED-Weekly-Statistics.xlsx?09:37:22

NHS England, A&E Attendances and Emergency Admissions 2016-17

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/06/May-17-Monthly-AE-Timeseries-with-growth-charts.xlsx

Time Spent in NHS Wales Accident and Emergency Departments: Monthly Management Information

https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/performanceagainst4hourtargetallemergencycarefacilities-by-localhealthboard

NHS Northern Ireland, Statistics on Emergency Care Waiting Times by Department & Month

https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-nitws-ecwt-tables.csv

Delayed Discharges in NHSScotland - Occupied Bed Days in April 2016 and census Figures for May 2016

Bed Days Occupied in April 2016
http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2017-07-04/BedDays_Occupied_Tables_To_May_2017.xlsx?09:55:30
Delayed Discharges in May 2016

http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2017-07-04/Census_Tables_To_May_2017.xlsx?09:55:30

Mid-2016 Population Estimates Scotland

All Tables
https://www.nrscotland.gov.uk/files//statistics/population-estimates/mid-year-2016/tables/16-mid-year-pe-alltabs.xlsx

Inpatient, Day case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 31 March 2016

Inpatient and Day case admission: Waiting Times and Activity, NHS Scotland
http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2017-05-30/IPDC_May17.xlsx

Influenza

HPS National Influenza Report - week ending 21 May 2017
http://www.hps.scot.nhs.uk/resourcedocument.aspx?id=5977

Norovirus

Weekly Norovirus Report – 27 June 2016
http://www.hps.scot.nhs.uk/resourcedocument.aspx?id=6058

UK Climate Summaries
http://www.metoffice.gov.uk/climate/uk/summaries/anomacts