

**REPORT TO:** HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 11<sup>TH</sup> DECEMBER 2024

**REPORT ON:** WINTER RESILIENCE PLAN NHS TAYSIDE AND PARTNER ORGANISATIONS 2024/25

**REPORT BY:** CHIEF OFFICER

**REPORT NO:** DIJB62-2024

## **1.0 PURPOSE OF REPORT**

- 1.1 The purpose of this report is to present to Dundee Integration Joint Board the Winter Planning arrangements for NHS Tayside and Health & Social Care Partnerships for 2024/25 (attached as Appendix 1).
- 1.2 A whole system Health and Social Care approach to develop an integrated plan is essential. The Tayside and Fife Health and Social Care Partnerships, the Scottish Ambulance Service (SAS), 3<sup>rd</sup> Sector, as well as staff side/partnership representation have been involved in the development of the plan to ensure timely access to the right care, in the right place, first time. Third sector involvement is through the Health and Social Care Partnerships

## **2.0 RECOMMENDATIONS**

It is recommended that the Integration Joint Board (IJB):

- 2.1 Approves and endorses the Winter Resilience Plan (NHS Tayside and Partner Organisations) 2024/25 for submission to the Scottish Government.
- 2.2 Notes ongoing whole system collaboration in preparation for anticipated winter challenges.

## **3.0 FINANCIAL IMPLICATIONS**

- 3.1 Similar to the previous 2 years, funding for 2024/25 is integrated across all Urgent and Unscheduled Care programmes to provide a holistic fund to support shared decision making and collaborative working that systematically works through the priorities. Therefore, there is no separate “Winter” funding allocation.

The IJB enhanced the external social care budget by £1546k in 2024/25 to support demographic pressures plus a shift of resources of £3500k from underspends/savings across the Partnership budgets – total additional investment of £5046k recurringly. Furthermore, the IJB previously set aside £1m of reserves to support winter pressures - £744k was utilised in 23/24 and the balance of £246k is assumed to be utilised during 2024/25.

## **4.0 MAIN TEXT**

- 4.1 The aim of the 2024/25 Winter Resilience Plan is to demonstrate collective and collaborative engagement between Acute Services and Health and Social Care Partnerships to improve capacity and system resilience through aligned planning. Setting critical improvement actions to effectively manage the challenges associated with the winter period whilst continuing to deliver against the national and local targets and standards for Health and Social Care. Using

data modelling and learning from previous years to inform a system response to anticipated pressures.

NHS Tayside Winter Resilience Planning will continue to build upon the design and delivery of a whole system framework for predicting, responding to, and managing peak periods of unscheduled activity. This will include a focus on whole system communication and response to support both unscheduled demand and urgent, cancer and planned elective care as possible.

4.2 The 2024/25 Winter Plan has been informed by external and internal sources, with a focus on delivery of the agreed Scottish Government Winter Plan priorities, with an emphasis on prevention to reduce avoidable demand:

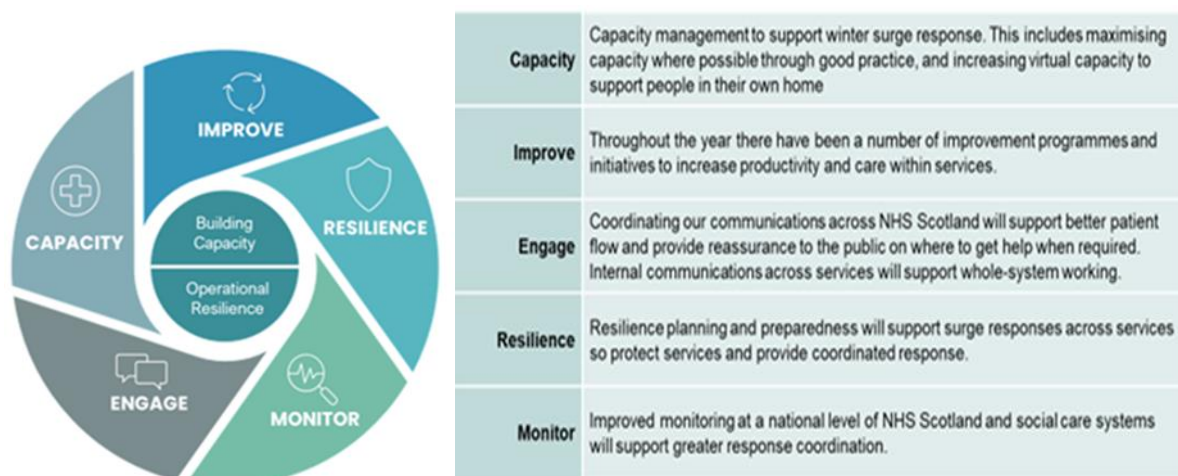
Priority One: Prioritise care for all people in our communities, enabling people to live well with the support they choose and utilise effective prevention to keep people well, avoiding them needing hospital care.

Priority Two: Ensure people receive the right care, in the right place at the right time, this includes prioritising care at home, or as close to home as possible, where clinically appropriate.

Priority Three: Maximise capacity and capability to meet demand and maintain integrated health, social care and social work services, protecting planned and established care, to reduce long waits and unmet need.

Priority Four: Focus on supporting the wellbeing of our health and social care workforce, their capacity and improving retention, as well as valuing and supporting Scotland's unpaid carers.

NHS Tayside continue to develop a multi-disciplinary approach to building capacity and maintaining operational resilience aligned to national strategy:



4.3 The scope of the NHS Tayside Winter Resilience Plan is whole system with a focus on the following key areas in line with the Scottish Government Winter Preparedness Checklist - Areas of Assurance:

- Overview of Preparedness and Business Continuity
- Urgent and Unscheduled Health and Social Care, and Planned Care
- Primary Care, Mental Health and Social Care
- Health and Social Care Workforce and Staff Wellbeing

4.4 Section 5 of the Winter Plan details the specific actions for the Health and Social Care Partnerships. This year's winter period is expected to be busier due to increased demand across all health and social care services. The primary focus continues to be ensuring that individuals receive appropriate care, in a timely manner, in the most suitable setting, with the goal of preventing unnecessary hospital admissions and promoting swift discharge when

readiness permits. This approach contributes to improved health outcomes and maximises resource utilisation.

#### 4.5 Key actions for Dundee Health and Social Care Partnership are:

- Partnership Oversight Report published weekly to monitor pressure areas and feed into the whole system heat map
- Business Continuity Plans in place across all services, including adverse weather conditions response
- GAP community discharge hub in place (Business as Usual)  
Enhanced recruitment into social care regarded as 'Business as Usual'
- An intensive programme of improvement has achieved a significant reduction in unmet care need hours through working with care providers to enhance efficiency. The focus is now on sustaining performance.
- A promotion campaign is being undertaken to encourage social care support workers to access vaccination services.
- A Self-Directed Support event was held for frontline staff on 4<sup>th</sup> September to raise awareness and identify opportunities for using different SDS options to deliver care at home.
- The Spasticity Service is now fully operational as a means of supporting further rehabilitative approaches for stroke and neurology patients in a community setting.
- There is ongoing development of the Community Rehabilitation Service as a means of shifting rehabilitation closer to community settings.
- An improvement programme is being progressed across Dundee Enhanced Care at Home Team (DECAHT) focusing on:
  - Streamlining the process for transfer of care between in-patient services and DECAHT to support care closer to home
  - Participating in optimising access workstream to ensure appropriate use of services to optimise early access to preventative approaches
  - Reviewing practice-based MDTs to support early appropriate referral
  - Promoting joint working between cluster consultants and GPs/ Community services to support care at home
  - Implementing remote prescribing to reduce unnecessary travel time and optimise capacity
  - Working collaboratively across MFE pathway to implement medication reviews for those most at risk of negative impact of polypharmacy
  - Ongoing review of patient pathways within the service to reduce risk, reduce duplication and improve the quality of service provided
  - Supporting the completion of RESPECT documentation to ensure that ceilings of care are agreed with the patient and shared across the MFE pathway
  - Continuing to embed the Cluster model to ensure MDT working across the MFE pathway
- Lead ANP structure now established to support development of whole system pathways of care
- Implementation of locality working model in community nursing to reduce unnecessary travel time and optimise capacity
- Discharge to Assess social care service has been re-focused on front door frailty wards within Ninewells. The service Team Leader works collaboratively with the ward multi-disciplinary team to prioritise how the service is most appropriately allocated to support early discharge and assessment in a home environment.
- An improvement programme is in progress across Royal Victoria Hospital site to reduce average length of stay whilst ensuring high quality care, focusing on:
  - Refreshing practice related to setting planned date of discharge
  - Implementation of the bed request function on Trakcare
  - Spread of 'Early Expectation meetings' to discuss discharge planning across Medicine for the Elderly
- Redesign of rehab model on the RVH site aligned to excellence in care standards
- The Stroke Neuro Rehabilitation Pathway Redesign is in progress, aiming to deliver an interdisciplinary approach to deliver an outcomes focused personalised rehabilitation pathway.
- Dundee remains committed to meet RAG status green (6 or less acute delays and 25 or less

total delays) and maximum 2 patients waiting step down bed from acute per day, as per previous RAG agreed delays position via Tayside DWD programme. Dundee remains committed to progressing RVH LOS towards 28 days for MFE and Orthogeriatrics, and LOS target of 42 days for stroke and neuro rehab.

## 5.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

## 6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it does not require any policy or financial decisions at this time.

## 7.0 CONSULTATIONS

Chief Finance Officer, Head of Service - Health and Community Care, Dundee City Council Management Team and the Clerk were consulted in the preparation of this report.

## 8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

## 10.0 BACKGROUND PAPERS

None

DATE: 11 November 2024



# NHS Tayside

## Winter Resilience Plan

### 2024/25

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## Executive Summary

NHS Tayside, the Health and Social Care Partnerships of Angus, Dundee and Perth & Kinross, Scottish Ambulance Service and other key stakeholders have continued to take a collaborative approach towards preparedness and planning for winter 2024/25 supported by Tayside Urgent and Unscheduled Care Board (UUCB) and the Winter Resilience Delivery Group.

The NHS Tayside Winter Resilience Plan is underpinned by the Unscheduled Care Collaborative and Redesign of Urgent Care Programme, taking full account of the Scottish Government's Winter 2024/25 Preparedness Programme and Checklist.

The Winter Resilience Plan has been developed based upon the key areas highlighted in the checklist to ensure early prevention and response, to minimise potential disruption to services and ensure that we continue to provide safe and effective care of our population and timely access to services.

Improvement work continues with our Partner organisations to optimise hospital attendances, manage and avoid admissions, while our acute service areas focus on the flow through acute care, cancer, mental health and outpatient services, to deliver against national standards.

The focus on improved resilience over the festive period taking account of learning from previous winters will ensure arrangements are in place to mitigate disruption to critical services. The plan will be underpinned by full business as usual continuity arrangements and daily management of safety, capacity and flow through the NHS Tayside Safety and Flow Triggers and Escalation Framework with senior clinical and management leadership and multi-professional input to the safety and flow huddle infrastructure seven days per week.

The Winter Resilience Plan will be supported by a suite of data and information tools including use of Command Centre, Safe Care and the Winter Planning Heatmap. This will be further supported by a weekly look back to encourage system learning and continuous improvement.

A whole system Health and Social Care approach to develop an integrated plan is essential. The Tayside and Fife Health and Social Care Partnerships, the Scottish Ambulance Service (SAS) as well as staff side/partnership representation have been involved in the development of the plan to ensure timely access to the right care, in the right place, first time. Third sector involvement is primarily through the Health and Social Care Partnerships.

## Executive Leads for Winter

Chief Officer, Acute Services, NHS Tayside  
Chief Officer, Angus, Health & Social Care Partnership  
Chief Officer, Dundee, Health & Social Care Partnership  
Chief Officer, Perth & Kinross, Health & Social Care Partnership

# 1. Introduction

## 1.1 Aim

The aim of the 2024/25 Winter Resilience Plan is to demonstrate collective and collaborative engagement between Acute Services and Health and Social Care Partnerships to improve capacity and system resilience through aligned planning. Setting critical improvement actions to effectively manage the challenges associated with the winter period whilst continuing to deliver against the national and local targets and standards for Health and Social Care. Using data modelling and learning from previous years to inform a system response to anticipated pressures.

NHS Tayside Winter Resilience Planning will continue to build upon the design and delivery of a whole system framework for predicting, responding to, and managing peak periods of unscheduled activity. This will include a focus on whole system communication and response to support both unscheduled demand and urgent, cancer and planned elective care as possible.

## 1.2 Planning Approach

The 2024/25 Winter Resilience Plan has been informed by external and internal sources, with a focus on delivery of the agreed Scottish Government Winter Plan priorities, with an emphasis on prevention to reduce avoidable demand:

**Priority One:** Prioritise care for all people in our communities, enabling people to live well with the support they choose and utilise effective prevention to keep people well, avoiding them needing hospital care.

**Priority Two:** Ensure people receive the right care, in the right place at the right time, this includes prioritising care at home, or as close to home as possible, where clinically appropriate.

**Priority Three:** Maximise capacity and capability to meet demand and maintain integrated health, social care and social work services, protecting planned and established care, to reduce long waits and unmet need.

**Priority Four:** Focus on supporting the wellbeing of our health and social care workforce, their capacity and improving retention, as well as valuing and supporting Scotland's unpaid carers. NHS Tayside continue to develop a multi-disciplinary approach to building capacity and maintaining operational resilience aligned to national strategy:



<b>Capacity</b>	Capacity management to support winter surge response. This includes maximising capacity where possible through good practice, and increasing virtual capacity to support people in their own home
<b>Improve</b>	Throughout the year there have been a number of improvement programmes and initiatives to increase productivity and care within services.
<b>Engage</b>	Coordinating our communications across NHS Scotland will support better patient flow and provide reassurance to the public on where to get help when required. Internal communications across services will support whole-system working.
<b>Resilience</b>	Resilience planning and preparedness will support surge responses across services so protect services and provide coordinated response.
<b>Monitor</b>	Improved monitoring at a national level of NHS Scotland and social care systems will support greater response coordination.

The scope of the NHS Tayside Winter Resilience Plan is whole system with a focus on the following key areas in line with the Scottish Government Winter Preparedness Checklist - Areas of Assurance (Scottish Government Checklist included as Appendix 1):

**Section 1:** Overview of Preparedness and Business Continuity

**Section 2:** Urgent and Unscheduled Health and Social Care, and Planned Care

**Section 3:** Primary Care, Mental Health and Social Care

**Section 4:** Health and Social Care Workforce and Staff Wellbeing

### 1.3 Finance

NHS Tayside received a letter dated 17th July 2024 from Scottish Government outlining the funding allocation of £2.5m for 2024/25. The letter stated that funding must be used to support delivery of the Boards improvement plan for urgent and unscheduled care, with a focus on the improvement impact around length of stay which will bring improved occupancy and flow.

Similar to last year, this funding for 2024-25 has been utilised to support costs already embedded & integrated into core service delivery to support delivery of Unscheduled Care and the associated outcomes and measures as described in the letter. This has been agreed through the local Urgent & Unscheduled Care Board and provides the Board with the greatest opportunity to maximise delivery against the core set of measures.

Therefore, for the third year in a row there is no separate “Winter” funding allocation. The Winter Plan Leadership team are working with operational leads to understand any additional costs in the system and how these can be mitigated, and further detail will be provided once this work has been concluded.

Any additional costs will require to be balanced against the financial, operational & performance risks of the Health Board.

### 1.4 Approval of Plan

The process and timeline for preparation, review and approval of this plan:

Action	Date Due
Care Group plans pulled together and shared at Winter Resilience ODG	28 August 2024
Angus Integration Joint Board	30 <sup>th</sup> August 2024

Divisional plans pulled together and shared at Winter Resilience ODG	11 September 2024
H&SCP plans pulled together and shared at Winter Resilience OGD	11 September 2024
Acute Divisional Plans reviewed at Acute Services level and shared at SLT	20 September 2024
Perth & Kinross Integration Joint Board	2 October 2024
Draft Winter Resilience Plan 2024/25 reviewed whole system at OLT	4 October 2024
H&SCP Plans and Acute Services Plan reviewed at Tayside Urgent & Unscheduled Care Programme Board	8 October 2024
NHS Tayside Winter Resilience Plan 2024/25 presented for approval to ELT	14 October 2024
H&SCP Plans reviewed within respective Management structure and IJBs	30 October 2024
NHS Tayside Winter Resilience Plan 2024/25 presented for approval to Tayside NHS Board	31 October 2024

The Health & Social Care Partnerships have contributed to the overarching plan and have taken their HSCP specific plans through their respective IJB's in October.

## 1.5 Governance Arrangements

Development, delivery, and monitoring of the Winter Resilience Plan is a key responsibility of the Urgent and Unscheduled Care Board and the Winter Resilience Delivery Group. The Urgent and Unscheduled Care Board is co-chaired by the Associate Director for Medicine and the operational leads for Urgent & Unscheduled Care, from each of the three HSCPs.

- The Winter Resilience Operational Delivery Group has whole system representation.
- An Urgent and Unscheduled Care Programme Team is in place led by a programme manager, these posts form part of the support team for unscheduled care, continuous improvement and the implementation and evaluation of the Winter Resilience Plan.
- Resilience and Business Continuity arrangements and management plans are in place and a Winter Planning Tabletop Exercise is planned for 13 November.
- NHS Tayside's Board Assurance Framework has a corporate whole system risk related to capacity and flow.
- Whole system Safety and Flow Huddle process including key partners 365 days per year. This will be extended through the winter period, where required, to include members from our HSCPs.
- A Communication Strategy for winter is in place and will inform the public and staff on our planning for winter, public health messages and where to go for access to services.

## 2. Lessons Learned from Previous Winter 2023/24

Key themes, learning and actions from local reviews across Tayside and from a whole system winter debrief session was held on Friday 26th April. This was well attended with representation from across acute services, Health & Social Care Partnerships and other partner organisations such as the Scottish Ambulance Service. The Board Room was at full capacity with 54 people.

### **Key priorities for winter 24/25 were identified as follows:**

- Planning for winter surge should cover the period December – February, but with an assumed peak early January.
- Planning to commence earlier than in previous years i.e. commence in the summer.
- Of high importance is the recognition and support of the requirement for a winter surge ward for medical and surgical unscheduled admissions. This was felt to be essential based on the lived experience of participants.
- Improvement required around escalation plans which enable a rapid reaction to avoid amber to black (as per Heat Map).
- Maximise use of the Surgical Assessment Unit (SAU) on the Ninewells site.
- Cohort specialties as far as possible, mainly Medicine for the Elderly, Respiratory and Vascular from winter 23/24 experience.
- Develop clear Guidance for when to step up/step down tactical cell meetings.
- Add radiology (CT) waits to Heat Map.
- Minimise short notice cancellations through better planning and improved communication.
- Protect urgent surgical elective capacity by optimising theatre scheduling.
- Maximise specialty seasonal working patterns.
- Improve communication, processes and sharing of data to allow Patient Transport to be mapped to need. This includes NHST Patient Transport Service, SAS and OOH Transport vehicles, as well as British Red Cross support.
- Maintain/Improve delayed discharge position across HSCPs, as was achieved during winter 23/24.
- Improve access for staff regarding vaccination roll out.
- Continue to progress increased 7-day working over winter for support team services who do not do this already.

### **3. Winter Resilience Plan 2024/25**

The Tayside Winter Resilience Plan 2024-25 is set out using the key headings aligned to the Scottish Government Winter Preparedness Checklist:

**Section 1:** Overview of Preparedness and Business Continuity

**Section 2:** Urgent and Unscheduled Health and Social Care, and Planned Care

**Section 3:** Primary Care, Mental Health and Social Care

**Section 4:** Health and Social Care Workforce and Staff Wellbeing

An overview of the work progressing in each of these areas to support delivery of our Winter Resilience Plan aim is provided below. Detailed operational-level divisional and partnership plans are progressing to support delivery of the strategic ambitions. An example of this is attached in Appendix 1 and 2.

Through the Winter Resilience Operational Delivery Group, the performance and delivery of the operational plans and actions will be reviewed using RAG status methodology and exception reporting, seeking solutions from across the system and progress of the escalation framework as appropriate.

### 3.1 Resilience Preparedness

NHS Tayside and its partner organisations have robust business continuity management arrangements and plans in place. Tayside wide groups involving all partner organisations such as the Local Resilience Partnership (LRP) meet regularly with a LRP Emergency Response Generic Multi-Agency Coordination Plan in place which describes the framework to be followed should an incident occur. The purpose of the LRP Emergency Response Generic Multi-Agency Coordination Plan is to provide a framework within which those who are responsible for the co-ordination and management of the successful resolution of an incident work together efficiently and effectively. The content aligns with the revised Preparing Scotland – Responding to Emergencies Guidance (2017).

The LRP links directly with the NHS Tayside Public Health Team around the co-ordination, command, control and communication requirements in the event of a high consequence infectious disease winter pressure being triggered.

### 3.2 Adverse Weather

An NHS Tayside Adverse Weather Plan is in place which provides a framework for ALL staff to follow in the event of extreme bad weather. An annual tabletop exercise is undertaken to test the efficacy of arrangements in place including:

- Link to HR policies/Once for Scotland Policy: NHSScotland Once for Scotland Policy DL (2022) 35 Interim National Arrangements for Adverse Weather
- Links to existing business continuity plans and the NHS Tayside Strategic Business Continuity Plan
- Ownership - operational rather than service specific
- Duty Manager/Director/Executive awareness of status – linked into daily huddle meetings/Whole System Safety and Flow Framework
- Safety and Flow Hub Action Card.
- Accommodation arrangements for 'essential' staff in the event of adverse weather
- Structure to monitor requests for extremis assistance
- Early and continued engagement with Tayside Local Resilience Partnership
- Organisational procedure for requesting 4x4 assistance reviewed and policy in place

### 3.3 Scottish Ambulance Service (SAS) Resilience Planning

The Scottish Ambulance Service maintains a comprehensive contingency planning framework to manage the consequences of when the level of demand exceeds the ability of the Service to meet it. The Generic Capacity Management Contingency Plan and Resource Escalatory Action Plan (REAP) Guidance Document are used for this purpose. The Capacity Management Contingency Plan may need to be implemented in circumstances when there is: increased demand, reduced capacity or reduced wider NHS services over festive periods.

SAS manages capacity and contingency through the REAP, which establishes levels of 'stress' within service delivery, whether from increased demand or reduced resource, and identifies measures to be implemented to mitigate the impact of such stress. Measures are service-wide and include activity from the Operational Divisions, Ambulance Control Centres (ACCs), National Risk and Resilience Department (NRRD), and Airwing.

The REAP – attached as Appendix 4 – provides the actions to cope with increased demand at any point, with SAS making decisions regarding what is relevant for the circumstances. For example, cancelling all non-essential meetings to allow the managers to provide support and concentrate on the management of resources / shift coverage etc.

The REAP is followed with a few additional directives for adverse weather:

- Ensuring there are shovels on each vehicle
- Additional supplies of consumables, grit/salt for the stations etc
- Map out where staff reside so that they can be directed to their nearest station rather than their base station if they can't make it there
- List and map all 4x4 vehicles so that they can be allocated to transport essential staff and patients e.g. renal/ oncology patients
- Liaise with the Health Board around activity and ensure any resources freed up from cancellations are used as additional staff on vehicles that require to go out in the severe weather to give us resilience

### **3.4 System Wide Escalation and Flow Huddle Framework**

The Whole System Safety and Flow Triggers and Escalation Framework continues to evolve and assist in the management of health and social care capacity across Tayside and Fife when the whole system, or one constituent part of the system is unable to manage the demand being placed upon it.

The aim of this Framework is to provide a consistent approach to provision of care in times of pressure by:

- Enabling local systems to maintain quality and safe care
- Providing a consistent set of escalation levels, triggers and protocols for local services to align with their existing business as usual and escalation processes
- Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at local level, within local authorities, and partner agencies

The Safety & Flow Huddle process is fundamental in identifying triggers and supporting the subsequent escalation processes required in response to system pressures.

There are currently four huddles per day on the Ninewells and PRI hospital sites with a whole system huddle at 9am each day that includes Mental Health and SAS colleagues, through winter 2024/25 members of our HSCP and Primary Care/Out of Hours teams will join this to encourage whole system awareness and escalation as required.

Flow Hubs on the Ninewells and PRI sites are well established and continue to support real time flow management through collaborative working.

The Tayside Tactical Cell will be operationalised as required by any Duty Director or Chief Officer as we move into the peak winter period. This whole-system real time forum to support immediate system pressures worked well through previous winters.

### 3.5 Speciality-Level Escalation Plans/Winter Action Cards

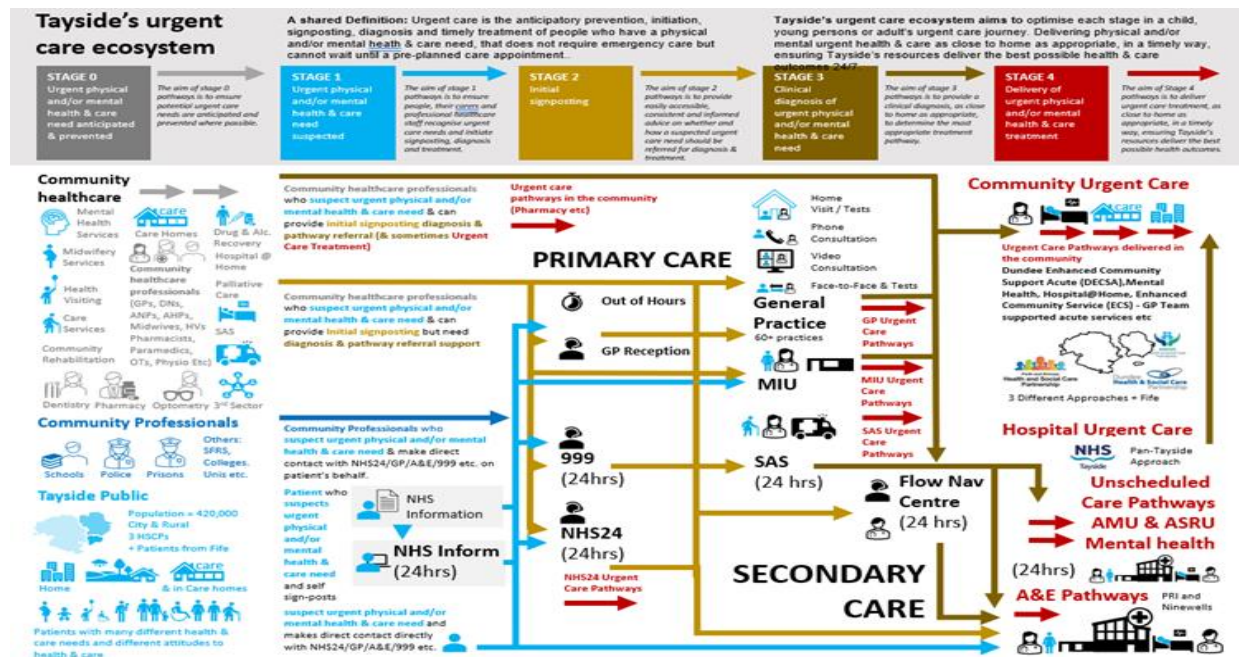
Winter Planning action cards and escalation plans are being progressed across all key speciality areas to support consistent and effective decision making. These will support both the frontline teams and Safety and Flow Leadership teams in delivering a consistent and agreed approach to implementation of escalation measures.

The action cards/escalation plans will all be stored within a dedicated winter plan section in the NHS Tayside Resilience App for ease of access in and out of hours.

### 3.6 Site Escalation Framework

Site Escalation Frameworks are being developed for both Ninewells Hospital and Perth Royal Infirmary, which are in the final stages of planning and approval through the relevant governance structures, and will be available by 31st October 2024.

## 4. Urgent & Unscheduled Care



The vision for the Urgent and Unscheduled Care Board is to work across health and social care to sustainably improve the timeliness, quality and experience of care for people accessing urgent and unscheduled care across Tayside. Three key strategic aims have been agreed supported by key enablers and are detailed below:

1. Optimising Access to Urgent Community Care & Acute Hospitals
2. Optimising In-Patient Flow / Discharge Without Delay
3. Performance 95

Each strategic priority has an associated workstream with key stakeholders and deliverables. They are supported by workplan/change packages and dashboards to demonstrate outcomes.

Key Enablers:



1. Digital Strategy
2. Realistic Medicine
3. Whole System Resilience
4. Whole System Financial Framework

## **1. Robust responsive operational management**

Tayside acute hospital sites (PRI and Ninewells Hospital) have robust operational clinical leadership and management arrangements in place 24 hours a day, 7 days a week. This ensures there is a strong, real-time understanding of the status of each site to support the delivery of high-quality, safe, and timely care and patient flow.

Each site has a dedicated Safety and Flow Hub supported by a Professional Nursing Lead and a Senior Manager is also available to support both sites based at Ninewells. The team is supported by a Duty Director.

Medical input is provided through the Clinical Care Group structure, providing subject expertise which informs and supports further decision-making. Senior nursing staff attend the site huddles throughout the day and provide an updated status on admissions, discharges, bed occupancy and escalate issues/concerns for support as required.

The team is available on site 8am to 7.30pm and located in the Patient Safety and Flow Hub on each site. In the out-of-hours period, a Duty Manager is on-call for each acute site to immediately respond to issues, supported by a Duty Director. The team is also supported by an Executive on Call.

## **2. Improve morning and weekend discharges and optimising patient flow (Discharge Without Delay (DWD))**

The hospital discharge team participate in the acute site huddles each morning and provide a detailed briefing to the Safety and Flow Team each day. NHS Tayside continues to have a strong focus on the DWD programme and has made significant investment in this.

Focussed workstreams continue to support Planned Date of Discharge (PDD) delivery on all inpatient wards in Tayside, including Community Hospitals. This includes seven-day planning, weekend discharges and improving performance of discharges as early in the day as possible.

The Optimising Patient Flow workstream aims to deliver flow performance in all Tayside inpatient ward / speciality in line with Upper Quarter Length of Stay. A structure of Division/HSCP Flow meetings have been established to identify any barriers impacting on flow and implement improvements across patient pathways to address these.

This programme (aligned to other work) is aimed at significantly contributing towards the 4 partner agencies equally delivering on pre-agreed flow performance targets. Service and workforce plans this winter are based on meeting these upper quartile targets:

Medicine Ninewells LOS <4days

Perth Medicine LOS <5days

Surgical LOS < 4.5 days

Ortho LOS < 7 days

Step-down hospital LOS <28 days

Delayed discharge position RAG GREEN for acute but also total delays

These performance targets are all reliant and interdependent of all agencies working together and delivering against their specific actions.

### **3. Rapid assessment and streaming out of ED**

Tayside acute services operate several “front doors” with acute admissions being referred directly into medical and surgical receiving areas, as well as directly to speciality wards, including stroke medicine, paediatrics, renal medicine, neurology, haematology, oncology and specialist surgery.

Some key areas are supported by a framework of pre-hospital decision support which facilitates Prof-to-Prof communication between Primary Care, SAS, Out of Hours Service, NHS 24 and hospital clinicians to ensure Right Care, Right Place. This provides a senior clinical decision maker at the point of referral to ensure that patients are placed on the correct pathway first time and that alternatives to admission are considered.

The medicine pathway from ED to AMU involves a direct nurse-to-nurse referral to ensure there are minimal delays to patients moving from ED into Medicine pathways.

Work is progressing to develop this within Surgery and Orthopaedics Pathways to reduce delays. Critically unwell patients are referred clinician to clinician to ensure safe transfer for ongoing management.

### **4. Monitor breach by reason, time and cause**

All ED breaches are reviewed daily by the ED team, as well as being visible through the Command Centre at Executive level. A flash report is provided daily to detail all breach reasons and highlight any key themes and learning. Any themes identified are raised with Departments and Divisions to ensure improvement actions are identified. An 8 /12 breach report is also produced on a weekly basis and shared at Executive level.

### **5. Emergency Department Duty Consultant**

There is an EPIC in charge from 0800 – 0100 Monday to Friday and 0800-2200 on weekends at the Ninewells site. This role is supported by a Stream 2 (Majors) Consultant 0800-0000 (Monday -Sunday).

In Ninewells Emergency Department, there is an 8 bedded Ward (Emergency Department Observation Unit), and Ward/FNC Consultant 0800-1700 and dedicated FNC Consultant 1400-2200 (Monday-Friday). The PRI site has a Consultant Monday-Friday 0900-1700. The Tayside Emergency Department provides a consultant-led pre-hospital Trauma Team and a Consultant-led Major Trauma response.

#### **4.1 Target Operating Model**

Aligned to the national approach, utilising performance data in our planning and preparedness, a target operating model for unscheduled care delivery has been progressed in NHS Tayside.

With the support of our Health & Business Intelligence (HBI) team, demand and capacity modelling has provided the basis for understanding and anticipating the required unscheduled acute hospital capacity through the anticipated winter peak periods, based on the principles of 95% occupancy levels and a 10% reduction in patient Length of Stay.

This has allowed our Clinical Care Group teams to work collaboratively to define a target operating model for both the Ninewells and PRI hospital sites to support increased unscheduled admissions while maintaining urgent and cancer care delivery.

The success of the target operating model is based upon consistent reduced length of stay and green status delayed discharge position. Whole system collaboration to achieve this will be critical.

## 5. Health & Social Care Partnerships

The winter period presents a significant challenge to health and social care services due to increased demand and seasonal pressures. Health and Social Care Partnership’s Winter Plan aims to ensure the delivery of safe, effective, and person-centred care, while also supporting the wellbeing of our staff and community. Our approach is grounded in three key principles and focused on four priority areas, ensuring that we continue to meet the needs of our community during this critical time.

To ensure comprehensive preparation for winter, key risks such as increased respiratory illness, potential staff shortages, and severe weather conditions, have all been considered and have guided our planning.

The plans are also cognisant of the ongoing plans to deliver care closer to home, take preventative action to increase in vaccine uptake, and minimise delays in transfer of care to evaluate our success throughout the winter period.

### Key Principles:

#### 1. Applying the Getting it Right for Everyone Principles:

Our commitment is to deliver care that is person-centred and responsive to the individual needs of everyone in our community. This principle guides our planning and service delivery decisions. We are committed to tailoring care to individual needs by further expanding the use of preventative and proactive care approaches, future care plans, self-directed support options, and specific interventions for vulnerable groups such as older adults and individuals with chronic illnesses.

#### 2. A Partnership Approach Across the Whole System:

We emphasise collaboration across all sectors—health, social care, third sector, and community services—to provide integrated, seamless care that meets the needs of individuals and families.

#### 3. Implementing Local and National Actions Proven to Improve Patient Flow:

We are dedicated to using evidence-based strategies, such as Discharge Without Delay principles, to enhance patient flow, reduce hospital admissions, and ensure timely, appropriate care in the community.

We will develop a resource allocation process for care home placements to ensure those in greatest need and to support hospital discharge will be allocated care home placements.

Consistent and sustainable performance against the following key performance indicators will be essential:

1. RAG acute delays green

Angus  $\leq 3$  delays  
 Dundee  $\leq 6$  delays  
 P&K  $\leq 5$  delays

2. Total reportable delays green

RAG status key:

	Red	Amber	Green
A	>30	15-30	$\leq 15$
D	>50	25-50	$\leq 25$
P&K	>50	25-50	$\leq 25$
T	>130	65-130	$\leq 65$

3. Community hospital LOS 28 days or less

## 5.1 Angus Health and Social Care Partnership

### Winter Planning Priorities:

#### Priority One: Prioritising Care for All People in Our Communities

Angus HSCP aims to enable people to live well and remain healthy within their communities, using effective prevention and early intervention strategies. We will:

- **Strengthen Community-Based Support:** Enhance access to community health and social care services to prevent unnecessary hospital admissions and support individuals at home.
- **Enhance Chronic Disease Management:** Proactively manage long-term conditions with regular reviews and personalised care plans, reducing the risk of complications during winter. Our primary care networks will proactively identify and reach out to patients with chronic illnesses, ensuring early intervention and tailored care plans to prevent complications during the winter months.
- **Health Promotion and Prevention Initiatives:** Increase outreach and education on vaccinations, cold weather preparedness, and self-care, targeting vulnerable populations.
- **To manage potential surges in respiratory illnesses, we will increase capacity at respiratory clinics and hold stock of essential supplies, including portable oxygen and PPE, in anticipation of heightened winter demand.**

#### Priority Two: Ensuring People Receive the Right Care, in the Right Place, at the Right Time

- We strive to ensure that care is delivered as close to home as possible, with the right support available when and where it is needed. This includes:
- **Home Care Services:** Strengthen and expand the contracted home care support to enable people to remain in their own homes, reducing the need for unnecessary hospital-based care through ensuring Resource Allocation process uses Eligibility Criteria effectively so care is contracted, or signposting referrals are made timeously. To strengthen our home care workforce, we will focus on workforce strategies, and training programs to support a sustainable and well-prepared team throughout the winter period.
- **Effective Triage and Care Navigation:** Utilise robust triage systems to direct people to the most appropriate services, including telehealth, community pharmacies, and primary care.
- **Rapid Response and Reablement Teams:** There is the ability to flex staff including AHPs across the partnership and prioritise as required provide urgent support in the community and reablement services to facilitate timely hospital discharges and prevent admissions.

#### Priority Three: Maximising Capacity to Meet Demand and Maintaining Integrated Health and Social Care Services

To ensure we can respond effectively to increased demand, we will:

- **Maximise Workforce Capacity:** Utilise additional staffing opportunities, to meet surge demands in critical areas. We will build a robust recruitment pipeline for essential roles

and a focus on professional development to ensure that temporary staffing solutions are used sparingly.

- Protect Planned and Scheduled Care: Maintain the delivery of routine and planned care wherever possible to prevent a backlog of unmet need.
- Integrated Care Pathways: Strengthen collaboration between hospital, primary care, and community services to ensure smooth transitions and continuity of care.

#### Priority Four: Supporting the Wellbeing and Capacity of Our Health and Social Care Workforce

- A resilient and supported workforce is essential for delivering high-quality care. To support our staff, we will:
- Staff Wellbeing: Provide mental health support, stress management resources, and wellbeing initiatives to help staff cope with increased pressure during the winter months.
- Flexible Working Arrangements: Where possible, offer flexible shifts and working conditions to support staff work-life balance and reduce burnout.
- Recognition and Support for Unpaid Carers: Acknowledge the crucial role of unpaid carers and provide resources, training, and respite options to support them in their roles.
- We will leverage predictive analytics to anticipate patient surges and utilise real-time dashboards to monitor resource allocation, ensuring a data-driven response to fluctuating demand.
- A robust data-sharing agreement between health and social care services will enable seamless communication and rapid information flow, ensuring timely interventions for those who need them most.
- Collaboration with Third Sector and Voluntary Organisations:
- We will work closely with third sector and voluntary organisations to expand our non-clinical support capacity, including community outreach, patient transport services, and social care support for vulnerable individuals.

#### General

- Daily Situation Reports: Implement a daily monitoring system to track service capacity, demand, and emerging issues, allowing for rapid response and resource allocation. Our daily situation reports will track key metrics such as hospital bed availability, staff sickness levels, flu incidence rates, and care home occupancy, enabling rapid responses to emerging issues.
- Maintain monthly unmet need reporting to Scottish Government and share relevant local data on levels of unmet need aligned to our Eligibility Criteria to ensure resources are aligned to need.
- Participate in meetings with partners across health, social care, and third-sector services to ensure coordinated planning and response. To ensure transparency and adaptability, we will create a feedback loop where data and insights from our daily reports and real-time monitoring will be shared with both staff and the public to improve service delivery.
- Continuous Evaluation and Adaptation: Monitor the impact of our winter plan through key performance indicators (KPIs) and adapt strategies as necessary based on real-time data and feedback.
- Robust business continuity arrangements in place to ensure we continue to provide health and social care services throughout the winter period.

Angus Health and Social Care Partnership is committed to delivering person-centred, integrated, and high-quality care throughout the winter period. By adhering to the principles and focusing on these four priorities, we aim to support the health and wellbeing of our

community, reduce hospital pressures, and ensure that our workforce remains resilient and well-supported. We will navigate the winter challenges and continue to provide excellent care to the people of Angus.

## 5.2 Dundee Health and Social Care Partnership

Key areas highlighted as part of the system wide winter planning Dundee Health and Social Care Partnership include:

- Partnership Oversight Report published weekly to monitor pressure areas and feed into the whole system heat map
- Business Continuity Plans in place across all services, including adverse weather conditions response
- GAP community discharge hub in place (Business as Usual)
- Enhanced recruitment into social care regarded as 'Business as Usual'
- An intensive programme of improvement has achieved a significant reduction in unmet care need hours through working with care providers to enhance efficiency. The focus is now on sustaining performance.
- A promotion campaign is being undertaken to encourage social care support workers to access vaccination services.
- A Self-Directed Support event was held for frontline staff on 4<sup>th</sup> September to raise awareness and identify opportunities for using different SDS options to deliver care at home.
- The Spasticity Service is now fully operational as a means of supporting further rehabilitative approaches for stroke and neurology patients in a community setting.
- There is ongoing development of the Community Rehabilitation Service as a means of shifting rehabilitation closer to community settings.
- An improvement programme is being progressed across Dundee Enhanced Care at Home Team (DECAHT) focusing on:
  - Streamlining the process for transfer of care between in-patient services and DECAHT to support care closer to home
  - Participating in optimising access workstream to ensure appropriate use of services to optimise early access to preventative approaches
  - Reviewing practice-based MDTs to support early appropriate referral
  - Promoting joint working between cluster consultants and GPs/ Community services to support care at home
  - Implementing electronic prescribing to reduce unnecessary travel time and optimise capacity
  - Working collaboratively across MFE pathway to implement medication reviews for those most at risk of negative impact of polypharmacy
  - Ongoing review of patient pathways within the service to reduce risk, reduce duplication and improve the quality of service provided
  - Supporting the completion of RESPECT documentation to ensure that ceilings of care are agreed with the patient and shared across the MFE pathway
  - Continuing to embed the Cluster model to ensure MDT working across the MFE pathway
- Lead ANP structure now established to support development of whole system pathways of care
- Implementation of locality working model in community nursing to reduce unnecessary travel time and optimise capacity
- Discharge to Assess social care service has been re-focused on front door frailty wards within Ninewells. The service Team Leader works collaboratively with the ward multi-disciplinary team to prioritise how the service is most appropriately allocated to support early discharge and assessment in a home environment.

- An improvement programme is in progress across Royal Victoria Hospital site to reduce average length of stay whilst ensuring high quality care, focusing on:
  - Refreshing practice related to setting planned date of discharge
  - Implementation of the bed request function on Trakcare
  - Spread of 'Early Expectation meetings' to discuss discharge planning across Medicine for the Elderly
- Redesign of rehab model on the RVH site aligned to excellence in care standards
- The Stroke Neuro Rehabilitation Pathway Redesign is in progress, aiming to deliver an interdisciplinary approach to deliver an outcomes focused personalised rehabilitation pathway.
- Dundee remains committed to meet RAG status green (6 or less acute delays and 25 or less total delays) and maximum 2 patients waiting step down bed from acute per day, as per previous RAG agreed delays position via Tayside DWD programme. Dundee remains committed to progressing RVH LOS towards 28 days for MFE and Orthogeriatrics, and LOS target of 42 days for stroke and neuro rehab.

### 5.3 Perth & Kinross Health and Social Care Partnership

The key developments within the P&K Health and Social Care Partnership to support appropriate care, in a timely manner, in the most suitable setting are;

Perth and Kinross Health and Social Care Partnership have nationally performed well over the last year, with us consistently having less delayed discharges than our comparators.

Our geography and demography mean that locally set targets remain challenging for us to achieve, however PKHSCP remains committed to the best possible results over the winter period.

Priority 1: Prioritise care for all people in our communities, enabling people to live well with the support they choose and utilise effective prevention to keep people well, avoiding them needing hospital care.

- A new Care at Home contract commenced in September and has increased the number of providers by seven, with an even distribution across all localities and are implementing an Alliance based approach to their delivery, we anticipate a further uptake in care and reduction in unmet need both in the hospital and community.
- We are increasing efficiency and capacity in our Care at Home services through the implementation of PinPoint, for both internal and external Care at Home, which plots care geographically in a live system, targeting unmet need.
- Implementing Advanced Nurse Practitioner (ANP) single point of triage for urgent care. Advanced nurse practitioners are highly qualified, senior nurses who have completed extra training and academic qualifications to be able to clinically assess, diagnose, refer and treat patients.
- Exploring ways to build Advanced Practice capability within our existing community teams for example non-medical prescribing and Advanced Clinical Assessment.
- We will work closely with our home safety partners, community wardens and community organisations to provide simple home safety and winter resilience advice.
- We will review, update and test Business Continuity Plans.
- We will review and update lists of particularly vulnerable people across P&K.

Priority 2: Ensure people receive the right care, in the right place at the right time, this includes prioritising care at home, or as close to home as possible, where clinically appropriate.

- Ambulatory Care: working in partnership with Acute colleagues to support the opening of our Ambulatory Care area at PRI. Ambulatory Care allows patients to have diagnostic tests (including imaging) and a full clinical assessment prior to being admitted. If admission to hospital is not clinically necessary, patients can then go home with advice and supports in place.
- We are targeting bed occupancy and LOS for MFE and Community Hospitals
- We are developing a new Home First to Rehab Pathway, our initial focus is Perth City, targeting where we have a shortage of rehab beds.
- We are reviewing our assessment activity to ensure Care at Home as a lone service is not the default, that assessments are holistic.
- We are targeting our workforce to support Community Hospitals in discharging people to their own home as timeously as possible, Community Hospital length of stay under 28 days has consistently been achieved since mid-summer and we will work towards lowering this length of stay over the winter period.
- We are piloting a Trusted Assessor role for Care Home placements.
- We have sought additional funding to continue the use of our commissioned Early Discharge Project till end March 2025.
- We are maintaining a small number of interim beds within our two internal Care Homes, and one externally block booked Care Home wing, these are available in exceptional circumstances only.
- We are maintaining four extra unfunded beds in Stroke, this is a challenging situation for us, with staffing precarious and will need reviewed as we move forwards.
- We are looking to utilise under-occupied internal Care Home capacity to provide additional rehab capacity.
- We are looking to work with our externally commissioned Perth City Care Homes to provide additional rehab capacity.

Priority 3: Maximise capacity and capability to meet demand and maintain integrated health, and social care and social work services, protecting planned and established care, to reduce long waits and unmet need.

- We are establishing integrated teams in Perth & Kinross, Perth City being the first of which to be introduced in the coming weeks. They will respond to a wide range of issues in the community and will send the most appropriate professional(s) as required. This will include urgent response and where possible the teams will support individuals to retain their independence and prevent hospital admission by providing a range of early interventions and support.
- The integrated locality teams will also have a role in facilitating early supported discharge to assist capacity and flow at PRI and within our community hospitals.
- The HSCP are running an ongoing programme of recruitment campaigns utilising multiple social media platforms and billboards with our most recent campaign achieving a reach of 18,516.
- The HSCP participated in a national project delivered by NHS Education for Scotland's Centre for Workforce Supply Social Care, Scottish Government, COSLA and Social Care Providers to identify opportunities to internationally recruit Social Care Workers, six staff were recruited from the Philippines. This experience has helped develop an ethical pathway for overseas recruitment which can be used in future if required.
- We have improved our Social Work recruitment pathway, recruited a dedicated Student Placement officer who has increased the number of Social Work Student placements within the HSCP significantly, with us then going on to recruit 11 of those students.



Priority 4: Focus on supporting the wellbeing of our health and social care workforce, their capacity and improving retention, as well as valuing and supporting Scotland's unpaid carers.

- Continue the work of the What Matters to You programme and promote a culture of collaboration and understanding and maintain staff wellbeing and resilience through the challenging winter period and beyond.
- Encouraging staff uptake of Covid and flu vaccinations, and sharing information on how they can access the vaccinations service; and
- Ensuring community staff have appropriate warm, safe uniforms for the winter period.

## 5.4 Primary Care and Out of Hours

Primary Care and OOH services will continue to collaborate across partnerships and interfaces to maximise the efficiency and effectiveness of community care. This will be driven by strong collaboration both at the partnership level and with NHS Tayside. Our commitment is to deliver high-quality community-based care through multidisciplinary teams, both during regular hours and OOH, wherever this is the safest and most appropriate option for patients.

### Primary Care

Access to General Practice:

Access to General Practice (GP) during the winter period will be based on the national access principles:

- **Inclusivity and Equity:** Ensure access is equitable for all individuals, based on Realistic Medicine principles and Value-Based Health & Care. Care will be person-centred, focusing on individual needs rather than a one size fits all approach.
- **Choice and Flexibility:** Patients will have a reasonable choice regarding how they access services, including in person, telephone, and digital consultations.
- **Compassionate and Person-centred Services:** Services will remain sensitive, compassionate, and considerate of everyone's needs and circumstances.
- **Care in the Right Place by the Right Person:** Efforts will be made to connect patients with the most appropriate healthcare professional within the right time frame, ensuring efficient use of resources.

Supplementary Principles:

- **Empowerment and Self-Management:** Encourage patients to manage their health through selfcare, using online resources like NHS Inform.
- **Direct patients to other primary care services** such as Community Pharmacies, Optometry, or Dental services where appropriate.
- **Prioritisation of Urgent Care:** In periods of high demand, practices will ensure that urgent care needs are prioritised.
- **Transparency and Communication:** Patients will receive clear, transparent information on accessing the most appropriate care.
- **Role of Administrative Staff:** Practice administrative staff (e.g., receptionists) will guide patients to the right service, a practice known as "Care Navigation." Staff will be trained to offer informed signposting to ensure patients are seen by the most

suitable service provider, whether within or outside of the practice. The "Care Navigation Toolkit" provides further guidance on this process.

- Multidisciplinary Team (MDT) Approach: Receiving care from various healthcare professionals (such as nurses, pharmacists, and other specialists) rather than solely from GPs will become standard practice.
- Continuity of Care for Complex Needs: Patients with complex health needs or frailty will receive continuity of care from a known and trusted healthcare professional to provide holistic, ongoing support. Practices will ensure familiarity between patients and their care providers to build trust and enhance care quality.
- Holistic Healthcare: General Practice will adopt a holistic approach, addressing not just physical symptoms but also considering psychological, social, and lifestyle factors that impact health.
- Use of Digital Resources: Where appropriate, digital tools such as online consultations, electronic prescriptions, and health monitoring will be used to provide convenient access to care. Provisions will be made for patients who are less digitally literate, ensuring equitable access for all.
- Patient Feedback and Improvement: Practices will continue to actively seek informal and formal feedback on patients' experiences, using this input to make real-time improvements to services.

#### Public Holiday Planning for Primary Care Providers

##### General Practice:

Ensure that continuity plans are in place, particularly during public holidays. Practices will communicate well in advance about closures and provide clear signposting to alternative services such as NHS 24 (111) and NHS Inform.

##### Pharmacies:

Community pharmacies will operate on a festive rota to ensure availability during holiday periods. They will inform patients about closures and direct them to alternative resources where necessary, such as NHS Inform and emergency contacts.

##### Optometry Services:

Optometrists are reminded of their obligation to act as the first point of contact for eye issues, including emergencies. If unable to provide care, optometry practices will coordinate with other providers or hospital eye services in rare cases.

##### Dental Services:

Dental practices are responsible for emergency care for NHS patients during holidays. If needed, they will work with the Public Dental Service (PDS) to ensure emergency coverage, and patients will be triaged to the appropriate service.

## Capacity Surge Plans

### Surge Staffing Plans

Providers will consider how best to prepare for unexpected staff shortages (due to illness or extreme weather conditions). This could include locum staff, bank nurses, etc. to fill gaps. They should prioritise care for those with the most urgent care needs in such circumstances.

Where capacity is reached despite this, practices should escalate both to Primary Care Services given the contractual implications and for GP Practices to their respective HSCP Primary Care Team to consider how to support operationally.

### **Out of Hours (OOH) Services**

We anticipate a 15% increase in OOH activity this winter and have prepared accordingly.

Key Actions and Commitments:

#### 1. Predictive Modelling and Staffing:

- Complete predictive modelling for the winter period (November 2024 - March 2025) to ensure multidisciplinary team (MDT) staffing levels meet the expected demand.
- Leverage a 75% salaried workforce during this period, with the relevant rate of pay over the festive period

#### 2. Enhanced Clinical Support:

- Ensure the availability of senior clinical decision-makers on weekend and public holiday shifts to facilitate effective clinical operational management and support.
- Consider re-instating the short 3-hour mid-week shifts (Mon-Thurs) in Dundee PCEC over the winter period (Oct-Mar) to manage the additional workload with winter illnesses.
- Consider this year the very peak winter to be between mid-December- Mid March (11 weeks) and over this period have 1 extra evening shift Saturday and Sunday in Dundee and Perth.

#### 3. Service Escalation and Contingency Planning:

- Review and update service escalation and contingency plans to respond swiftly and effectively to any emerging challenges.
- Increase the use of Near Me video consultations where clinically appropriate to maintain accessibility and reduce the need for in-person visits.

#### 4. Paediatric Care Provisions:

- Prepare for increased paediatric contacts during the winter period by ensuring sufficient GP coverage and utilising the Paediatric Advanced Nurse Practitioner during busier periods.

#### 5. Weather-Related Procedures:

- Continue to adhere to robust procedures for managing inclement weather to ensure continuity of care.

#### 6. Collaboration with NHS 24 and Pharmacy First:

- Work closely with NHS 24 and Pharmacy First to direct patients to the most appropriate care settings, reducing unnecessary pressure on emergency and OOH services.

#### 7. Professional-to-Professional Support:

- Maintain the provision of professional-to-professional advice to support clinical decision-making and patient care.

#### 8. Support for Care Homes:

- Provide timely responses to calls from care and nursing homes, ensuring prompt and appropriate care for residents.

#### 9. Integration with Mental Health Services:

- Continue to work with mental health services to ensure good access to crisis teams and mental health support during the winter period.

#### 10. System Planning and Heat Mapping

- Continue to populate and utilize heat maps to support comprehensive system planning and resource allocation.

A detailed OOH Winter Action Plan has been submitted to the Scottish Government, in conjunction with the Winter Checklist response, outlining our strategies and preparedness for the upcoming winter season.

This proactive approach will ensure that the service is well-equipped to meet the needs of the community, support the whole system and provide the highest standard of care throughout the challenging winter months.

## 6. Planned Care

Throughout the winter period, NHS Tayside will continue to maximise theatre efficiency by focussing on treating urgent and cancer patients as a priority, and longer waiting routine elective cases where feasible.

To support delivery of the Unscheduled Target Operating Model, the surgical teams will focus on increased delivery of day case procedures through the peak unscheduled demand periods to minimise the need for inpatient beds.

Surgical teams will continue to optimise the elective only theatre resource at of Stracathro.

Key activities progressing to support elective care preparedness across main hospital sites include:

- Theatre scheduling to determine the management of the unscheduled care/cancer and clinically urgent procedures as a priority
- Reduction in non-urgent elective surgery to create unscheduled care capacity, optimising day surgery
- Continue elective care prioritisation meetings to align to available capacity
- Optimisation of the Surgical Assessment Unit (SAU) on the Ninewells Hospital site to ensure that admission and discharge here for Surgical Division day-cases is the norm, minimising unnecessary inpatient bed use.
- SAU to support admission of elective patients who will be cared for in a critical care unit to minimise unnecessary inpatient bed use
- SAU to use remaining capacity to support elective admissions who will transfer to a ward area post operatively.

- Reduced elective medicine activity through peak winter period to support flow

NHS Tayside will continue to refer patients to Golden Jubilee and NHS Highland through the NTC Programme allocation for Orthopaedic and General Surgery procedures. We will also continue to link with the National Elective Co-ordination Unit (NECU) for any national capacity to support long waiting patients.

## **7.COVID-19, RSV, Seasonal Flu, Norovirus, Staff Protection & Outbreak Resourcing**

### **7.1 Infection Prevention and Control**

The Infection Prevention and Control Team (IPCT) will continue to follow the National Infection Prevention and Control Manual (NIPCM) with regard to Winter 24/25. The delivery of Infection Prevention and Control education during this period will be in line with ARHAI Scotland and NHS Education for Scotland and focus on key Infection Prevention and Control principles.

The IPCT will provide proactive surveillance of respiratory and GI infections. The Senior management Team will be actively involved in the Winter Preparedness Group and cascade relevant local and national intelligence within the organisation.

### **7.2 Health Protection Team**

The Health Protection Team in NHS Tayside are planning for winter and are working with care homes to ensure readiness for winter and potential surges of COVID-19, other respiratory viruses such as flu and RSV, and gastrointestinal infections including norovirus. Outbreak plans are in place for outbreaks including respiratory viruses and norovirus.

### **7.3 Vaccination Programme**

The NHS Tayside central vaccination service provides access to winter vaccinations for staff across Tayside in -

- Staff only appointment-based clinics on acute sites
- Appointments for staff in all community clinics central and more rural locations
- Opportunities for drop-in vaccinations at all clinics (workplaces and community)
- Peer vaccination for both flu and COVID being rolled out across acute areas again this year to support further opportunities for staff; the number of peer immunisers recruited this year has hugely increased, from fewer than 10 in 2023/24 to over 70 in 2024/25
- Occupational Health teams supporting vaccinations on Ninewells site for staff to access vaccination later in programme to support mop-up

Clinics are advertised on internal Staffnet, local social media and through regular staff bulletins as well as posters on wards with links to relevant information on NHS Inform.

A staff vaccination tracker will be shared and collated to provide individual areas as well as a whole system overview of uptake.

The public winter vaccination programme for COVID and flu commenced on 16<sup>th</sup> September 2024 in line with national programme directions and schedules. In accordance with JCVI guidance, the majority of vaccinations, especially for those most vulnerable, will be delivered

from October, in order to optimise protection over the winter period. The programme will include appointed and drop-in community clinics, outreach and pop-up clinics in underserved communities, clinic and school-based vaccinations for all 2–5 year olds, and primary and secondary school age children, and care home and domiciliary vaccinations.

The 2024/25 programme has been planned so as to ensure everyone eligible will be offered an appointment no later than 15<sup>th</sup> December 2024, to provide the best possible protection over the winter and in advance of the main festive period. COVID and flu uptake in Tayside has consistently been above the Scottish average, and we aim to replicate and further build on this track record in 2024/25.

## 8. In Patient Mental Health

The whole system mental health change programme has a number of active workstreams which serve to revise the Model of Care and support people to receive care in the most appropriate place, and in doing so supports the ability to maintain capacity and flow. The winter peaks in demand experienced by other parts of the system are not the same in mental health; however occupancy levels remain in excess of 85% and therefore robust plans are required to maintain efficiency.

The following mechanisms are in place to support:

- Business Continuity Plan in place
- Use of command centre data to support planning
- Use of safecare to support safe staffing and system wide support
- Escalation SOP for staffing deficits
- Safety and Capacity huddles embedded
- BD involvement in whole system huddles
- Discharge Co-ordinator in place to support PDD
- Review of all inpatient stays exceeding 90 days
- Rapid Run-Downs in place across GAP estate which involve community and inpatient teams
- Hope Point in Dundee operational in 2024, supporting individuals who present in distress
- Optimisation of Early Supported Discharge
- Out of hours site co-ordinators support ability to communicate and create capacity
- Support NHST vaccination programme
- Introduction of revised admissions pathway to support step up/step down approach
- Boarding SOP developed to maximise capacity within existing footprint
- Review of all out of sector and out of specialty patients currently in GAP

## 9. Communication Strategy

The NHS Tayside Communications Team has a comprehensive communications strategy to cover the winter months. This includes planned staff and public communications on vaccination, prevention and self-care of seasonal illness and accessing services over the festive period.

The team works with the clinical lead for winter to produce regular videos with key messages for the public, focusing on topics relevant to the current situation in hospitals and the community. In addition, there are assets to be used as needed for incidents such as adverse weather.

As in previous years, the Communications Team supports the organisation's preparations for winter through the local and national winter campaigns, tailoring the national key messages for the local situation and a local audience throughout the winter period. This is targeted at staff, patients, and the public alike. Social media is the most effective channel for instant updates to information and will be used extensively, along with media releases, website updates, radio updates and sharing of messages with local partners for onward distribution.

The Communications Team updates the 'Keep Well in Winter' pages on the NHS Tayside website and the 'Winter Zone' on Staffnet with all relevant winter information. Ready Scotland is also promoted on the front page of its website.

The team will continue sharing the Right Care, Right Place messages around how and where to access the right healthcare for people's needs e.g., 111 for urgent care, A&E when life-threatening, and what to do when GP surgeries are closed, e.g. NHS 24 and community pharmacies. This is supported by regular social media and website posts to share information and signpost to available services.

## 10. Workforce

The aim is to have the appropriate levels of staffing in place across the whole system to facilitate efficient and effective patient care, to ensure consistent discharge during weekends and the holiday periods.

As such system-wide planning is in place to ensure the appropriate levels of cover needed to effectively manage predicted activity across the wider system and discharge over the festive holiday periods.

Examples of this include:

- Infection, Prevention and Control Teams (IPCT) rotas organised to ensure appropriate levels of cover in particular to days following the festive break/public holiday periods
- Nursing rosters are managed in accordance with NHS Tayside Roster policy, Health roster are provided six weeks in advance. Patient demand and acuity is managed in accordance with Safecare to support reallocation of staff
- Whilst every effort has been made cross system to ensure capacity for increased winter activity can be absorbed within the funded footprint, it is recognized there may be a period where unfunded capacity is required.
- Due to ongoing nursing workforce challenges, the senior nursing team will ensure in the event of requiring to utilise unstaffed beds, that a robust risk assessment of staffing to support realignment of resource is undertaken to safely care for patients using the toolkit available including Safecare; Roster perform and collapsible hierarchy models.
- To manage staffing gaps in ward areas, proposed focused update for staff being moved or deployed through the clinical educators/Practice Education Facilitator with familiarisation to new areas, documentation and ways of working before winter and if possible aligning individual staff to identified wards where they will have confidence to be redeployed during the winter months
- Development of action card to aid decision-making to support implementation of collapsible hierarchy aligned to increased demand or reduced resource

### 10.1 Allied Health Professions (AHP)

The Allied Health Professions (AHP) directorate team have worked collaboratively with services managers and professional leads from across all professions and organisations to

plan for a system of mutual support and professional prioritisation to maintain essential functions of AHP services whenever possible throughout winter 2024/2025. This guide details the escalation plans as agreed by all professions, with the understanding this is subject to ongoing review for service demand and capacity.

The majority of AHPs in Tayside are employed by NHS Tayside (each council also employs Occupational Therapists) but the professions are operationally managed across the three health and social care partnerships and the clinical care groups of NHS Tayside. Some professions already work within the structure of a single Tayside wide service whilst Occupational Therapy and Physiotherapy are managed across all parts of the system. All AHPs working within integrated systems, already work to the principles within the AHP professional and operational interface guidance document which aims to support the role of the operational leader, the individual and the professional lead to navigate matters such as professional issues, practice development, personal development, workforce issues and capability.

This escalation plan simply applies the understanding of utilising the professional leadership available to support operational management decisions and actions to the challenges of workforce planning and winter contingency escalation.

It is well documented through strategic risks and all organisational structures that some of the professions are experiencing staffing shortages and are listed on the national shortage occupation list (SOL).

Whilst teams already work well within multi-disciplinary structures for support and shared working, some essential tasks require the expertise of an individual from a specific registered profession.

This plan offers a clear process for considering mutual support as one solution to workforce or capacity challenges across the system. Whilst each operational area has systems for supporting workforce needs, we have recent and ongoing experience of areas having significant challenges with minimal solutions available to them. There is an established AHP bank but this has limited staff available at this point due to the National shortage of AHPs. Work is ongoing to further develop this. This solution limits the need to escalate to costly agency or bank recruitment and offers robust evidence of alternative solutions being considered before an agency solution is used.

Services can identify their workforce challenge and raise it to the Tayside AHP command group. This group will seek to agree any staffing capacity that can be released to support the need across Tayside in collaboration with service leads and professional leads. The plan employs a 5 tier escalation process and the group would seek support from services in lower tiers on a flexible, temporary or short term basis. A comprehensive communication strategy will be employed to ensure all parties are kept informed of progress.

## **10.2 Nursing & Medical Workforce**

As part of the Winter plan staffing the unfunded beds ,or surge beds, within the Acute in-patient wards, will be supported by incorporating the over recruited Newly Graduated Practitioners (NGPs) as approved earlier this year by the Executive Leadership team; these NGPs will be blended with existing registered nurse teams, to ensure staff have the requisite knowledge and skills to deliver safe patient care. In addition, the Nurse Bank will support supplementation of the HCSWs required to staff the surge beds.



### 10.3 Pharmacy Workforce

Pharmacy will endeavour to deliver the full range of range of services over the winter period. In those situations when demands exceed capability, pharmacy will work collaboratively via the safety huddle to:

- Prioritise workload taking into due consideration of NHST priorities of unscheduled, cancer care and planned care.
- Explore cross cover options across the service with a primary focus on high-risk patients with complexed medication needs and discharging of patients to maintain flow.
- Explore agency options including bank and locum staff.
- Consider other options to meet patient demands and maintain staff wellbeing including reviewing workload deadlines as well as reviewing hours of operation across a 7-day period as appropriate.

### 10.4 Staff Wellbeing

It is recognised that our staff are our greatest asset as we approach the winter period. Supporting their wellbeing requires to be a priority as part of our preparedness. The Staff Wellbeing Service and the Department of Spiritual Care will support staff in a proactive and timely manner.

We will meet weekly with the winter planning group:

- Giving the opportunity for managers to bring issues concerning staff support to our attention
- To remind managers that the support is available for them also
- To give reminders of how the service can be accessed over all inpatient sites 24/7

As a service we will undertake:

- To provide regular check ins with all wards and areas over Tayside
- To provide opportunities for proactive support to areas in need
- To develop resources to help staff over winter and share these through comms
- To support the work of the Staff Wellbeing Champions

### 10.5 Volunteer Service

Discharge services, supported by volunteers, can provide vital support to individuals when leaving the hospital environment. Historical research illustrates that, when receiving support from volunteer discharge services, patients feel safer, less lonely, less frightened, more reassured and more supported.

Following on from the 18-week pilot of a volunteer discharge support service in 2022/23, funding has been secured from the Charitable Foundation to support a volunteer led service that supports patients for up to five consecutive days following discharge. The service will be managed by two Discharge Support Volunteer Co-ordinators, interviews are being held on 23 September 2024 with a view to start dates in November 2024. The funding is for 18 months to take in two winter periods.

The service involves telephone calls being made to the patients which include questions regarding their wellbeing, any medical needs or concerns and to make recommendations of community support services. Additionally, volunteers are able to provide support to the family members/carers of the patient to ensure that they are managing well with caring for their loved one post discharge.

The volunteer discharge service is an excellent example of where volunteers can make a positive difference to patients and their loved ones.

## 11. Digital & Technology

The use of information and data is critical for effective forecasting of unscheduled and elective winter demand and capacity planning.

### 11.1 Command Centre & Heat Map

The Command Centre continues to evolve to meet planning and management of flow including: bed reconfiguration: viral illness rate and impact on resource availability; 4 hour wait position.

The HEAT map has been revised and extended to include diagnostic measures. Reporting on these additional measures will commence end of October 2024.

This will be generated and widely circulated on a weekly basis to inform the whole system position. This will be reviewed weekly through the Winter Resilience Operational Delivery Group and subsequent escalation, or de-escalation of plans agreed and implemented. The HEAT Map will also be available within the Safety & Flow Hub for the purpose of daily management of capacity and flow and to support planning for the week.

### 11.2 Resilience App

To support winter planning arrangements, a section on 'Whole System Pressure' was added to the NHS Tayside Alert App during 2023/24. Key documents such as our escalation plans and SOPs and will be available to all Safety & Flow staff who are responsible for managing optimal patient flow as well as our Mental Health H&SCP/ Primary Care & OOH colleagues who contribute to the safe and efficient management of our unscheduled care pathways. The Risk & Resilience Planning team supported the development of the broadcast group and maintain documentation upload.

This development supports accessibility to information in and out of hours as well as off site, and provides greater consistency in approach and decision-making, allowing the most efficient use of available resource.

### 11.3 Outcome and Performance measurement

The following measures will provide an overview of the whole system temperature and specific areas of pressure/challenge. The data will be reviewed daily and weekly through the Safety & Flow Huddles, the Winter Resilience Operational Delivery Group and Tactical Cell meetings as required:

- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95%)
- Earlier in the Day Discharges - Hour of Discharge (inpatient wards)
- Weekend Discharge Rates - Day of Discharge weekday v's weekend discharges
- Reduction in delayed discharges to meet green RAG status
- Early initiation of flu vaccination programme to capture critical mass of staff
- Achieve target operating model for unscheduled admissions, achieving and maintaining Upper Quartile Average Length of Stay Targets
- Use of information and intelligence from Primary Care, OOH Services and NHS 24 to predict secondary care demand.
- Standardised approach to speciality – level escalation plans
- Monitor planned care cancellation rates

Performance against these measures will be provided within the Board Business Critical weekly reports and updates to the Board Business Critical Gold forum.

The 24/25 Winter Plan, inclusive of the actions relating to prevention and management of seasonal illness, reflects the collective actions NHS Tayside and its partner organisations will take to achieve our intention to provide a consistent high quality of service for all our patients throughout winter and beyond.

# Appendix 1- Scottish Government Winter Readiness Checklist



Return Due: 16 October 2024

## WHOLE SYSTEM CHECKLIST RETURN - AREA DETAILS

<b>Board</b>	NHS Tayside
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*Please select Health Board from drop down above*

<b>Partnerships</b>	Angus, Dundee City, Perth & Kinross
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<b>Board Chief Executive</b>	Nicky Connor
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<b>Chief Officers</b>	Jillian Galloway, Dave Berry (acting), Jacquie Pepper
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<b>Number of integration partnerships</b>	3
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<b>Submitted by</b>	<i>Please complete</i>
<b>Approved by</b>	<i>Please complete</i>
<b>Date of approval</b>	<i>Please complete</i>

## SUMMARY DASHBOARD

#	Area	Progress	Status	Partial	No	Yes	n/a
1		0	Incomplete	1	0	4	0
2		In progress	Incomplete	0	0	4	1
3		0	Incomplete	0	0	0	0
4		0	Incomplete	0	0	5	0

## Appendix 2 – Ninewells Hospital, Medicine Division Winter Resilience Plan

	Sep24	Oct24	Nov24	Dec24	Jan-midFeb25	Feb-Mar25
<b>Total Funded beds</b>	275	275	275	275	275	275
<b>Total beds required (90% Occ)</b> PRAG status based on Winter 23/24	275	275	286	288	317	285
<b>Medicine Winter Surge Beds</b>			14	16	26	16
<b>Surge beds available (+/-)</b>	0	0	3	3	-16	6
<b>Milestones:</b>						
<b>Bed base</b> (Cohorting of patients into surge beds controlled within Medicine)	Wd33 MfE footprint operational		Winter beds available to open as per demand: Stroke Wd6, Wd32, Wd33	Winter beds available to open as per demand: MfE Wd5	Increase Winter surge beds: MfE Wd5, CIU 6 + 7 day working	Decrease Winter beds: Stroke Wd6, MfE Wd5, CIU (back to 6 beds M-F)
<b>Escalation Plans/Surge Ward</b>		Specialty & Divisional Plans in place	Monitoring PRAG status at Specialty & Division level via Weekly Medicine Flow meetings			
			Step up Medicine daily Huddles in AMU, if required			
					Surge wd open if required	
<b>ADP Priorities</b>	Optimising Flow – planning and implementation			Achieve and maintain optimal flow as far as possible (AMU 80% occ; Wds 90% occ + UQ ALOS)		
	Optimising Access – planning and implementation			Reduce admissions/attendances by 5%		
<b>Infection Prevention control</b>	Face Fit Testing as appropriate					
	Peer vacc for Flu + optional covid					
	Viral isolation plan in place					
<b>Multidisciplinary Workplace Planning</b>		Surge bed staffing plans in place		CIU 7 day rota in place		
<b>Elective Step-down tbc</b>				Resp CIU	Gen Med peripheral Resp, CIU, Cardiology	

## Appendix 3 – Perth Royal Infirmary, Medicine Division Winter Resilience Plan

Plan / Month	September		October		November		December		January - Mid February		Mid February - March		
Anticipated RAG Status													
Substantive Bed Base - PRI	120	90%	120	90%	120	90%	120	90%	120	90%	120	90%	
Winter Bed Base	120	90%	129	90%	134	90%	139	90%	140	90%	125	90%	
Surplus / Shortfall	0	90%	-9	90%	-14	90%	-19	90%	-20	90%	-5	90%	
<b>Additional Impact (-6 beds Tay Ward)</b>			<b>-15</b>		<b>-20</b>		<b>-25</b>		<b>-26</b>		<b>-11</b>		
Bed Base / Key Requirements Ninewells	Create capacity in morning to support early flow from AMU (inc. appropriate sitting out of patients). Morning 'Board Rounds' in place across all wards. All Medicine wards achieve Target LOS. All Medicine wards to achieve 90% occupancy / AMU 85%.						Reduction in Admissions / Attendances - Achieved (5%)						
Increasing Bed Base within PRI Acute			Surgery	6	Surgery	12	Surgery	18	Surgery	18	Surgery	12	
Dependencies	P&K HSCP Winter plan - work to reduce delays to Green RAG status and establish step down rehab model for Perth city patients. (RAG : green<25 amber <50 red>50). <u>10-12 beds TBC</u>												
Acute Medicine Action Plan	Engagement - MDT to discuss winter planning opportunities	Working with consultant Connect - OOH, SAS, NHS24, HSCP to create a SPOC referral into community Links Teams. Admission avoidance (JW). TOC - Perth City											
	Capacity for COVID testing overnight confirmed	Optimise pathways for Ambulatory Assessment Area (PRI) (JW/COG1/HSCP)											
		Ward 1 - Rehab/Stroke Acute Model to be operationalised: - Separation of acute and rehab patients - additional and continuity of nursing numbers - Faster turnover in the acute bays											
		Nursing establishment is supported at safe staffing levels. RN and HCA uplift		P&K HSCP to establish step down rehab model for Perth City Patients									
		Discussions/planning for nursing model, medical model and AHP support for any move into additional Surgical beds. Discussions with Specialist Surgery ongoing re cohorting of patient and safe staffing. Guidance to be completed											
	Review Pan-Tayside Call Handling and ensure protocols clearly defined												
Requirements	Staffing Plan Communication Plan												

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**Scottish  
Ambulance  
Service**  
*Taking Care to the Patient*

# **Generic Contingency Plan – Capacity Management**

**Incorporating the**

## **Resource Escalatory Action Plan - REAP**

**Version 9.2**

**November 2023**

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**Scottish Ambulance Service**  
**Generic Capacity Management Contingency Plan**  
**And**  
**Resource Escalatory Action Plan (REAP)**

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**Scottish Ambulance Service**  
**Generic Capacity Management Contingency Plan**

**Introduction**

1. There is a need to maintain a comprehensive contingency planning framework to manage the consequences for the Scottish Ambulance Service of a level of demand being at a point where it exceeds the ability of the Service to meet it. This may arise when, whether in isolation or in combination, there is a rise in demand or a reduction in the capacity. This situation could be triggered through pressures exerted directly on the Scottish Ambulance Service or through referred impact of pressures exerted elsewhere within the health system. Should such a situation arise, health care provision may need to be planned or delivered differently, services prioritised or re-scheduled and partnership working, including mutual aid, extended or special contingency arrangements invoked.

2. The Capacity Management Contingency Plan may need to be implemented in circumstances when there is:

a. **Increased Demand.** There is a significant surge in demand for services provided by the Service, NHS 24, an NHS Board or Social Care for which that organisation does not have the capacity to compensate immediately. A flu outbreak, extreme weather challenge or significant major incident could escalate to the point where the Scottish Ambulance Service, NHS 24, an NHS Board or Social Care is unable to sustain or provide a normal level of service.

b. **Reduced Capacity.** There is a significant reduction in the capacity of the Service, NHS 24, an NHS Board or Social Care, which severely restricts its ability to respond to patient demand or deliver care. Understaffing, major staff sickness, localised IT system failures, or wider failures of service continuity, including external suppliers of goods and services, could escalate to the point where the Scottish Ambulance service, NHS 24, an NHS Board or Social Care is unable to sustain or provide a normal level of service.

c. **Reduced wider NHS services over Festive Periods.** Routine practice closure for 4 consecutive days on two consecutive weeks will occur in certain years. In addition to pressures due to capacity challenges within NHS out of hours services, trends for 999 calls indicate that demand may rise from between 10% - 150% above normal Friday night levels at certain times over that period. The patient care consequences and potential for uncompensated major incident at special events over the festive period and certain other times also contribute to the pressures on the Service.

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## Capacity Management - Planning Rationale

3. In order to plan effectively for the impact of increased demand, reduced resources or other unanticipated disruption, including significant systems or infrastructure failure, an assessment of existing demand and capacity is necessary together with an accurate assessment of the impact and range of consequences likely to impinge on service delivery. At given levels of escalation, a pre-determined consistent framework for action is required to support decision making and to manage and preserve the mission critical aspects of the operational service.

4. Managers, with the assistance of risk, resilience and business continuity colleagues have considered the likely consequences of any realistically foreseeable occurrence on service delivery, and identified the actions that could both, reasonably be taken in advance of an adverse situation to reduce the impact, and best maintain critical services should the situation come to fruition.

5. Generic action in preparation for a capacity management challenge is varied depending on the foreseeable risks but may include participating in immunisation programmes, issue of PPE or other buffer stocks, predetermined increases in operational or other staffing or deployment of special resources such as personnel, vehicles (including four-wheel drive) or equipment, to cover anticipated pressures. Preparation may also include training of additional staff or volunteers in specific priority duties and effective, planned communication with external stakeholders.

6. A common understanding of these planning assumptions and the development of consistent inter-agency contingency plans, escalation triggers, communications and management policies will reduce any adverse effect of disruptive challenge.

7. The Service will continue to develop policies to underpin its ability to enhance capacity or reduce demand at times of peak pressure or specific rising tide incidents. The introduction of alternative arrangements for service delivery during periods of escalation, i.e. The Scottish Ambulance Escalation Plan or Pandemic Escalation Plan will identify alternative methods to ensure the delivery of safe and situationally appropriate patient care during periods of increased pressure.

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## Scottish Ambulance Service

### Resource Escalatory Action Plan - REAP

#### Introduction

8. Unlike the operational model used within some other emergency services, it is recognised that ambulance services work operationally at, or near, capacity, especially in urban areas, for much of the time. This high level of utilisation severely limits surge capacity thereby causing a degree of vulnerability in the delivery of patient care.

9. The Scottish Ambulance Service will continue to deliver the best level of patient care within resource for the population of Scotland when experiencing capacity pressures. This is in keeping with the ethos and strategy of the Service and recognises the need to maintain public confidence and the Service' good reputation.

#### Background

10. The Scottish Ambulance Service manages capacity and contingency through its Resource Escalatory Action Plan (REAP). The REAP establishes levels of 'stress' within service delivery, whether resultant from increased demand or reduced resource, and independent of cause, and identifies measures to be implemented to mitigate the impact of such stress. Measures are Service wide and include activity from the Operational Regions, Ambulance Control Centres (ACCs), National Risk and Resilience Department (NRRD), and Airwing.

#### REAP

11. **REAP Levels.** There will be an overall REAP level for the Service. During periods of normality the REAP Level is 1. During times of service delivery stress this level may rise up to the highest defined level, 4. REAP Levels, their service delivery impact, and associated colour coding are given in Table 1.

<b>REAP Level 4</b>	<b>Critical Impact / Service Failure</b>
<b>REAP Level 3</b>	<b>Significant Impact</b>
<b>REAP Level 2</b>	<b>Moderate Impact</b>
<b>REAP Level 1</b>	<b>Normal Service Delivery</b>

**Table 1 - Scottish Ambulance Service REAP Levels**

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12. **REAP Level Triggers.** A number of factors could cause stress to Service Delivery. The most common are categorised into Staff, Fleet, Supply, Demand, System Pressures, and Weather factors. For these factors a set of pre-determined triggers have been established to assist decision making in identifying and declaring a REAP Level. Of note is that, although it is expected that the majority of events able to cause service delivery stress would fall into one of these categories, the absence of a suitable category, or indeed an appropriately defined trigger, should not prevent the declaration of a specific REAP Level if necessary. Secondly, there may be good reason for a specific REAP Level not to be declared, even though an associated trigger has been activated. These triggers are simply to guide and support decision making and should not be followed dogmatically. REAP Level Triggers are given in Table 2.

13. **Declaration of REAP Levels.** REAP levels for the Service will be declared by the Chair of the Service Delivery conference call on a Wednesday and revised weekly or as disruptive challenges dictate. Each Operational Region, ACC, and department, as required, will declare a REAP level, which will contribute to the national REAP level. The national Service, REAP level will not necessarily be the worst of Regional REAP levels or, indeed, an aggregate of them. It will be a subjective view, based on all contributory factors, and on the Service’s national ability to meet demand with the resources it can call upon. When moving to REAP level 3 the Chair of the Daily Service Delivery conference call should seek approval from the on-call Strategic Manager. When moving to REAP level 4 approval should be given by the on-call Executive Director.

Triggers	Staff	Demand	System Pressure	Fleet	Supply	Weather
REAP 1	Operational shift coverage over a 24hr period ≥ 95.0%	Demand is over forecast by ≤ 10.0% of normal base line level OR BAU – Levels within the National Escalation Plan are used sporadically to manage on day system pressures	Average local Hospital turnaround times ≤ 30 mins (Where periods extend and cause concern)	Local Emergency Fleet provision is at establishment	Essential supplies being delayed by ≤ 7 Days	Be aware weather warnings issued from Met Office
REAP 2	Operational shift coverage over a 24hr period between 95.0 - 90.0%	Demand is over forecast by >10.0 - 15.0% of normal base line level OR Levels of the National Escalation Plan are used for prolonged periods in some sub regions to manage sustained	Average local Hospital turnaround times >30 but <60 mins (Where periods extend and cause concern)	Local Emergency Fleet provision reduced by 2 by workshop area	Essential supplies being delayed by >7 - 14 Days	Be prepared weather warnings issued from Met Office

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		periods of pressure				
REAP 3  (On-Call Strategic Manager Approval)	Operational shift coverage over a 24hr period between 90.0 - 80.0% AND/OR Utilisation rate >65%	Demand is over forecast by >15.0 - 20.0% of normal base line level OR There is limited opportunity to deescalate levels within National Escalation Plan, which is in place to manage pressure within regions or sub regions	Average local Hospital turnaround times >60 but < 90 mins (Where periods extend and cause concern) OR National average weekly hospital turnaround of over 60 minutes or hospital turnaround times > 2hrs at two or more sites in one region for a sustained period (3+ hours).	Local Emergency Fleet provision reduced by 3 by workshop area	Essential supplies being delayed by >14 - 21 Days	Take Action weather warning issued from Met Office
REAP 4  (On-Call Executive Approval)	Operational shift coverage over a 24hr period < 80.0% AND/OR Utilisation rate >80%	Demand is over forecast by >20% of normal base line level OR There is no opportunity to deescalate levels within National Escalation Plan, which is in place to manage pressure regionally or nationally	Average local Hospital turnaround times > 90 mins (Where periods extend and cause concern) OR National average weekly hospital turnaround of over 90 minutes or hospital turnaround times > 5 hrs at two or more sites in one region for a sustained period (4+ hours).	Local Emergency Fleet provision reduced by 4 by workshop area	Essential supplies being delayed by > 21 Days	Weather conditions have a significant and sustained impact on critical infrastructure

**Table 2 – REAP Level Triggers**

14. **REAP Mitigation Measures.** During periods of increasing demand, the Service will consider a variety of operational, tactical and strategic measures to address the prevailing situation. These measures are designed to safeguard the most critical and vulnerable patients, by re-deploying resources in order to protect mission critical activities. Decisions will be made at a strategic (Service) level. This may result in resources being redeployed from a geographic area or activity of lower priority to one with a greater need. Suggested Mitigating Measures at each REAP Level are given at Table 3. Once again, this table is for guidance only and should not be followed dogmatically. Pressure may be higher in one part of the country and normal in another,

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for example. There may be additional or alternative measures that can be used to manage the situation, and it may be useful to implement several measures at the same time. Operational Regions, ACC and Departments should also refer to their own Capacity Management Plans. For ease of use, tables 1, 2 and 3 are available in Annex A which can be printed as an aide memoire card.

Actions	Staff	Demand	System Pressure	Fleet	Supply	Weather
REAP 1	Business As Usual					
REAP 2 (Consider Capacity Management Meeting / Arrange staffing for possible establishment of Regional Cells)	Maximise ALL non-critical resources to operational shifts. Utilise Emergency Drivers and Bank Staff.	Preparation and consideration to implement Escalation Plan Level 1 with all appropriate actions implemented	Increase frequency of Local Management Discussions / Interventions with Integrated Health & Social Care Partners and Acute Units	Prioritise workshop capacity to maximise patient carrying fleet capacity.	Each Regional Hub holds 3 months of stock, and each Ambulance Station holds 3 weeks stock. This is relation to the core critical station consumable products circa 200 products.  Hubs to monitor stock levels in anticipation that stock may need to be redistributed.	Managers to monitor local predicted impacts and gain assurance from key services in relation to preparedness.  Consider the requirement to link in with LRP's and NRRD Resilience Leads
REAP 3 (Consider opening Regional Cells / Consider opening NCCC if there is an operational need)	Postpone ALL non critical activities/ meetings that do not directly assist in resolving or managing the current/imminent pressures.	Implementation and action review of Escalation Plan Level 1. Preparation and consideration to implement Escalation Plan Level 2 with all appropriate actions implemented.	Facilitate deployment of key staff and managers (Local ASM/HoS in hours & CTL during the on call period with escalation as required to the on call team) to site in response to pressures. Consider Review of attendance at nursing homes without FNC/doctor approval.	Consider Redeployment of ALL resources to core business (Ambulances/ Lease Cars/4x4). Consider LRP liaison and engagement.	Invoke plan with National Distribution Centre, 3 <sup>rd</sup> party suppliers and engage with SAS Clinical team to source alternative products/suppliers if required. To ensure essential patient care supplies	Managers to ensure ALL appropriate actions are invoked. Ensure that specialist transport arrangements (4x4) are prioritised.
REAP 4 (Consider Opening NCCC / Potential MACA Request)	Consider all appropriate clinical staff to be redeployed to frontline duties. Consider Managers and support staff to be redeployed to directly assist	Implementation and action review of Escalation Plan Level 2. Preparation and consideration to implement Escalation Plan Level 3	NCCC to coordinate Service Priorities and resources ensuring appropriate deployment of National Assets	Consider Extended hours of operation across 7 days. Ensure all conveying resource in the system is made available for front line use	As per REAP 3, in conjunction with colleagues from Clinical Governance/H &S/Infection Control/IT Systems.	NCCC to seek, prioritise and coordinate all available national resources to respond to Service need.

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