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Purpose: For Approval

CÙRAM IS SLÀINTE NAN EILEAN SIAR

WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

NHS
Eileanan Siar
Western Isles

Winter Plan 2018-19

Date of issue	Consultation process September - November 2018
Issued by	Winter Planning Group
	IJB SMT October 2018 Single Operating Division October 2018
Approved	Present to Integrated CMT for approval November 2018
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Contents

1. INTRODUCTION

This Winter Plan outlines the provision for services during the winter period and has been informed by a multi-disciplinary Emergency Planning and Public Health Incidents Coordination Group (EPPHICG) with representation from partner agencies and system wide health professionals.

The plan also takes account of the possibility that an outbreak of flu or other seasonal illness will place above-normal demands on services during this period. A separate plan exists for the management of Pandemic Flu and there is also an Outbreak Control Plan (Hospital).

The key objectives of the partnership are to:

- continue to provide the full range of emergency, elective, primary care and social care services throughout the winter period.
- continue to work in collaboration with our partner agencies to provide enhanced protection and services and support to the vulnerable groups, particularly older people.
- enhance the ability of staff to face the challenges of the winter period efficiently, effectively, safely – with no avoidable patient events and with confidence.

The aim of this plan is to outline how we can continue to deliver and maintain services throughout the winter period.

The following plans set out (Internet and local Intranet) detailed policies and procedures which relate to or are part of Western Isles' response to winter pressures:

- NHS Western Isles Emergency Planning & Business Continuity (Intranet)
- NHS Western Isles Business Continuity Management:- Critical Incident Protocols and Procedures - V1D2
- NHS Western Isles Business Continuity Management: Departmental Business Continuity Plan Template
- NHS Western Isles Attendance at Work during Adverse Conditions
- NHS Western Isles Lone Working Policy
- NHS Western Isles Managing Work Related Driving Risks
- NHS Western Isles Outbreak Control Plan (Hospital) Under Review
- NHS Western Isles Bed Management Plan (Bed Capacity Escalation Plan)
- Winter Flu Campaign
- NHS Western Isles Emergency Contingency Plan for failure of the NHS24 Out of Hours Service
- Admission and Discharge Policy in Draft.

- NHS Western Isles Day of Care Survey
- NHS Western Isles Shared Clinical Guidelines (Intranet)
- NHS Western Isles Major Emergency and Major Incident Policy & Procedure
- NHS Western Isles Major/Adverse Incident – Re-deployment Protocol
- NHS Western Isles Outbreak Plan (Public Health) under review
- NHS Western Isles Pandemic Influenza Plan under review
- NHS Western Isles Information Sharing Protocols

- Comhairle Emergency Planning & Business Continuity Plans
- Comhairle Lone Working Policy
- Comhairle Risk Policy on Driving
- Comhairle and NHS Joint Infection Control Plan
- Joint Bed Capacity Escalation Plan
- Admission and Discharge Policy

- IJB Strategic Plan
- 6EA Quarterly Report
- 6EA Priority Action Plan

ACTIONS TO STRENGTHEN RESILIENCE

Actions	Actions
We have clearly set out what additional capacity (beds or alternative forms of capacity) can be operationalized this winter.	Respite capacity diverted to allow for response to surge in demand Contingency bed capacity defined in plan
Robust social care arrangements are in place for each acute hospital and support to care homes and other community-based services to prevent avoidable hospital admissions. There should be a clear communication about this service.	Work is on-going in respect of the recruitment challenges to enable establishments within services to be operating at full capacity. Deployment of available staff will be maximised over the winter period to address prioritised needs and sustain services
Appropriate social care services are fully aligned with existing OOH services, including acute hospital.	Senior social work on-call 24/7 and OOH care at home services capable of making adjustments to packages based on availability with resources and risk assessments
Social Care services have authority/flexibility to change individual social care support arrangements and facilitate timely access to flexible care at home / care placements.	Ongoing communication with senior management during the festive period Work being undertaken to explore GP, Community Nursing and social care service

	developments to avoid admissions in relation to dehydration
Proactive discharge planning is in place prior to the weekend, including full alignment of all relevant tasks, for example, decision making, pharmacy, equipment, transport, and care packages.	Weekly MDT Delayed Discharge meeting to be expanded to include a huddle to anticipate and respond to winter pressures Individual plans for each service area have been drafted and agreed, which define presence over the festive period
Systems are in place to manage effective demand and capacity planning, including continuous monitoring of discharge levels against predicted activity levels.	
Appropriate levels and alignment of staff working across health and social care are deployed to ensure timely access to services over weekends and public holidays.	
Appropriate level of senior decision makers are rostered across health and social care services over the weekends and festive period.	NHS Executive on-call 24/7 Senior social work duty manager on-call 24/7 Additional MDT discharge meetings planned for festive period
Early effective decision making process at emergency/acute assessment areas are linked to improving flow for admission, discharge or transfer.	Overall capacity and resilience of A&E and pharmacy considered with contingency arrangements in place to support additional demand.
Availability of medicines at hospital front door as appropriate, with availability of hospital pharmacy extended hours or on call service to meet the needs of the service.	
Community pharmacy is promoted as first point of contact for patients with minor ailments and medication enquiries/repeat prescriptions.	Where applicable, community pharmacies will be available and promoted as first point of contact.
Integrated local crisis services are available for people with mental health difficulties.	MH wards fully operational over festive period

2. PREPARING FOR WINTER 2018/19

This report sets out the partnership's preparedness against each of the core planning areas outlined.

2.1. Resilience Preparedness

Action 1: The Partnership has robust business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on lessons learnt from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose

1. Each year local arrangements are tested in live incidents involving adverse weather and its impacts (loss of utilities, travel disruption, loss of supply chain, reduced staffing capacity, etc). On average we respond annually to between 2-5 Amber weather warnings involving winds gusting to 90-110mph, long duration (1-5 days) loss of power, lightning strikes, and ice and snow.
2. All weather events requiring a response, albeit multi-agency or organisational are subject to a formal debriefing process and actions points are tracked by the Western Isles Emergency Planning Group.
3. Strategic BCMS Policies and Protocols are in place to ensure an organisation wide response to Critical Continuity Incidents. Each Department is charged with developing a BCP using a template provided by Emergency Planning. This template includes a recovery plan specific to adverse weather conditions. Multi-agency debriefs are conducted every spring to provide a set of actions points to improve planning and include lessons learned.
4. The Emergency Planning and Business Continuity Facilitator for the Board is a member of the Winter Planning team and provide advice, support and guidance to the group throughout the planning process.
5. Winter Plan is circulated for consultation prior to publication.

Action 2: Business continuity (BC) plans take into account the organisations critical activities, analysis of the effects of disruption and the actual risks of disruption and develop plans based on risk-assessed worst case scenarios.

1. Both Strategic level and Departmental Plans are based on risk assessments and this is built into the Business Impact Analysis section of the organisational template. Each BCM Plan includes a series of recovery plans for differing scenarios. These include staffing, adverse weather, loss of utilities, loss of supply chain, etc. Each recovery plan focuses on impacts.

2. The Western Isles Emergency Planning Co-ordinating Group (WIEPCG) regularly deals with the impacts of adverse weather and provides support and aid across a multi-agency platform.

Action 3: The NHS Board and Local Authority have HR policies in place that cover:
- what staff should do in the event of severe weather hindering access to work, and
- how the appropriate travel advice will be communicated to staff and patients

1. Relevant NHS Western Isles policies include:
    - Attendance During Adverse Weather Conditions
    - Lone Working Policy
    - Managing Work Related Driving Risks
2. Relevant Comhairle policies include:
    - Comhairle Lone Working Policy
    - Comhairle Risk Policy on Driving
3. NHS staff policies are approved through Area Partnership Forum (APF) with a summary communicated to staff via email.
4. Comhairle policies are approved through the Joint Consultation Committee.
5. Emergency Planning issues a series of warnings in advance of any adverse weather conditions which are flagged with a weather alert or warning by the Met Office. A series of all mail user e-mails is issued advising of the weather type and possible impacts and links to organisational policies and procedures is included. Where the weather warning is for an Amber or Red Warning, the Emergency Planning and Public Health Incidents Group will meet to prepare for the impacts and alter working arrangements to suit.
6. Effective, proactive use will be made of local media, including broadcast media (TV and radio), local, regional and community newspapers, social media and website to advise members of the public of local arrangements.
7. There is an NHS duty manager on call out of hours to coordinate communications in the event of disruption due to adverse weather. The same applies at the Comhairle.

Action 4: The NHS Board's website will be used to advise on travel to hospital appointments during severe weather and prospective cancellation of clinics.

1. Use of NHS Western Isles Website, the Comhairle website, Local Radio, (WIEPCG) Facebook page and Twitter are used to communicate information.
2. Medical Records staff also phone individual patients directly if clinics are disrupted.

Action 5: The NHS Board and local authority have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process involves funeral directors.

1. There is limited mortuary capacity. Local Authority and Funeral Directors are not included in the current process as they do not have mortuary capacity (rely on Hospital mortuary capacity).

2. Triggers are in place in the event of demand rising and alternative arrangements are in place.
3. NHS Western Isles has purchased 2 portable, modular body storage systems: one located in Lewis and Harris and one in the Southern Isles.

Action 6: The partnership will test the effectiveness of its winter plan by 30 Oct with stakeholders. The final version of the winter plan will be approved by the Integration Joint Board.

1. NHS Western Isles continues to work in partnership with emergency planning colleagues and will practice together in annual exercises.
2. The Winter Plan has been considered by the Single Operating Division, Health Board CMT and Integrated Corporate Management Team with final version presented to the IJB and Health Board in December 2018.

2.2. Unscheduled / Elective Care Preparedness

A number of actions within the 6 Essential Actions for Unscheduled Care have been identified and current Health improvement projects include; Criteria led Discharge, Structured Ward Rounds, Anticipatory Care Plans and Early Escalation.

Action 1: Clinically Focused and Empowered Hospital Management

Action 1.1: Clear site management process is in place with operational overview of all emergency and elective activity.

1. NHS Western Isles hold weekly meetings to maximize elective and emergency Theatre activity including a summary of monthly performance.
2. A range of real-time dashboards in place for service managers and key clinicians covering Hospital Inpatient/Day Case services, Outpatients, A&E, Beds, Theatre and Waiting Times These support active monitoring of service activity levels, impacts upon waiting times, theatre utilisation and bed management practices.
3. Safety Huddle meeting taking place daily, including weekends. Clear triumvirate leadership team identified, with deputies.
4. Daily Dynamic Discharge Multidisciplinary Team (DDDMDT) meeting is now embedded and is aimed at improving patient flow and prepare for discharges the following morning.
5. Plan to reduce pre-op stays to maximise bed occupancy.

Action 1.2: Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur escalation procedures are invoked.

1. The Safety Huddle (as described above) has developed procedures for a) being informed b) escalation of information on an exception reporting basis.

2. The Huddle participants are regularly reviewing their progress and will further develop the system.
3. Regular daily handover meetings take place with clinical teams and Clinical Support Nurses.
4. Escalation procedures in place to manage system pressures. Escalation Policy incorporated in Bed Management Plan Appendix 1.

Action 1.3: Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector.

1. The Western Isles Emergency Planning Coordinating Group (WIEPCG) is a multi-agency group including all key partners, and the final plan will be shared with all partner agencies.
2. The Integrated Management Teams at Service and Corporate level have contributed to this Plan and responsible for ensuring effective information sharing protocols are in place.
3. A Bed Management Plan in place. Escalated to partners as required. The Bed Management Plan is attached as Appendix 1.
4. Process in place to ensure effective communication by senior manager on- call 24/7.
5. Multi-disciplinary weekly Delayed Discharge meetings are facilitated to address delayed discharges, potential delays and agree the allocation of resources.
6. Daily updates on capacity of acute and community resources are shared with NHS Hospital Management by Social Work Out of Hours Service.

Action 1.4: A Target Operating Model should be communicated to all staff. Escalation policies are well defined, clearly understood, and well tested.

1. An escalation plan is in place and is regularly tested in multi-agency exercises. The Bed Management Plan is attached as Appendix 1.

Action 1.5: Escalation policies are in place and consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU.

1. NHS Western Isles hold weekly meetings to maximise elective and emergency Theatre activity including a summary of monthly performance.
2. Bed Management Plan is in place and is reviewed regularly to ensure issues are identified. Bed Management Plan is attached Appendix 1.
3. There is a weekly meeting to plan Theatre elective schedule.

Action 1.6: Escalation policies are focused around in-patient capacity across the whole system.

1. Daily Huddle identifies pressures and capacity issues across the whole system.
2. Day of Care Survey utilising severity of illness and service intensity to assess "appropriateness" as an inpatient as a tool.
3. Bed Management Plan in place.

4. Working closely with Third Sector or patient transport to facilitate discharges.
5. Risk Assessment in place for Uist and Barra hospital if number of patients exceeds staffed levels.

Action 1.7: Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes.

1. The potential to utilise the bed based intermediate care service for winter planning will be explored and alternative staffing arrangements considered if recruitment to social care posts continues to be unsuccessful.

Action 2: Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity. This has specifically taken into account the surge in activity in the first week of January.

Action 2.1: Demand, capacity, and activity plans across emergency and elective provision are fully integrated.

1. Statistical Process Control (SPC) charts for number of metrics included in new Business Intelligence (BI) dashboard on clinical activity in support of monitoring of variations. Discovery National tool also rolled out across users with sessions on use in supporting variation analysis. Projecting of demand and capacity to form part of Gooroo planning tool once analyses developed further.
2. Work to include analysis in formulation of service capacity plans to be undertaken – *Planning and Performance Manager.*

Action 2.2: Arrange of analysis and management tools to enable effective and related planning and management of scheduled and unscheduled services have been implemented.

1. Gooroo capacity planning tool has been implanted and developing its use in range of planning and forecasting applications.
2. Unscheduled Care 6EA toolkits inc. bed planning to be explored for potential local uses in support of bed management and capacity planning subject to Analytical capacity.
3. Considered using System Watch last year but found predictive accuracy too variable for a small setting. Range of predictions were too wide to be operationally useful in weekly planning.

Action 2.3: Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions.

1. Suite of metrics in support of capacity planning to be developed from those identified as part of 6EA unscheduled care and discharge planning workstreams for potential incorporation into BI dashboard, subject to analytical capacity.

2. Weekly meetings looking at capacity for the following 4 weeks to maximise Theatre efficiencies.
3. Contingency beds (surge beds) have been identified and are used year round to manage demand.

Action 2.4: Pre-planning and modelling has been undertaken around elective activity to plan responses, escalation and recovery to minimise the impact of winter peaks in demand on the delivery of routine elective work.

1. Limited by the number of available Theatres and Theatre staff in remote and rural location
2. Weekly meetings to review activity.
3. GOOROO projections have been introduced.
4. Bed Management Plan includes escalation plan to manage winter peaks.
5. There is a weekly meeting to plan Theatre elective schedule.

Action 2.5: Planning and analysis will facilitate the Board to consistently deliver the 4 Hour Emergency Access target (95%) and work towards the (98% Standard), eliminate 12 hour breaches whilst avoiding 8 hour breaches, and maintain the delivery of all elective care.

1. Weekly automated A&E Waiting Times Performance emailed to relevant staff
2. Target of 98% consistently achieved.
3. Escalation Plan in A&E identifies and triggers potential breachers.
4. Monitored real-time for main Hospital site in dashboard and reported to weekly operational management meetings.
5. Predictive modeling using previous data. Demand and capacity analysis of medical pathway undertaken.
6. Breaches are reviewed continually for potential of improvement.

Action 2.6: NHS Boards review and take stock of their performance against the British Association of Day Surgery (BADS) Directory version 4 to ensure that they have achieved optimum performance against the surgical procedures identified as being suitable for day case surgery"

1. Day Case rates included in BI dashboards but will review against BADS procedures.
2. Not all BADS procedures are applicable to NHS Western Isles.
3. Working with QUEST team to use most effective use of resources.

Action 3: Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities such as MDTs, and projected peaks in demand. These rotas should include services that support the management of inpatient pathways, (e.g.) diagnostics, pharmacy, phlebotomy, AHPs, IPCT, portering, cleaning etc.

Action 3.1: Consultant (Medical and Surgical) cover along with multi-professional support teams, including IPCT cover, will be planned to effectively manage predicted activity and discharge over the festive holiday periods, by no later than the end of October.

1. Appropriate staffing rotas will be in place in October for Medical, Nursing, AHP and support staff.
2. Any planned service closure or alternative arrangements will be coordinated and communicated to the public via local media. i.e. local radio, local newspaper and social media sites.
3. Western Isles Hospital Theatre and OPD will reduce elective activity over the festive period but accommodate scope lists for bowel screening and USC referrals, main lists for TTG patients at risk of breaching, and ortho/fracture clinics in line with the following timetable:

Medical clinics are not scheduled for the festive period.

Surgical/Theatre Timetable

Up to Friday 21st December 2018	Business as usual
Saturday 22nd December 2018	Weekend closed
Sunday 23rd December 2018	Weekend closed
Monday 24th December 2018	Fracture Clinic (AM)
Tuesday 25th December 2018	PH
Wednesday 26th December 2018	PH
Thursday 27th December 2018	Ortho Clinic (AM) Urgent scopes only
Friday 28th December 2018	Urgent scopes only and emergency theatre
Saturday 29th December 2018	Weekend closed
Sunday 30th December 2018	Weekend closed
Monday 31st December 2018	Fracture Clinic (AM)
Tuesday 1st January 2019	PH
Wednesday 2nd January 2019	PH
Thursday 3rd January 2019	Ortho Clinic (AM) Urgent scopes only
Friday 4th January 2019	Urgent scopes only and emergency theatre
Saturday 5th January 2019	Weekend closed
Sunday 6th January 2019	Weekend closed
Monday 7th January 2019	Business as usual

There will be no scheduled elective work in Uist & Barra Hospital over the festive period 24th December 2018 to 2nd January 2019.

AHP Support

AHPs – Physiotherapy and Occupational Therapy will provide a limited service over the festive period to facilitate discharge. They proactively plan and prepare for patient discharges to ensure there are no delays in pre discharge assessments. Arrangements mirroring the 2017/2018 holiday period through the voluntary staffing of services during the festive break are being addressed.

- The SALT staff will be covering ward patients and any outpatients/community patients with swallowing difficulties, as a priority, during the festive period.
- The OT Service ensures that there is sufficient staff to maintain a service that focuses on supporting safe discharges and avoiding preventable admissions.
- The Department of Nutrition and Dietetics provides out of hours guidance on starting an enteral feed which is to be used when the department is closed over the festive period.
- The Podiatry service will continue to provide a reduced level of service over the Christmas & New Year period.
- The Radiographers on call rota for the Christmas and New Year period will be issued for Western Isles Hospital.
- Consultant Radiologist cover out of hours will be provided via the obligate network with NHS Borders.
- On call cover in Uist and Barra Hospital will be provided from 9am until 9pm, 7 days per week as per normal arrangements out with the Radiographer's core hours.

Action 3.2: Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements.

1. Extra capacity is difficult as Theatre is fully utilised. (Two Theatres available).
2. Weekly meetings take place to maximise Theatre efficiencies.

Action 3.3: Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc.

1. Action for Children provide a 6 week Alcohol Education Programme which runs year long. Child and Adolescent Mental Health Service work with partner agencies signposting, providing advice and referring into the service as necessary.
2. Emergency Out of Hours Social Work and Home Care Out of Hours Management arrangements operate throughout this period. Supervisors in Home Care will be operational during the holiday period in Lewis and Harris and localised interagency arrangements for Uist and Barra. There will be Care Home senior and management presence in all care homes across this time.
3. WIEPCG coordinate multi agency events i.e. Fireworks on Hogmanay.

Action 3.4: Out of Hours services, GP, Dental and Pharmacy provision over festive period should be communicated to clinician/manager on call to ensure alternatives to attendance are considered.

1. Closures are coordinated and communicate to staff and the general public using Facebook, Twitter, Local Radio, Local newspapers and Health facilities notice boards.
2. The senior manager on call will have access to all service provision arrangements.

GP Practices festive timetable:

Monday 24 December 2017	Business as usual
Tuesday 25th December 2018	Closed PH Closed. GP care and associated pharmacy prescriptions* can be accessed via NHS24 if can't wait until 28th December.** but additional clinics could be held
Wednesday 26th December 2018	Closed PH Closed. GP care and associated pharmacy prescriptions* can be accessed via NHS24 if can't wait until 28th December.** but additional clinics could be held
Thursday 27th December 2018	Business as usual
Friday 28th December 2018	Business as usual
Saturday 29th December 2018	Closed
Sunday 30st December 2018	Closed
Monday 31 December 2018	Business As usual
Tuesday 1st January 2019	Closed** PH Closed. GP care and associated pharmacy prescriptions* can be accessed via NHS24 if can't wait until 4 January but additional clinics could be held
Wednesday 2nd January 2019	Closed PH Closed. GP care and associated pharmacy prescriptions* can be accessed via NHS24 if can't wait until 4 January
Thursday 3rd January 2019	Business as usual
Friday 4 January 2019	Business as usual

**There will be a pharmacy rota for these dates as per previous years and so community pharmacy can be accessed rather than needing to call in hospital pharmacy for any important but not usual out of hours medication.*

***If required, additional sessions (i.e. 10am-4pm clinic) could be held during the festive period. There is now a second GP available on GP OOH Rota who could be called in for busy general activity and not just the visits/FME work for which they are usually called in.*

Action 3.5 Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during autumn to minimise the risk of the TTG being breached.

1. Weekly Theatre scheduling meeting to align capacity against demand and introduce a buffer before the winter shutdown to ensure TTG targets are met.

Action 4: Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge process which includes determining an Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of discharge, ensuring there are no delays in patient pathways.

Action 4.1: Discharge planning will commence at the point of admission or at pre-admission assessment using, where available, protocols and pathways for common conditions to avoid delays during the discharge process.

1. Policies and Procedures are in place to manage the discharge process. The use of EDD is built into admission documentation.
2. Daily Huddle identifies pressures and capacity issues across the whole system which includes Discharge planning.
3. Discharge planning happens on a daily basis Monday to Friday, with a view to expanding this to 7 days a week. On a hospital wide basis it is part of the DDDMDT (Daily Dynamic Discharge Multidisciplinary Team) meeting.

Action 4.2: There will be on-going engagement with the SAS to effectively plan patient transport when it is known, or anticipated, that patients will require transport home or to another care setting.

1. Patients will be transported where they meet eligibility criteria through “Patient Needs Assessment” (PNA) those patients not meeting criteria would be signposted to other agencies e.g. (Third Sector)
2. SAS is limited but alternative arrangements with Third Sector/Contracted Taxi to enable transport of patients out with SAS hours i.e. early morning/weekends.
3. Weekends/mid afternoons/late evening. Solution being looked at to provide patient transport for discharge home over festive period.

Action 4.3: Multi-disciplinary Ward Rounds will be embedded to proactively manage the patient journey and prepare for discharge detailing the estimated date of discharge.

1. In place and work is on-going to consolidate recent improvements in the management of delays.
2. Coordination of need across community and hospital provision.
3. Focus on anticipation/likely delays

Action 4.4: Regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, including over weekends, and should involve key members of the multidisciplinary team, including social work. Daily ward rounds occur in all acute settings. DDDMDT includes social work attendance.

1. Utilising Third Sector/Contracted Taxi for discharges and transfer outwith Monday to Friday 9-4pm and Public Holidays as SAS unable to facilitate transfers.

Action 4.5: Predictive data will be used to assess the hourly demand for beds allowing for discharges to be scheduled to optimise flow.

1. In remote and rural locations hourly demand plan is not appropriate.
2. Daily Handover and Huddles take place.
3. Completeness of Expected Discharge Date recording is actively being monitored via automated reporting available to operational managers. Plans to incorporate Ready for discharge date further into recording processes relating to discharge are in development pending national review of definitions on delayed discharges.
4. TOPAS ED module will inform a change in practice in how the module is used. i.e. EDD link to length of stay.

Action 4.6: Discharge lounges should be fully utilised to facilitate pre-noon capacity.

1. There are no discharge lounges. However, this is being explored locally.

Action 5: Ensure that senior clinical decision making capacity is available for assessment, care planning, MDTs and discharge and that AHP rotas are structured, to facilitate the discharging of patients throughout weekends and the fortnight in which the two festive holiday periods occur in order to maximise capacity.

Action 5.1: There is adequate medical, nursing and AHP cover across both, the festive holiday period, and over weekends to conduct assessments, plan effective care programmes and perform dedicated discharge rounds.

1. In place, Senior clinical decision making available 24/7.
2. AHP service working on prioritising resources to facilitate timely discharge pre the festive holiday and recruiting volunteers to provide a limited service during public holidays.
3. Appropriate Medical and Nursing Rotas will be in place by October 2018.
4. Plan to increase A&E staffing on Public Holidays over festive period, to meet demand.

Action 5.2: Key partners such as: pharmacy, transport and social care services will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this.

1. The delayed discharge process is managed through weekly meetings between hospital and community based health and social care leads. This group seeks to facilitate discharge by exchanging information and coordinating discharge arrangements. Ongoing capacity challenges are having an impact on acute and community services. Planned respite and engagement with family carers of home care service users is central to anticipating and planning for the demands on hospital and community based services.
2. The potential to re-shape the allocation for planned respite and unscheduled step up/step down community beds is being explored. Likely to have new intermediate care service in place by winter.
3. Pharmacy has capacity to support the discharge process.
4. Transport is provided by SAS and supported by Third Sector/Contracted Taxi when necessary.

Action 6: Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.

Action 6.1: There is close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet predicted discharge levels.

1. Patients with existing care packages have their services held during their hospital unless their care need have been assessed as requiring alternative services. The weekly Delayed Discharge meeting is used to review and accelerate assessments and consider availability for new or increases in care packages by patients.
2. The new intermediate care service is planned to be in place and working in the New Year.

Action 6.2: Ongoing and detailed engagement between local partners around the capacity of social care services to accommodate predicted discharge levels will start no later than October.

1. The learning from the previous year's actions and the need to manage the current patient delays and community capacity issues are focusing Partnership engagement at service and corporate level.
2. A Delayed Discharge Action plan continues to drive improvement.

3. Application of an Estimated Discharge Date is a key component to support discharges within existing resource.

Action 6.3: A clear escalation plan is in place to resolve issues that might arise.

1. There are effective escalation channels in place to allow for consideration to be given to cases which are unable to be resolved at practice level. This pertains not just to communication channels through to senior management but to the opportunity for review through the weekly meeting, which will give active consideration to complex cases. During Out of Hours the on call Senior for Social Work will facilitate the escalation of the joint protocols for bed management.

Action 6.4: Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised, where possible.

1. A new intermediate care service is being established, which will bring on stream four reablement beds with community outreach capacity.
2. Care at Home staff are working in hospital with patients, AHPs and ward staff to provide continuity of care when preparing and managing discharge when appropriate.

Action 6.5: Host partnerships are taking the discharge requirements of patients who are receiving treatment at the Golden Jubilee National Hospital into account.

1. These arrangements are in place.

Action 6.6: Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge.

1. Anticipatory Care Plans are being used more widely than in previous years and work continues to provide the use of these.
2. The ACP's take the form of a Key Information Summary (KIS) which is filled in in the GP software system (EMIS). This is available automatically to all unscheduled care areas (I.e. SAS, NHS24, A&E, AAU). For governance and confidentiality reasons other groups who do not provide unscheduled care (e.g. Podiatry) in the same way have not had access to these directly.
3. SPARRA data is routinely uploaded into real-time hospital activity dashboards to provide managers with view of SPARRA patient's impacts on hospital activity.
4. SPARRA information is included in Primary Care dashboard to assist GP Practices in actively monitor their high risk patients.
5. A further risk cohort of potentially avoidable admissions is included in Primary Care and hospital activity dashboards which is based on basket of ambulatory sensitive conditions.

Action 6.7: All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances.

1. Liaising with Overnight Nurse Service to avoid unnecessary admissions. An active register is held of vulnerable/ Palliative patients in the community and continue to implement anticipatory care plans for target groups. This will also involve work on the effective transference of information. We have just been through a process of reform in respect of out of hours care, and hope that this will provide a more resilient service over the winter months.
2. Consideration of standby agency resources or flexible use of partnership staff is planned for the winter period.
3. The Care for People Group will be fully briefed on the detail of the Winter Plan and associated actions to enable their ability to react effectively in the emergency planning context.
4. Data capture of ACP flag in PAS system being considered for introduction of further risk cohort into above dashboards and automated alerting upon hospital admission.

Action 7: Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.

Action 7.1: Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as soon as they occur, and that escalation procedures are invoked at the earliest opportunity.

1. Effective communications mechanisms are in place. Each ward and department has a Departmental Communications Plan, outlining in detail how communication takes place both within the department and out to the wider organisation.
2. The weekly Delayed Discharge meeting incorporates whole system pressure discussion and will be extended to incorporate the broader winter planning agenda on a 2 weekly basis with Senior Managers requested to contribute.

Action 7.2: Demand, capacity, and activity plans across emergency and elective provision are fully integrated.

1. Bed Management Plan in place.
2. OOH Emergency Contingency Plan is in place.
3. A local review of OOH underway, initial workshops held in August 2016.

Action 7.3: Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector.

1. Effective partnership links are in place.
2. Protocols are in place for accessing emergency and routine multi-disciplinary engagement.

3. Overarching Scottish Accord on the Sharing of Personal Information (SASPI) agreement for data sharing between local authority and health board is in place. Development of specific Information Sharing Protocols (ISP) for instances of data sharing are underway with ISP completed for extraction, transfer and linkage of social care and health data for management information purposes.
4. WIEPCG have agreed communication protocols in place all year round.

Action 7.4: Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent.

1. NHS Western Isles has well established social media pages (Facebook and Twitter), which can be updated at any time. The NHS Western Isles website can also be updated as and when required with information. The organisation has a positive relationship with local media organisations (including local radio and TV organisations), which support us to communicate information to the wider public. NHS Western Isles links with CnES and UHI also mean that information can be issued to 'all users' in these organisations as and when required.

2.3. Out of Hours Preparedness

Action 1: The OOH plan covers the full winter period and pays particular attention to the festive period.

1. Setting up of rotas will be finalised by middle of November 2019.
2. The OOH Service has an approved Emergency Contingency Plan. Appendix 2

Action 2: The plan clearly demonstrates how the partnership will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.

1. Escalation & contingency planning will utilise activity data from Highland Hub/NHS24.
2. Opening hours & prescription arrangements have been confirmed with Practices.
3. Practices will be reminded to review Just-in-Case plans, update ACPs/KIS etc. & communicate this to Community nursing staff.
4. Two specialty doctors covering A&E have been employed and this strengthens GP capacity in the OOH period.
5. OOH rotas are created in advance and cater for predicted demand. Unpredicted demand is managed appropriately at the time. An Emergency Contingency Plan exists for staffing issues.
6. Community Unscheduled Care Nurses (CUCNs) continue to support GP Out of hours.

7. CUCNs will be based in A&E taking appropriate referrals. This will enable collaborative working to balance care needs across those two services according to availability and workload demand.
8. Increased capacity for NHS 24 referrals on public holidays with 2nd GP facilitating drop in clinic.

Action 3: There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period.

1. Use of specialist paramedics to be investigated with Scottish Ambulance Service.
2. Depending on predicted demand, OOH GP clinics may be arranged in advance over the festive period.

Action 4: There is reference to direct referrals between services.

1. The two Western Isles Primary Care Emergency Centre (PCECs) are located in the A&E departments of the two hospitals and direct referrals between services are standard practice.
2. Appropriate redirection of patients from A&E to NHS 24 is facilitated.
3. ADASTRA contains any KIS created by primary care – this is also available to SAS and NHS24. A&E and AAU can access ECS.
4. ADASTRA is in place for out of hours which links in to in-hours primary care.
5. TED is in place in A&E and the GPs have access to this. Appropriate referral pathways are in place for A&E and AAU.
6. Referral SOPS in place to and from social work.
7. Referral pathways in place for NHS 24.

Action 5: The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.

1. Use of existing systems which allows NHS 24 to triage appropriately and make information available to the relevant GP the following morning.
2. Existing systems (ADSTRA/SCI Store/(Topas Emergency Department) and a series of dashboards are available to service managers and other key staff which enables real-time reporting from A&E, SCI Gateway referrals and hospital admissions. Work to extend the data capture and reporting to include Primary Care is underway with corporate access to EMIS GP systems scheduled to begin this year.

Action 6: There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa

1. Consider using the appropriately trained Primary Care pharmacists in support of OOH activity.

2. There are no pharmacy services available OOH from the community pharmacies. Associated pharmacy prescriptions can be accessed via NHS24 and if not available in the out of hours or A&E the on-call hospital pharmacist can be called.

Action 7: Clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.

1. Mental Health Services have a generic team that provides an OOH service for psychiatric emergencies.
2. Consultants Psychiatrists work an on-call rota.

Action 8: There is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres

1. There are three OOH locations used for Dental Services in the Western Isles. These are based at the Western Isles Dental Centre in Stornoway, Liniclate Dental Clinic Benbecula and Dental Clinic St Brendan's Hospital Barra. In the event of power failure, the Dental Room in OPD Western Isles Hospital Stornoway and Dental Room OPD Uist & Barra Hospital will replace other locations in Stornoway and Benbecula until power is restored. All sites provide OOH services from 6pm to 10pm Mondays to Fridays via NHS 24 triage. Saturdays/Sundays/Bank Holidays between 9am and 10pm. Outside these times patients are treated at A&E units in Stornoway, Balivanich and Castlebay. Clinics are staffed by Health Board Dentists/Dental Nurses. All OOH dental activity is coordinated through NHS 24.

Action 9: The plan displays a confidence that staff will be available to work the planned rotas.

1. The Rotas for OOH cover over the festive period have been compiled.
2. The OOH Emergency Contingency Plan is in place for any unexpected deviations to the Rota.
3. The senior team will operationalise the plan and will report monthly to ICMT over the winter period.

Action 10: There is evidence of what the partnership is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24.

1. NHS Western Isles has an approved Media Policy which states how information is distributed to the media (i.e. through press releases and/or media interviews). Arrangements for out of hours services will be issued via press release to all local, regional and national media, as required. NHS Western Isles' Communications Manager also works with NHS 24 to ensure that any national materials are distributed effectively locally. In addition to this, NHS Western Isles also makes use of its social media sites (Facebook and Twitter) to cascade information, and the NHS Western Isles website is also used to communicate

information to the public. Hospital information screens will also include information on out of hour's arrangements.

Action 11: There is evidence of joint working between partnerships and the SAS in how this plan will be delivered through joint mechanisms, along with examples of innovation involving the use of ambulance services.

1. Example of innovation in joint working include SAS staff covering OOH shifts, based in Emergency Department providing 'See and Treat' interventions for call outs.
2. Treat and refer is undertaken by Paramedics on ambulances with decision support provided by local on call GPs where required.
3. Third Sector/contract taxis are utilised outwith Monday to Friday 9-4pm
4. Multi agency response to emergencies in severe weather includes GPs and ambulance staff working closely through WIEPEG triaging and responding to appropriate calls.

Action 12: There is evidence of joint working between partnerships and NHS 24 in preparing this plan.

1. Draft plan was shared with NHS24 & Highland Hub to gather their views & input.

Action 13: There is evidence of joint working with the acute sector and primary care Out-of-Hours planners in preparing this plan.

1. Monthly liaising with Acute Service to ensure Acute and Primary Care OOH cover
2. OOH covers Acute Service as part of the service model.

Action 14: There is evidence of working with social work services in preparing this plan.

1. Chief Officer, IJB coordinates the Winter Plan across health and social care services.

Action 15: There is evidence of clear links to the pandemic plan including provision for an escalation plan.

1. Pandemic Plan has been updated.
2. Outbreak Plan in place.
3. Any predicted increased level of demand will be communicated to NHS24 (Action 12) using real-time NHS data to predict increase in staff for NHS 24.

2.4. Prepare for and Implement Norovirus Outbreak Control Measures

Action 1: Infection Prevention and Control Teams (IPCTs) should read the HPS Norovirus Outbreak Guidance due to be refreshed in September 2016.

1. The IPCT will read the guidance, make it available on their Intranet page and ensure that NHS Western Isles (NHS WI) is optimally prepared.
2. The IPCT will be responsible for cascading the above information throughout NHS WI three hospital sites and partner organisations.
3. The guidance will be provided in all Priority Training for nursing and community staff, local Council care home staff and also their home carers.

Action 2: IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts.

1. NHS WI will support the IPCT to provide education and training to all staff on norovirus.
2. The IPCT and HPT will work collaboratively to share preparedness and optimise systems to reduce norovirus impact in both the hospital and care home environment.
3. The IPCT and HPT will ensure all campaign materials will be cascaded throughout the organisation and partner organisation.

Action 3: HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.

1. Current information on HPS Norovirus Control Measures will be available on the IPCT Intranet page.
2. Over the winter months norovirus will be the main topic for all Priority training sessions alongside a practical assessment of all staffs hand hygiene technique and their skin integrity.
3. Ward based education sessions will be undertaken by the IPCT to ensure all clinical areas are aware of where to access the HPS Outbreak guidance.
4. Risk assessment held on Operational Management Group risk register.

Action 4: NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time.

1. Outbreak Control Plan (Hospital) is available to all staff via Intranet.
2. Infection Control Communication Plan available and content known to the whole of the IPCT.
3. Outbreak Control Team (OCT) will communicate ward closures and any restrictions on hospital visiting as a result of a norovirus outbreak.

Action 5: Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks.

1. The OCT will undertake a debrief to ensure systems in place were effective, or to determine how it could have been prevented, detected earlier and/or managed better.
2. The OCT will also write a report with any recommendations in an action plan and disseminate the report to all relevant parties.
3. NHS WI will ensure the report recommendations are implemented.
4. NHS WI will share any lessons learned with colleagues in NHS Scotland to prevent similar outbreaks.

Action 6: IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.

1. Weekly Norovirus figures are shared across the organization.
2. Personal Protective Equipment/ Respiratory Protective Equipment (PPE/RPE) are key elements in protecting front-line staff from winter illness and viruses eg influenza and norovirus. NHSWI provide PPE and RPE to front-line staff to minimise the spread of these winter illnesses and viruses. Face Fit Testing of all staff face masks is a requirement for all front-line staff.

Action 7: Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.

1. Procedures in place throughout NHS WI.
2. NHS WI 'Team Brief' circulated to all OOH GP's.

Action 8: NHS Boards must ensure arrangements are in place to provide adequate IPCT cover across the whole of the festive holiday period.

1. Infection Control Doctor's on-call 24/7.
2. HPT on call also 24/7.
3. Duty Manager on call with list of all contacts.

Action 9: The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days.

1. Procedures are in place across NHS WI.
2. Outbreak Control Plan would be implemented.

Action 10: There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.

1. IPCT and HPT communicate effectively and would bolster one another in a changing norovirus situation working closely with the other members of the Outbreak Control Team.

Action 11: The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message.

1. Embedded throughout NHS WI and IJB.
2. All Norovirus publicity materials are deployed internally and locally as appropriate
3. Priority Training session for both Health and Social Care will include information on Norovirus from the ICPT.

2.5. Seasonal Flu, Staff Protection & Outbreak Resourcing

Action 1: At least 50% of all staff working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients, as recommended in the CMO(2015)12.

1. Ongoing work to achieve 50% target.
2. All Clinical Heads of Department have been identified as Flu Champions.

Action 2: All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2014)12 clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible.

1. **Staff Flu Immunisation Programme**

The Scottish Government Health Department Circular SGHD/CMO (2017)12 advises that free seasonal influenza immunisation should be offered by NHS organisations to all employees directly involved in delivering care. Social care providers should also consider vaccination for staff.

Influenza immunisation is recommended in preventing influenza in working age adults. In addition, influenza immunisation may reduce the transmission of influenza to vulnerable patients, some of whom may have impaired immunity and thus reduced protection from any influenza vaccine they have received themselves. It may also prevent illness related staff absence and as such is an important element of winter contingency planning.

The uptake rate for seasonal influenza vaccine amongst health care staff continues to be low in line with other health boards in Scotland. This programme is led and coordinated by NHS WI Health Protection and the Occupational Health Department.

Activities to improve uptake take into account the wide geographical area and disparate nature of staff groups and will include:

- Regular communication briefings to all staff via email and intranet
  - Notice of flu season entered into individual pay slips
  - Advertising throughout work places
- Established dates for flu immunisation clinics including increased input into inter-island and community settings
- Roving clinics in all hospital departments
- Monitoring of uptake is coordinated via Public Health.
- In line with SGHD/CMO (2012)6 a seasonal flu staff vaccination champion has been identified to promote and support the vaccination of staff.
- Peer vaccination will also be available in season 2018/19.

Action 3: The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period.

1. Information from early spotters utilised
2. Data is currently week behind and trends are analyses and relevant actions taken
3. Major/Adverse Incident – Re-deployment Protocol in place to ensure placement of staff to deal with potential flu outbreak.
4. Immunisation

Coordination of the Immunisation programme including Seasonal Influenza and Pneumococcal vaccination is led by the Division of Public Health and Health Strategy. The Influenza programme will run from 1st October 2018 until 31st March 2019, concentrating efforts to maximise uptake by the end of November 2018. Pneumococcal vaccination will be available all year round with a concentrated effort being made to vaccinate at the same time as Influenza.

This year's 2018-2019 childhood flu vaccination programme will offer vaccination to the same groups as last year. Specifically: all children aged two to five* (not yet at school) through GP practices (*children must be aged two or above on 1 September 2018); and all primary school-aged children (primary 1 to primary 7) at school. The only significant change to the programme this year is that any primary school child in Scotland who misses their school session (for whatever reason) can make an appointment with their GP practice to be immunised.

The local Health Protection Team leads the coordination of the seasonal Influenza and Pneumococcal Campaign. There are a number of project strands being developed.

- Work will continue for this year to improve uptake rates in the over 65's, as well as for those in the younger 'at risk' groups, and health care staff.
- The Midwifery service are providing all pregnant women with an information pack on the seasonal influenza vaccine women are advised to attend their GP for vaccination.
- The Western Isles NHS Board H1N1(v) Influenza Vaccination Plan will be adapted in accordance with epidemiological evidence and implemented in the event of a pandemic situation
- The communication campaign has targeted NHS Staff to promote their effective immunisation.
- Public material can be accessed through the Western Isles internet site and professional materials via the intranet. The site provides a one stop shop for information and materials to support the vaccination programme and updates on the local situation.
- Coordination of practice-based activity & sharing of best practice is undertaken via meetings with local Practice Manager & Practice Nurse Networks.

The National Scottish Immunisation Recall System invitation letter and Flu information leaflet will be distributed to all relevant members of the population during September and October 2018.

Contingency arrangements will be considered as part of a 'catch-up' programme in the event of an outbreak or pandemic.

5. Pneumococcal Vaccine

Pneumococcal vaccination continues to be recommended for those in the at-risk groups and those aged over 65 years. The vaccine will be offered to those people who reached 65 years of age before 31st March 2018, those eligible but did not want to avail themselves of the vaccine last year, and new "at risk" groups. This programme, which is combined with the flu vaccination programme runs all year round, however, concentrated efforts are made to give at the same time as the influenza vaccine to maximise uptake.

Action 4: HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity.

1. Yes, in place and cascaded to relevant departments.
2. Monitoring Uptake

Health Protection Scotland (HPS) will take the lead in monitoring uptake on behalf of the Scottish Government and will provide monthly uptake data from October 2018 to March 2019. HPS are also providing a weekly children's uptake report. These reports will be circulated by HPS to the Scottish Government and NHS Boards. Final uptake figures for seasonal influenza vaccination will continue to be based on GP payment data, which will be available from PSD Claims for Payment following the end of the financial year. The Health Board will observe the data and monthly reports are provided on HPS

website. If uptake is low the Health Board will contact practices with offer of assistance/ discussion on what can be done to improve.

Action 5: Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods.

1. BCPs take into account: Staffing, adverse weather, Surge Capacity, etc
2. Norovirus

Health Protection Scotland provides advisories on Norovirus outbreaks, control measures and practical considerations.

Interagency Health Protection community work includes preventative and control advisory support.

Locally this is interpreted through the National infection Updates dashboard which feeds into CMT updates/reviews. Outbreak Control Plan and the National Infection Prevention and Control Manual are utilised. When Care homes notify Health Protection Team (HPT) of an outbreak- HPT will support the home through the outbreak using HPT SOP: Viral outbreak in a care home.

If and when norovirus is identified the Norovirus Decision Tree is used in the clinical areas and by the IPCT. Local control measures include daily checklists to ensure norovirus measures are in place and patients are isolated appropriately. Enhanced cleaning of the patient equipment and NHS WI patient information leaflets and advisory on sudden onset nausea and vomiting – Guidance for relatives and visitors, Patient information is also to anybody attending the Emergency Department with norovirus symptoms.

NHS Western Isles runs a norovirus awareness campaign on an annual basis to remind members of the public that they should not visit a hospital if they have experienced symptoms of norovirus in the last 48 hours. The publicity materials also remind the public of the symptoms, how to avoid spreading norovirus, and what steps to take if they catch norovirus.

The Board also includes up to date information and advice on its website, on hospital information screens, on Social Media sites and circulates national publicity materials (posters and leaflets) where available.

In terms of visiting restrictions as a result of cases of norovirus, NHS Western Isles uses the above channels to communicate information to the public and also issues all mail user bulletins to staff so that staff are aware of restrictions/arrangements. Staff attending outbreak meetings are also responsible for cascading, as appropriate, relevant information to their teams/staff.

2.6. Respiratory Pathway

Action 1: There is an effective, co-ordinated respiratory service provided by the NHS board.

Action 1.1: Clinicians (GP's, Out of Hours services, A&E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.

1. Highland Pathway.
2. Shared Clinical Guidelines – Respiratory (Intranet).

Action 1.2: Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.

1. GP Practices hold register of all patients.
2. Patients will have a Key Information Summary (KIS) on EMIS. This will include self manage management plans. Housebound patients are known to the Community Staff and provide support as required.

Action 1.3: Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times.

1. The ACPs for patients with respiratory disease (as with all other ACPs) take the form of a Key Information Summary (KIS) which is filled in in the GP software system (EMIS). This is available automatically to all unscheduled care areas (I.e. SAS, NHS24, A&E, AAU). For governance and confidentiality reasons other groups who do not provide unscheduled care (e.g. Podiatry) in the same way have not had access to these directly.
2. Patients will have Emergency Medication information to hand in their self management plan.
3. Shared Clinical Guidelines on Intranet.
4. Respiratory Traffic Lights available on Shard Clinical Guidelines.
5. ACP in place by GP but no access to information by Respiratory Nurse.

Action 1.4: Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients.

1. National Campaigns.
2. Text alert service re: adverse weather.
3. Twitter.
4. Facebook.
5. WIEPCG.

Action 2: There is effective discharge planning in place for people with chronic respiratory disease including COPD

Action 2.1: Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation.

1. Pharmacist/Pharmacy technician training in correct use of inhalers.
2. Monitor medication at clinics.
3. Smoking Cessation.
4. Nutrition advice.

Action 2.2: All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.

1. Pharmacist/Pharmacy technician training in correct use of inhalers.
2. Monitor medication at clinics.

Action 3: People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.

Action 3.1: Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease.

1. In place.
2. ACP are generated by GPs via KIS and shared with Out of Hours Practitioners.
3. Community Unscheduled Care Nurses (CUCN) manage patients in Out of Hours capacity.
4. To investigate making ACP flag available on Hospital IT systems with alerting made available to key staff.

Action 4: There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board

Action 4.1: Staff are aware of the procedures for obtaining/organising home oxygen services.

Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860).

Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period.

Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated.

1. In place. Confirmation has been received from Senior Nurse that staff are satisfied that they have access to local equipment.
2. Emergency plans are in place to enable patient to receive timely referral to home oxygen service.
3. Guidance for Home Oxygen supply has been updated on September 2015 and is accessible on the Shared Clinical Guidelines website (Intranet). This includes guidance on referral pathways, clinical assessment, accessing oxygen Shared Clinical Guidelines.
4. Contingency arrangements are in place for clinical staff to access equipment for temporary use.

Action 5: People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.

Action 5.1: Emergency care contact points have access to pulse oximetry.

1. A&E.
2. Shared Clinical Guidelines.

2.7. Management Information

Health Boards are required to demonstrate preparedness against core actions:

Action 1: Admissions data will be input to the System Watch predictive modelling system as close to real time as possible. Local quality assurance of the site and board level data is in place.

- Weekly admissions data is fed to System Watch currently. More frequent uploads of data can be produced to inform forecasting during peak winter periods as needed. This may be achieved by creation of an automated data extraction process. Data is extracted from hospital PAS and is part of ongoing routine data quality arrangements.
- Local hospital Inpatient, beds utilisation and A&E real-time dashboards are available to service managers with weekly automated alerting to GP Practices of all admissions via Primary Care dashboard. These dashboards contain range of parameters available to users on type of admission, specialty, GP Practice, admission/discharge/attendance dates, location, diagnostic conditions, discharge types.

Action 2: Effective reporting lines are in place to provide the Scottish Government with routine weekly management information and any additional information that might be required on an exception / daily basis.

1. Daily automated reports are sent to manager on call.

Action 3: Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise.

1. There are effective reporting lines in place.
2. Exception reports will be submitted as necessary.
3. Automated reports with key indicators are submitted over the festive period.

2.8. Sign Off

Action 1:
Draft winter Plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements

Draft winter plan(s) and should be published online.

1. Proposed to be presented to CMT in November 2018.
2. Proposed draft to be published November 2018, with report subsequently taken to Health Board and IJB.

Action 3: Arrangements are in place to include governance of winter planning within local Unscheduled Care Management Groups or other relevant management groups as appropriate.

1. The Winter Planning team will report into the Integrated CMT on a monthly basis over the winter period.
2. The Winter Planning Group will review the Winter Plan in April 2018 and any lessons learned will be incorporated into the Winter Plan for 2018-19.

3. CONCLUSION

With ongoing pressure throughout the year most of the Winter Plan is applicable all year round.

The Plan has been tested and updated through experience of recent winters and of managing capacity pressures all year round.

The Winter Planning Group will continue to meet over the winter period. Assessment and decision-making may be required at very short notice as challenges emerge for the system. Ad hoc meetings of the appropriate membership/groups will be convened as required.

The Winter Plan continues to endeavour to provide a comprehensive mix of contingencies that will effectively support services and enhance their ability to respond to the challenges which may arise for the system over the winter period.

A formal review meeting will take place in April 2018 to review the plan.

Any queries regarding the plan should be directed in the first instance to:

Ron Culley
Chief Officer, IJB
ron.culley@nhs.net
Tel No: 01851 708039

4 APPENDICES

Appendix 1 – Bed Management Plan

NHS
Eileanan Siar
Western Isles

Western Isles Hospital
Bed Management Plan

October 2018

1 Bed availability will be recorded daily at:

	Green >9	Amber	Red <4
	10 or more	4 to 9	3 or less
0800	√	√	√
1300		√	√
1700	√	√	√
2200	√	√	√

By the Bed Management Page Holder (**BMPH** - Discharge Planning Manager, Clinical Support Nurse, Senior Nurse or the nominated Bed Management Page Holder – providing 24 Hr cover).

2. The total available bed complement at each of the above times will inform necessary action. The available bed complement for acute beds:

- Medical 1 (including HDU & Children's bay)
- Medical 2 (including MAU)
- Erisort
- Surgical

Non-Acute beds (Maternity, APU, Clisham) are recorded for information/contingency purposes. Contingency beds can be utilised short term in Amber Status, and full time in Red Status

3 The status of red, amber and green will be used to describe the bed state and any action necessary. The status will be recorded on the daily bed state (see Appendix 1).

Status	Trigger Points for Action (number of available beds).	Action
Green	**>9** acute beds available	No action required, whilst total beds available is 10 or more acute beds. **(Aim for minimum of 2 HDU, 3 Surgical, 4 Medical & 1 Stroke)**
Amber	**4 – 9** acute beds available (including 2 HDU Beds if possible)	▪ BMPH ensures bed state is accurate by visiting all wards ▪ Ascertains expected discharges. If sufficient discharges (ie. sufficient to create more than 9 available beds) are definite - take no further action - pending return to GREEN status. ▪ BMPH liaises with nurses in charge of wards ensuring patients waiting for completion of discharge arrangements wait in day room/sitting area if available. ▪ All adult beds must be used flexibly to ensure capacity is maximised (eg. male/female bays & side rooms to create capacity). ▪ Inform A&E, medical, surgical and orthopaedic consultants of the situation. ▪ Possible discharges to be expedited. ▪ Collate list of all pending elective admissions across all specialties. ▪ In hours, the BMPH will inform the Senior Nurse, Capacity Planning & Performance Manager and the Associate Chief Operating Officer (Acute) of the situation. ▪ Out of hours, the BMPH will inform the Director on Call. ▪ Consider using HDU beds for routine admissions (ensuring 2 available for emergencies). ▪ Consider utilising 'contingency beds' short term throughout the hospital, using crisis care as appropriate and if available. **Remain at Amber, whilst total beds available, are in the range '4 to 9' acute beds.**
Red	**<4** acute beds available. (aim to keep 1 HDU Bed available)	▪ Follow the action plan as per amber status. **In addition:** ▪ Use HDU beds for admissions (aim to keep 1 HDU bed available). ▪ BMPH will utilise all contingency beds in the hospital, using crisis care / community staff as appropriate. ▪ BMPH will contact Primary Care to alert all GP practices to the hospital's position.

		▪ The BMPH will inform the A&E dept. ▪ BMPH will explain the situation to ambulance control. ▪ During normal hours, the BMPH will inform the Social Work Dept and the Community Care Team and ascertain residential and nursing bed availability. ▪ Consultant staff will be informed and asked to expedite patient discharges wherever possible. ▪ In hours, The Hospital Operational Management Group (OMG) and available consultant staff will meet urgently and discuss all practical and realistic options (see Appendix 2): ✓ prioritise available capacity for emergency admissions, ✓ review case mix, staffing, weather projections, ✓ consider use of day surgery, mental health, & maternity capacity, ✓ health and social care collaboration to provide additional appropriate safe care within the community (eg. emergency care packages, respite beds), ✓ liaise with Southern Isles to take delayed discharge patients ✓ liaise with mainland hospitals to take emergencies for a given period (eg. UBH patients to mainland), ✓ plan to maintain performance against legal targets ✓ potential for cancelling elective admissions, ✓ liaise with Communications Manager in relation to press statement/public relations. ▪ Out of Hours, the Director on Call will meet urgently with CSN & On Call Consultants to discuss issues mentioned above. ▪ If a mainland hospital agrees to take emergencies this should be confirmed by email. ▪ Extensive communications will occur between WIH consultants and mainland receiving counterparts for each patient to be transferred. ▪ Any option, which includes the possible cancellation of elective admissions, must be discussed with the Chief Executive prior to decision being taken. If the Chief Executive is not available, contact the Director on Call. **Note: The decision to cancel elective admissions is not delegated.** ▪ <u>If there are no beds available (100% capacity inclusive of contingency arrangements), ambulance service to be informed that WIH has reached capacity, and patients will be triaged on arrival at A&E.</u> ▪ The A&E Dept does not close but continues to treat and stabilise patients until their next place of care is determined and arrangements made. A&E Dept Escalation Tool is attached at Appendix 3. ▪ **Whilst the bed-state remains at RED, the above team will meet twice daily (Out of Hours, as determined by Director on Call).** ▪ Notes will be taken of these meetings with decisions recorded. ▪ All relevant staff will be informed when the situation eases.

		Remain at Red, whilst <u>total beds</u> available, are less than 4 acute beds.

SG 04/03; LMP,KG,CC 03/10; LMP,GJ 06/15 CMT 07/15; LMP,CMT 02/16; SMA,LMP 10/16

Appendix1.1

Western Isles Hospital Bedstate (EMPTY BEDS - ie. Available Beds) *File - Daily Beds Status for Bed Management Plan [9 NOV 2015]*

To be completed routinely 08:00, 1300, 17:00 & 22:00 Mon - Sun. **DATE:**

		M	F	SR	TOTAL
MEDICAL 1	08:00				
6 BEDS	13:00				
6 SRs	17:00				
{6 Cont Beds}	22:00				
CHILDREN	08:00				
3 BED	13:00				
{Bay in M1}	17:00				
	22:00				
SURGICAL	08:00				
18 Beds	13:00				
3*4 + 6 SRs	17:00				
{6 Cont Beds}	22:00				
MEDICAL 2	08:00				
18	13:00				
3*4 + 6 SRs	17:00				
{4 Cont Beds}	22:00				
ERISORT	08:00				
17 Beds	13:00				
3*4 + 5 SRs	17:00				
{3 Cont Beds}	22:00				
BED MANAGEMENT PLAN - AVAILABLE BEDS					
CLISHAM	08:00				
12 Beds	13:00				
8+4SRs	17:00				
{2 Cont Beds}	22:00				
MATERNITY	08:00				
6 Beds	13:00				
2*2+2SRs	17:00				
{2 ward att beds}	22:00				
APU	08:00				
5 Beds	13:00				
5 *SRs	17:00				
	22:00				

HDU (4)	COMMENTS (Including TCI, boarding out, type & numbers)
IN ACUTE TOTAL	
MAU (5)	
IN ACUTE TOTAL	
71 Acute Beds - 9 Nov	

TOTAL ACUTE BEDS AVAILABLE (INCLUDING H.D.A and CHILDREN'S SIDE ROOM)

Green	**Total available beds > 9**
Amber	**Total available beds 4 - 9**
Red	**Total available beds < 4**

AVAILABLE ACUTE BEDS

TIME	GREEN	AMBER	RED
08:00			
13:00			
17:00			
22:00			

Appendix 1.2

If planned admissions reduce bed availability to TWO contingency beds (in Red Status) then:

Working Hours – Emergency OMG, Director on Call, and available consultant staff.
Out of Hours – Director on Call meets with CSNs & on call Consultants.

Review case mix in wards, staffing levels, & weather projections.
Meeting should discuss possibilities of utilising Day Surgery Area (trolleys in bay), Clisham, Maternity, and local respite capacity, before transfers off island.

If beds & staffing are not available locally (hospital or community), then plans must be made to transfer patients out of Western Isles Hospital, in liaison with SAS, in the following order:

1: Utilise local resources (day surgery, Clisham, maternity, local respite/residential capacity, & emergency care packages) in liaison with Social Work, Community Staff, SAS & Third Sector.

***** Contact SAS & Scottish Government and explain that we are moving to Phase 2 - transferring patients out of WIH *****
***** Contact Regional Performance Manager (West Boards) at Scottish Government 0131 244 2396 *****

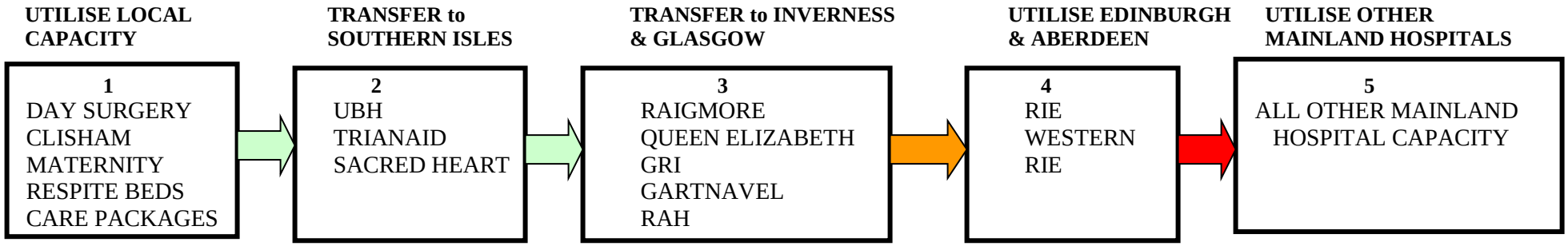
2: Transfer Delayed Discharge patients to Southern Isles (Uist & Barra Hospital, Trianaid, & Sacred Heart House).

***** Prioritise patients (eg. mobility), and liaise with patient / family& carers / Social Work to manage transfers *****
***** SCNs / Senior Management Staff and On Call Director to be involved in selecting order for transfer *****

3: Transfer Acute patients to main SLA providers - Inverness (Raigmore) or Glasgow (Queen Elizabeth, GRI, Gartnavel, & RAH)

4: Utilise hospitals near airports - Edinburgh (RIE, Western General) or Aberdeen (ARI)

5: Utilise hospitals in other Health Board areas with capacity.



Social Work
01851 822708

SAS
0345 602 3999
0300 123 1236

Trianaid
01876 580202
Sacred Heart
01878700970

Scottish Government
Regional Perf. Mgr. (West)
0131 244 2396

Raigmore
01463 704000
Queen Elizabeth
0141 201 7000
GRI
0141 211 4000
Gartnavel General
0141 211 3000
RAH0141 887 9111

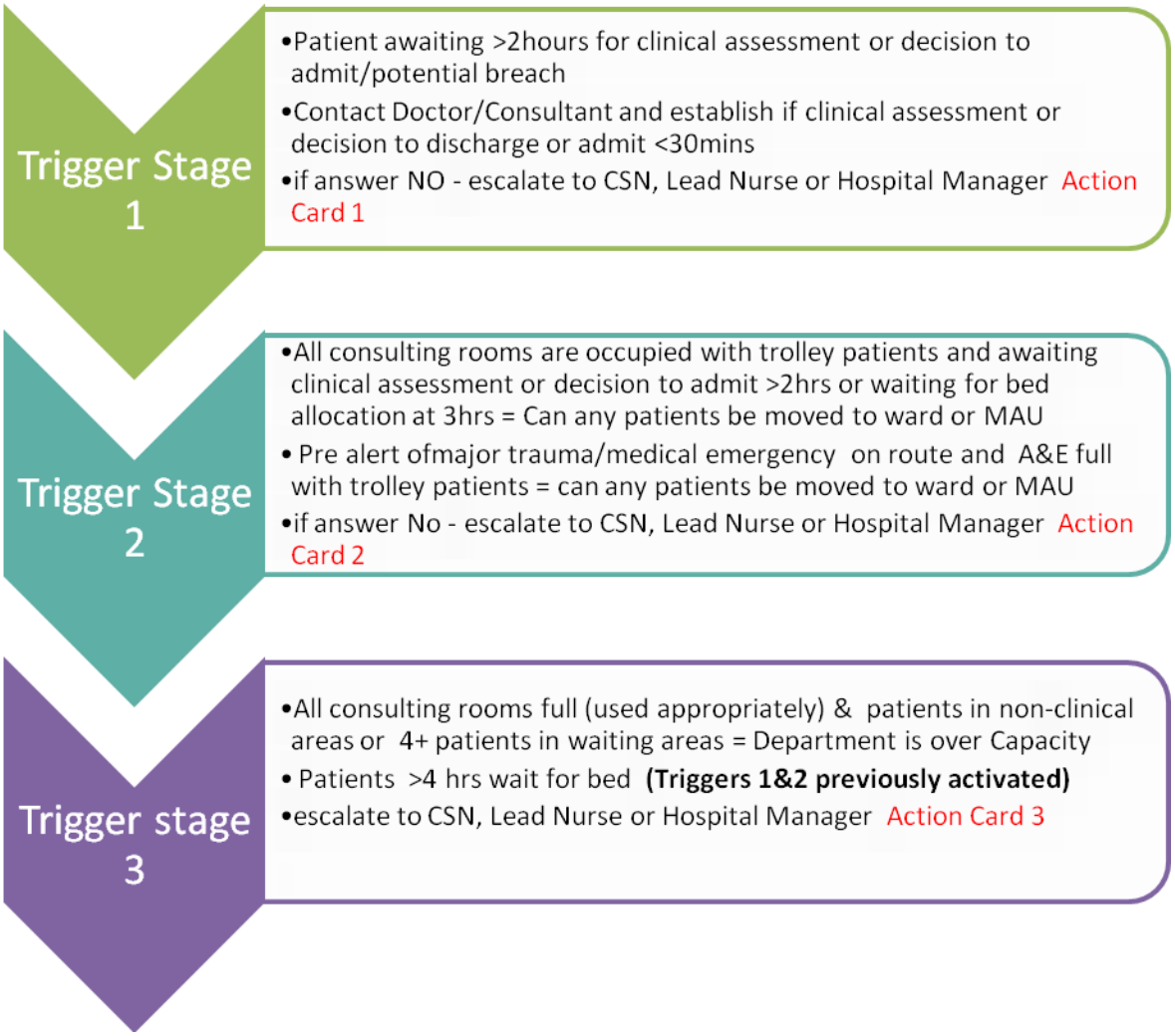
ERI
0131 536 1000
Western General
0131 537 1000
ARI
0345 456 6000

Utilise Reception
to get relevant numbers

Appendix 1.3

Title: Accident & Emergency Department Escalation Tool

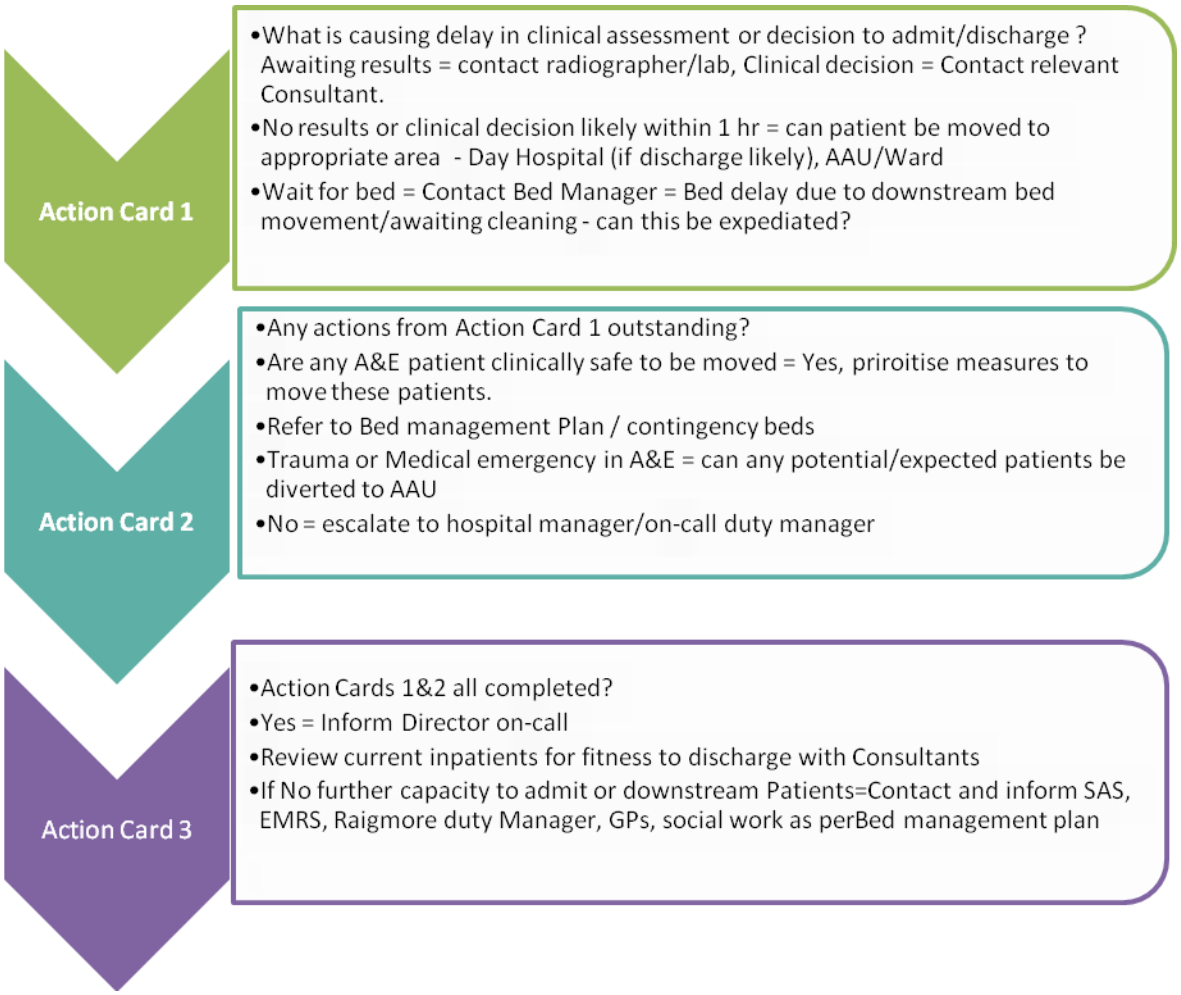
Poor patient Flow results in crowding in A&Es and has negative implications for patient experience, quality and safety. A standardised process for managing A&E capacity and maintaining patient flow is required to proactively avoid crowding, and ensure patient flow is safe, effective and high quality.



References/Evidence Base

Emergency Department Capacity Management Guidance (2015) SG, Edinburgh
NHS Lanarkshire Case study: Testing the ED Capacity management Guidance document within Hairmyers Hospital (2016) SG, Edinburgh
Royal College of Emergency Medicine (2014) Crowding in Emergency Departments – Revised June (2014. RCEM, London

Escalation Action Cards



Appendix 2 – OOH Emergency Contingency Plan

Emergency Contingency Plan for failure of the NHS24 Out of Hours Service, NHS Western Isles

Definition of 'failure': the unexpected non-availability of GP cover (range being from 1 shift to the entire service).

The following is a Standard Operating Procedure (SOP) for failure of the Out of Hours Service in Lewis, North Harris, North Uist and Benbecula.

If a GP does not turn up for a shift or is not contactable after repeated attempts (maximum 30 minutes) and their whereabouts is not known, the Duty Manager (DM) should be contacted through switchboard.

If the GP is considered 'missing in action' the DM should contact the Police.

If there is a second GP rostered (as per Lewis/Harris rotas) then they should be instructed to take on the role of both GPs and make the necessary arrangements to relieve themselves of any Hospital-based acute services OOH service responsibility. If no second GP then DM should phone all GPs on the 'Emergency List'. The Emergency list for Lewis/Harris is in the WIH Out of Hours consulting room locked cupboard (key at A&E nurses station) and on the OOH PC. The Uist Emergency List is with hospital reception (personal contact details not to be appended as this document may be publicly available) If no-one available, the DM will contact NHS 24/Highland Hub 01463 667573 / 667571 to advise of no service, defining the geographical area affected. DM should inform the duty ENPs and CSNs of the situation. DM to contact SAS to advise of potential for increase in calls and that paramedics will not be able to contact GPs for advice.

DM should contact the Communications Dept and/or local radio (at the discretion of the DM) and arrange for local public broadcast of the situation.

On most occasions the absence of a GP will mean that A&E is also uncovered. The following action therefore needs to be taken for the management of NHS24 patients. A separate contingency plan exists for failure of emergency hospital services.

Lewis/Harris failure **Duty Manager to.....**	**Uist failure** **Duty Manager to.....**
Ask Highland Hub to redirect Lewis /Harris NHS24 calls to the Uist on call GP by phoning the on call Uist GP as per current practice.	Ask Highland Hub 01463 667573 / 667571 to fax NHS24 patient case paperwork to WIH A&E and to redirect Uist NHS24 calls to the Lewis/Harris on call GP
Inform Lewis/Harris CUCNs that their GP back-up is the on-call Uist GP	Inform Uist District Nurses and OUaB that they their GP back-up is the second on-call Lewis/Harris GP
Inform Uist A&E and instruct them to retain all NHS24 documentation	Inform Stornoway A&E and instruct them to retain all faxes
Inform the senior U&B Hospital staff plus Scottish Ambulance Service	Inform senior staff at Western Isles Hospital plus Scottish Ambulance Service
Ask Uist on call GP to give phone advice where possible	Ask WIH duty Consultant to give phone advice where possible
For all NHS24 patients requiring face-to-face medical assessment & management, Uist GP to arrange (in collaboration with the duty ENP and DM) for transfer to the OOH centre at Stornoway WIH. ENP to see and treat minor ailments/injuries where appropriate.	Ask WIH duty Consultant to manage any NHS24 cases that arrive at OUaB A&E for medical assessment using remote technology as appropriate. Duty senior nurse at OUaB to conduct initial Consultant-guided medical assessment on site.
Complete Datix	Ask Duty Consultant or Locum to complete clinical notes for all contacts and attach to the relevant NHS24 fax

Predict requirement for Agency locum cover and contact HR as soon as possible	Complete Datix
	Predict requirement for Agency locum cover and arrange as soon as possible

In the event of failure in Lewis/Harris and Uist:

Entire OOH NHS24 Service failure **Duty Manager to.....**
Ask Highland Hub to fax NHS24 patient case paperwork to WIH A&E and to redirect all Lewis, North Harris and North Uist NHS24 calls to the WIH duty Consultant
Inform Uist and Lewis/Harris CUCNs and District Nurses that their medical back-up is the Duty Consultant at WIH
Inform WIH A&E and instruct them to retain all faxes/emails from NHS24
Inform senior staff at WIH and U&B Hospital. Inform SAS.
Ask WIH duty Consultant to give phone advice where possible and manage any Lewis/Harris NHS24 cases that arrive at A&E for medical assessment using ENPs where appropriate for 'see and treat' cases.
For all NHS24 Uist patients requiring face-to-face medical assessment & management, duty Consultant to arrange (in collaboration with the duty ENP and DM) for transfer to the OOH centre at Stornoway WIH
Ask Duty Consultant to complete clinical notes for all contacts and attach to the relevant NHS24 fax
Complete Datix
Predict requirement for Agency locum cover and contact HR as soon as possible (bearing in mind that HR are not available over the weekend). If locum cover required urgently then duty manager to contact locums directly.

At the end of every OOH shift cover the Duty Manager should contact the daytime Hospital Manager and Primary Care Manager in order 'hand over'.

These emergency plans have been agreed with the Hospital Consultants c/o the Clinical Director.

Consultation and agreement has been reached with the OOH GPs.

Reviewed September 2018

Stephan Smit, Primary Care Manager
Dr Kirsty Brightwell, Associate Medical Director