CÙRAM IS SLÀINTE NAN EILEAN SIAR

WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

NHS
Eileanan Siar
Western Isles

Winter Plan 2020-21

This Winter Plan outlines the provision for services during the winter period and has been informed by a multi-disciplinary Winter Planning Coordinating Group with representation from partner agencies and system wide health and social care professionals. The Winter/Pandemic Resilience Group chaired by the NHS CEO has oversight of the plans and will monitor until at least May 2021. Multi-Agency, public sector, category 1 responders are all members

This year's plan is particularly challenging. The impact of Covid 19 has been wide ranging. Health and Social Care Services moved swiftly to enhancing service capacity and bracing for the appearance of cases. There was wide service reorganisation on an unprecedented scale and complexity associated with the pandemic. The present objective is to continue to recover and renew as many patient services as possible while maintaining Covid surge capacity and support for staff. The plan 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 plan 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 vulnerable groups, particularly older people.
- Enhance the ability of staff to face the challenges of the winter period efficiently, effectively and safely, with no avoidable adverse 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.

Challenges

The need for health and social care undergoes seasonal fluctuations, peaking in the winter. NHS and social care systems in the Outer Hebrides have high levels of activity throughout the year but typically operate at maximal capacity in the winter months, with bed occupancy regularly exceeding 95%.

There are a number of additional challenges that have great potential to exacerbate winter 2020/21 pressures on the health and social care system, by increasing demand on usual care as well as limiting surge capacity:

1. A large resurgence of COVID-19 nationally, with local consequences

Modelling of our reasonable worst-case scenario – in which the effective reproduction rate of SARS-CoV-2 (Rt) rises to 1.7 from September 2020 onwards - suggests a peak in hospital admissions in January/February 2021 coinciding with a period of peak demand on the NHS. We are already seeing local outbreaks.

Response

Our Test and Protect response is in place and has been implemented during these outbreaks. There has also been increased experience of our staff by supporting other regions manage their contact tracing. We have increased our testing capacity and have arrangements with other regions. Contact tracing remains a vital line of defence in managing the pandemic and the support of our community is well communicated.

There has been a challenge for hospitals and Care Homes in enhancing capacity for surge beds due to the need to maintain physical distancing and safe spacing in our facilities.

However services have been reconfigured and plans for escalation are in place**.** Business Continuity Plans with surge bed capacity, trigger points for escalation and redeployment of staff are in place and being tested. This recognises that the mobilisation of staff and resources that occurred during the first wave of covid is likely to be affected by other winter pressures, urgent delayed care and a potential increase in staff sickness.

Our urgent delayed care has therefore been systematically addressed in anticipation of further potential disruption to our health and care systems. Our remobilisation plans continue to address the backlog in routine clinical. Much work has already taken place in organising health and social care settings to maximise infection control and ensure that COVID-19 and routine care can take place in parallel while minimising nosocomial infection**.**

2. A possible influenza epidemic and increase in winter illness.

The size and severity of the influenza wave in winter 2020/21 is difficult to estimate, Previous significant flu seasons were combined with colder weather an increase in respiratory illness and death. The most recent significant influenza season in winter 2017/18 coincided with a colder winter; nationally this led to excess respiratory deaths and a reduction in elective admissions.

Response

The Influenza Vaccination programme is a vital component in preventing the spread of illness. 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 2020 until 31st March 2021.However influenza cases start to increase from late November into early December, with a peak in mid to late January therefore, to provide protection of staff and by extension vulnerable patients, the programme focuses on maximising vaccination of the main body of staff from October to mid-November. The vaccination programme will see a mixed model of delivery throughout the Western Isles. Where possible vaccinations will be delivered to eligible groups within their GP practice, however, due to the implications and challenges of COVID-19, centralised clinics will also take place in the localised community setting. This year's 2020/21childhood flu vaccination programme will

offer vaccination in two strands; all children aged two to five and all primary school aged children aged 5 to 11 years. The programme will be further impacted by the introduction of a Covid 19 vaccination programme and Lateral Flow Tests

We are optimising patient flow by proactively managing the Admissions and Discharge Process utilising the 6 Essential Actions to improve unscheduled care.

Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked There will be **c**onsistent application of discharge arrangements so that there will be no or minimal delays going into the Winter period. Policies and procedures are in place to manage the discharge process with daily discharge arrangements in place. The delayed discharge process is managed through meetings between hospital and community based health and social care leads. This group seeks to facilitate discharge by exchanging information and coordinating discharge arrangements for potential delays. 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. In partnership with SAS we are ensuring that arrangements are in place to transport patients home or to care home both to enable discharge and avoid admission.

There will be active monitoring of admissions and use of alternative services to maintain patients in the community. We will continue to use alternatives to face to face consultations through increased use of Near Me in Primary Care and by Consultants. NearMe is utilised for assessment of patients in the community prior to admission or assessment at hospital. Systems are in place for primary care and medical support to allow older frail patients to stay where they are in our communities. Hospital at Home will be utilised to enable Hospital admissions to be reduced overall and early facilitated discharge from the Medical Assessment unit for 'at home' treatment will become usual practice

A wide range of patients will be accommodated including those requiring Intravenous (IV) Antibiotics, IV fluids, Subcutaneous (SC) fluids, Other IV therapies, Oxygen Therapy, those requiring observation monitoring and medication titration, and patients requiring regular blood monitoring to ensure safe recovery from acute illness. The START service will work in partnership to ensure a supported environment and continued rehabilitation.

We have adopted a system wide approach that is inclusive of the urgent care agenda. Of particular importance this year is the local implementation of a 'single point of access' for Urgent Care through NHS24 and onwards to local Flow Navigation Centres for early clinical decision making. This is a key part of the Redesign of Urgent Care Programme, which will help mitigate the risks presented by increased emergency presentations and hospital associated infection.

We have paid particular attention to public holidays and the festive season. Service profiles and staff rotas are in place across acute, primary and social care settings including over the weekends and festive period with access to senior decision makers to prevent delays in discharge and ensure patient flow.

3. A no deal Brexit.

There remains good reason to put in place mitigation arrangements for an Eu-Exit (No Deal) on 31st December 2020. Reciprocal health arrangements are coming to an end. There is the possibility of

disruption to the distribution of goods and services through congestion at points of entry and transportation difficulties. European contracts of supplies and medicines may be affected.

Response

There are key areas of pressure, including pharmacy and laboratory supplies, PPE as well as other surgical equipment. NHS WI is supported through National Procurement arrangements where solutions to the ongoing purchase of essential items is being addressed through either continued sourcing of appropriate supplies or the sourcing of alternate or substitute products. Guidance on stocking of key supplies has been addressed. Guidance to staff has been issued to enable European citizens to continue to work within the UK.

There is representation at Local and Regional Resilience Partnerships, where Regional Risk Assessments are in place that focus on those risks requiring a civil contingency/emergency planning related response. The Western Isles Emergency Planning Coordinating Group (WIEPCG) regularly deals with the impacts of adverse weather and provides support and aid across a multi-agency platform on a wider community basis. 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).

The NHS Board and IJB have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks. These arrangements have built on the lessons learned from previous events, and are tested to ensure they remain relevant and fit for purpose.

The aim of this plan is to outline how we can continue to deliver and maintain services throughout the winter period. It details our response in the following sections:

- Resilience
- Unscheduled / Elective Care
- Out of Hours
- Norovirus
- Covid -19, Seasonal Flu, Staff Protection & Outbreak Resourcing
- Respiratory Pathway
- Integration of Key Partners / Services

Preparing for Winter 2020/21: Checklist of Winter Preparedness

Winter Preparedness: Self-Assessment Guidance

RAG Status	Definition	Action Required
Green	Systems / Processes fully in place & tested where appropriate.	Routine Monitoring
Amber	Systems / Processes are in development and will be fully in place by the end of October.	Active Monitoring & Review
Red	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	Resilience Preparedness *(Assessment of overall winter preparations and further actions required)*	RAG	• Further Action/Comments
1	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather, EU Exit and Covid-19 resurgence. These arrangements have built on the lessons learned from previous events, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The Preparing for Emergencies Guidance sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	 	• The Winter/PandemicResilience Group chaired by the NHS CEO will remain 'stood up'until at least May 2021. Multi-Agency, public sector, category 1 responders all members • 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. • 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. • 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 learnt. • The Emergency Planning and Business Continuity Facilitator for the Board is a member of the Winter Planning team. He provides advice, support and guidance to the group throughout the planning process. • An additional Resilience manager has been recruited and in place until March 2021 • Two Exercises have been undertaken this year. One to test Emergency Planning response and procedures the

			other to test Health and Social Care Resilience. Further exercises were carried out in relation to Care Home procedures, provision and staffing including extensive preparation arrangements for the impact of covid on services and arrangements for nursing support in Care Homes • The Winter Plan is circulated for consultation prior to publication.	
2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios, including Covid-19 reasonable worst case scenarios. Risk assessments take into account staff absences including those likely to be caused by a range of scenarios including seasonal flu and/or Covid-19 as outlined in section 5 and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner. The Health Board and HSC partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	  	• 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. Business Continuity Plans have been reviewed to assess the impact of a surge in coronovirus transmission and increases in Covid -19 patients • Winter 2021 will see the development of a Staff Absence Escalation Plan which will interact with and be considered alongside the Bed Escalation Plan and the Service Retraction Plan. • The Winter/Pandemic Resilience Group chaired by the Health Board CEO will remain in place until at least May 2021. This group is a multi-agency leadership and co-ordination group predominantly addressing H&SCP service continuity. • The Western Isles Emergency Planning Coordinating Group (WIEPCG) regularly deals with the impacts of adverse weather and provides support and aid across a multi-agency platform on a wider community basis. • The Pandemic Resilience Group Risk Register includes Winter Plan risks. More detail is provided in departmental risk registers.	

3	The NHS Board and HSCPs have appropriate policies in place should winter risks arise. These cover: • what staff should do in the event of severe weather or other issues hindering access to work, and • how the appropriate travel and other advice will be communicated to staff and patients • how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*		• Relevant NHS Western Isles policies include: • Attendance During Adverse Weather Conditions • Lone Working Policy • Managing Work Related Driving Risks. • Relevant Comhairle policies include: • Comhairle Lone Working Policy • Comhairle Risk Policy on Driving. • NHS staff policies are approved through Area Partnership Forum (APF) with a summary communicated to staff via email. • Comhairle policies are approved through the Joint Consultation Committee. • 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. • 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. • There is an NHS duty Executive level manager on call 24/7 to coordinate communications in the event of disruption due to adverse weather. The same applies at the Comhairle. • A Caring for People sub group considers Third sector and community support as well as arrangements with Local authority and community transport.	

4	The NHS Board's and HSCPs websites will be used to advise on changes to access arrangements during Covid-19, travel to appointments during severe weather and prospective cancellation of clinics.		• Use of NHS Western Isles Website, the Comhairle website, Local Radio, (WIEPCG) Facebook page and Twitter are used to communicate information. • Medical Records staff also phone individual patients directly if clinics are disrupted.	•
6	The NHS Board, HSCPs and relevant local authorities have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.		• Mass Deaths Plan has been activated and mortuary capacity reviewed. Local Authority and Funeral Directors have been included in the current Pandemic resilience process. They do not have mortuary capacity (rely on Hospital mortuary capacity). • Triggers are in place in the event of demand rising and alternative arrangements are in place. • NHS Western Isles has purchased 3 portable, modular body storage systems: located in Lewis Benbecula and on in Barra. • Body storage capacity is: WIH: 6 units plus 18 Nutwell units OUAB; 3 units plus 6 Nutwell units St.B: 1unit plus 4 Nutwell units.	
7	The NHS Board and HSCPs have considered the additional impacts that a 'no deal' EU withdrawal on 1 January 2021 might have on service delivery across the winter period.		• Consideration has been made on supplies and stocks of PPE, Pharmacy, laboratory supplies and surgical equipment and containment products. Procedures are in place aligned with national procurement arrangements- Impacts on staffing of services have been assessed with guidance issued to management and staff groups. • The supplies of other critical goods and services is considered by WIEPECG • Brexit management/response is within the remit of the Winter/Pandemic Resilience Group	

2	**Unscheduled / Elective Care Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity. *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*			• A range of real-time dashboards is in place for service managers and key clinicians covering Hospital Inpatient/Day Case services, Outpatients, A&E, Beds, Theatre, Waiting Times, Clinical Quality, Hospital Scorecard, Ward Present Bed Status. This supports active monitoring of service activity levels, impacts upon waiting times, theatre utilization, bed management practices and for a range of other quality metrics for the hospital settingNHS Western Isles hold weekly meetings to maximise elective and emergency Theatre activity including a summary of monthly performance. • Safety Huddle meeting takes place daily, including weekends. Clear triumvirate leadership team identified, with deputies. • Daily Dynamic Discharge Multidisciplinary Team (DDDMDT) meeting is embedded and is aimed at improving patient flow and prepare for discharges the following morning. • Plan to reduce pre-op stays to maximise bed capacity. Same day admissions in respect of orthopaedic procedures • Service profiles and rotas are established and shared across agencies. ○
1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked.			• The Safety Huddle (as described above) has developed procedures for a) being informed b) escalation of information on an exception reporting basis. • The Huddle participants are regularly reviewing their performance and identify areas requiring action or improvement Regular daily handover meetings take place with clinical teams and Clinical Support Nurses. • 3 Operational Huddles occur on Monday, Wednesday and Friday • Escalation procedures in place to manage system pressures. Escalation Policy incorporated in Bed Management Plan • Staff absence Escalation Plan and Service Retraction Plan under development.

1.3	A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.* *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*		• NHS Western Isles hold weekly meetings to maximise elective and emergency Theatre activity including a summary of monthly performance. • Templates for service predictions are in place based on previous year's activity. • Bed Management Plan (appendix 1) is in place and is reviewed regularly to ensure issues are identified. • There is a weekly meeting to plan Theatre elective schedule. • Daily updates on capacity of acute and community resources are shared with NHS Hospital Management by Social Work Out of Hours Service. • The Integrated Management Teams at Service and Corporate level have contributed to this Plan and are responsible for ensuring effective information sharing protocols are in place • Process in place to ensure effective communication by senior manager on- call 24/7. • Daily Discharge meetings take place • Multi-disciplinary weekly Delayed Discharge meetings address delayed discharges, potential delays and agree the allocation of resources. A review of the daily discharge performance is carried out. • Daily updates on capacity of acute and community resources are shared with NHS Hospital Management by Social Work Out of Hours Service.
1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*		• The social care bed escalation plan details the appropriate actions. In addition the established START intermediate care service supports two bed based intermediate care flats will be utilized for those with rehabilitation potential when this is not possible to be delivered within the individuals own home. • All available beds within the Western Isles are commissioned by the Partnership, with scheduled respite cancelled to enable care home beds to facilitate discharge and avoid admission when appropriate. Any request for an out of area placement in line with the CEL guidance is progressed.

2	• **Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID activity (both short and medium-term) based on forecast emergency and elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**		
2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *Weekly projections for Covid demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity.* *Plans in place for the delivery of safe and segregated COVID care at all times.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*		• Statistical Process Control (SPC) charts for number of metrics included in new Business Intelligence (BI) dashboards on Hospital and Integration Joint Board Performance Scorecards. These support monitoring of variations over time and benchmarking between Boards and Partnerships across a range of metrics. Discovery National tool also rolled out across users with sessions on use in supporting variation analysis. • Gooroo Planning software will be used to populate "Waiting Times Improvement Template" which forms part of Board Annual Operational Plan. The WTI Template provides a process to document proposed improvement plans for meeting Outpatient, Diagnostics, Cancer and TTG WT targets. It contains key demand and capacity management indicators, at Specialty and NHS Board level, which enables the Board to demonstrate our short, medium and long term capacity requirements to achieve the trajectories set out by the WTIP. • Considered using System Watch but found predictive accuracy too variable for a small setting. Range of predictions were too wide to be operationally useful in weekly planning. • Business continuity Matrix in place for management of surge in covid patients. Includes trigger points, service reprovision and staff deployment Plan in place showing escalating patient numbers and associated staff requirement. Mapped against business continuity matrix to assess wider impact. • Weekly scheduling meetings for elective surgery and outpatient clinics to plan and place patients on a three week rolling programme. • Scheduled lists have been proactively managed to optimise ability to respond to a covid surge. Patients are clinically prioritised P1-4 and scheduled accordingly • Forecast modelling is monitored and checked against our plans for a covid surge

2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter / COVID surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work. *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution.* *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.* *Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical prioritisation and planning assumptions*		• Unscheduled Care 6EA toolkits including bed planning are being explored for potential local uses in support of bed management and capacity planning subject to Analytical capacity. Local 6AE In/Out balance toolkit created online for use in unscheduled care service planning with analysis disseminated weekly to operational teams together with further monthly analysis on daily discharge rates (weekday/weekends), attendance by flow group, hourly discharge distribution and ward occupancy. • Developmental Work is underway with national PHS Whole System Modelling team to explore the use of predictive BI tools to augment existing BI dashboards with forecasting capability for service planning. Initially this is focused on forecasting specialty and common diagnosis/procedure level activity by hospital provider with particular reference to local v. mainland service volume projections and in future modelling Western Isles population disease prevalence demand drivers. • Work includes analysis in formulation of service capacity plans by the Planning and Performance Manager.
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.**		
3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including*		• Appropriate staffing rotas are in place by October for Medical, Nursing, AHP and support staff. • 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. • 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

	impact of significant events on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations.		breaching, and ortho/fracture clinics in line with the following timetable: • Medical clinics are not scheduled for the festive period. • There will be no scheduled elective work in Uist & Barra Hospital over the festive period 24th December 2019 to 2nd January 2020. • Social work operate a 24/7 on call service with social care operating 24/7 including the service specific on call arrangement to address any emergency situations and to facilitate increases in care packages to avoid admission or package breakdown.
3.2	Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services.		• Medical and ED rota has been increased to manage increased activity on ph and return to work days. • AHP will 'frontload' services in advance of the festive breaks and on return to address any service pressures • Primary Care assess the workload over the festive period, arrange planned leave at less pressurised times and manage rota accordingly.
3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*		• At present there are no known additional planned festive services. SAS have detailed their response in their escalation and staffing plans. PRG and WIEPEG will note any developments.
3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*		• GP, OOH, Dental and Pharmacy provision over festive period is established. • Closures are coordinated and communicated to staff and the general public using Facebook, Twitter, Local Radio, Local newspapers and Health facilities notice boards. • The senior manager on call will have access to all service provision arrangements. • 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.
	Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of healthcare associated infection and crowded Emergency Departments. **Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.**		
	To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate. Referrals to the flow centre will come from: • NHS 24 • GPs and Primary and community care • SAS • A range of other community healthcare professionals. If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide visable appointments / timeslots at A&E services.		• Readiness assessment in place and regularly updated in preparedness of redesign of Urgent care 1st December launch date. • MAU extended hours to reduce risk of crowding in ED • As per readiness assessment. Highland hub will continue to support Redesign of urgent care, but a blended approach with local navigation and shared clinical decision maker to enable scheduling of care. • Near me digital pathway being developed for minor injuries for 1st December and scheduled care • Equality impact assessment , currently being undertaken as part of Redesign of urgent care

	The impact on health-inequalties and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.		
	Professional to professional advice and onward referral services should be optimised where required Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission.	 	• Hotclinics to facilitate professional to professional advice in place for medicine • Development of pathways for referral to community services and avoid admission being developed.
4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge to shift the discharge curve to the left and ensure same rates of discharge over the weekend and public holiday as weekday.**		
4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*		• 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 for potential 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. • The potential to re-shape the allocation for planned respite and unscheduled step up/step down community beds is being explored. Intermediate Care Service (Short Term Assessment and Reablement Service) operating in Lewis with a step up step down service to support rural Lewis and Harris clients. • Policies and procedures are in place to manage the discharge process. The use of EDD is built into admission documentation. • Patients will be transported where they meet eligibility criteria through “Patient Needs Assessment” (PNA). • Weekends/mid-afternoons/late evening. Solution being looked at to provide patient transport for discharge home over festive period. Transport Escalation Plan in place.

			• Contracted Taxi for discharges and transfer outwith Monday to Friday 9-4pm and Public Holidays when SAS unable to facilitate transfers.
4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate. *Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.*		• Daily Huddle identifies pressures and capacity issues across the whole system which includes Discharge planning. • 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.
4.3	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*		• There are no discharge lounges.
4.4	Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services should be aware of any		• NHSWI have invested in a team of Primary Care Pharmacists who work closely with the hospital pharmacy team to provide ongoing support once patients are discharged • Transport is provided by SAS and an escalation plan is in place.. • Hospital @ Home service now facilitating earlier discharge

	initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre-Christmas discharge *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*		
5	**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.**		
5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.* *Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*		• Patients with existing care packages have their services held during their hospital stay unless their care needs 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. • The intermediate care service is established and working well with positive regulatory inspections. • There remain geographical areas where care packages are difficult to establish.
5.2	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible. *Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.* *All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible*		• Hospital at Home will be utilised to enable Hospital admissions to be reduced overall and early facilitated discharge from the Medical Assessment unit for 'at home' treatment will become usual practice • A wide range of patients will be accommodated including those requiring Intravenous (IV) Antibiotics, IV fluids, Subcutaneous (SC) fluids, Other IV therapies, Oxygen Therapy, those requiring observation monitoring and medication titration, and patients requiring regular blood monitoring to ensure safe recovery from acute illness. The START service will work in partnership to ensure a supported environment and continued rehabilitation.
5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a		• SPARRA data is routinely uploaded into real-time hospital activity

	care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*		dashboards to provide managers with view of SPARRA patient's impacts on hospital activity. • SPARRA information is included in Primary Care dashboard to assist GP Practices in actively monitor their high risk patients. • A further risk cohort of potentially avoidable admissions is included in Primary Care and hospital activity dashboards which are based on basket of ambulatory sensitive conditions.
5.4	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.*		• Anticipatory Care Plans are being used more widely than in previous years and work continues to provide the use of these. • 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. • NHSWI developing a system (Terminal Server's) to allow other clinicians including specialist nurses direct access to patient primary care records. This is being rolled out throughout November and December to allow remote support. In the meantime, staff groups without direct access can liaise directly with practices in hours or with staff who have access rights out of hours. • Liaising with Overnight Nurse Service to avoid unnecessary admissions. An active register is held of vulnerable/ Palliative patients in the community and we 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. • Consideration of standby agency resources or flexible use of partnership staff is planned for the winter period. • 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. • 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.
5.5	Covid-19 Regional Hubs fully operational by end November. Additional lab capacity in place through partner nodes and commercial partners by November. Turnaround times for processing tests results within 24/48 hours.		• We continue to use Inverness as the regional NHS24 centre and this links through to the CAC for testing and clinical assessment, although this is rarely used. • The regional laboratory hubs in Aberdeen, Glasgow and Edinburgh enable extension of capacity. Direct to Glasgow NHS lab for Barra patients and for Uist NHS Inform bookings. Overflow in place to NHS Lothian for samples travelling from WIH lab. • Our additional lab capacity is via full use and conversion of existing machines. • Turnaround times for WIH lab will be 4 hours plus travel time – weather dependent as winter advances
6.0	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**		
6.1	Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector and into the Scottish Government. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*		• Effective communications mechanisms are in place detailed within the NHSWI Communications Strategy. Each ward and department has a Departmental Communications Plan, outlining in detail how communication takes place both within the department, out to the wider organisation and externally.. • Service Profiles including contact details are developed and shared. • 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.
6.2	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. *SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around direction to the appropriate service are effectively*		• Effective partnership links are in place. • Protocols are in place for accessing emergency and routine multi-disciplinary engagement. • 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

	communicated to the public. *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*		are underway with ISP completed for extraction, transfer and linkage of social care and health data for management information purposes. • NHSWI has approved Communications Strategies and Media policies which outline communication arrangements.

3	**Out of Hours Preparedness** *(Assessment of overall winter preparations and further actions required)*	**RAG**	**Further Action/Comments**
1	The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays. *This should include an agreed escalation process.* *Have you considered local processes with NHS 24 on providing pre-prioritised calls during OOH periods?*		• Setting up of rotas will be finalised by middle of November 2020. • The OOH Service has an approved Emergency Contingency Plan (see appendix).
2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.		• Escalation and contingency planning will utilise activity data from Highland Hub/NHS24. • Opening hours and prescription arrangements have been confirmed with Practices. • Practices will be reminded to review Just-in-Case plans, update ACPs/KIS etc. and communicate this to Community nursing staff. • Specialty doctors covering A&E have been employed and this strengthens GP capacity in the OOH period. • 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. • Community Unscheduled Care Nurses (CUCNs) continue to support GP Out of hours. • CUCNs will be based in the Outpatients department adjacent to

			A&E taking appropriate referrals. This will enable collaborative working to balance care where required needs across those two services according to availability and workload demand. • Increased capacity for NHS 24 referrals on public holidays with option of 2nd GP facilitating drop in clinic.
3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.		• Use of specialist paramedics are being used through Scottish Ambulance Service. • Depending on predicted demand, OOH GP clinics may be arranged in advance over the festive period. Additional ANPs to support NHS24 demand over public holidays and festive weekends.
4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*		• 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. • Appropriate redirection of patients from A&E to NHS 24 is facilitated. • ADASTRA contains any KIS created by primary care – this is also available to SAS and NHS24. A&E and AAU can access ECS. • ADASTRA is in place for out of hours which links in to in-hours primary care. • 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. • Referral SOPS in place to and from social work. • Referral pathways in place for NHS 24.
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.		• Use of existing systems which allows NHS 24 to triage appropriately and make information available to the relevant GP the following morning. • 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.

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		• 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. • Community pharmacies will offer limited opening hours during daytime over the four bank holidays, excluding Sundays
7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.		• Mental Health Services have a generic CPN team that provides an OOH service for psychiatric emergencies. • Consultants Psychiatrists work an on-call rota.
8	Ensure there is reference to provision of dental services, that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*		• 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.
9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*		• The Rotas for OOH cover over the festive period have been compiled. • The OOH Emergency Contingency Plan is in place for any unexpected deviations to the Rota. • The senior team will operationalise the plan and will report monthly to ICMT over the winter period.
10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24.		• 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

	This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.		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.
11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.		• Joint working include SAS staff covering OOH shifts, based in Emergency Department providing 'See and Treat' interventions for call outs. • Treat and refer is undertaken by Paramedics on ambulances with decision support provided by local on call GPs where required. • Third Sector/contract taxis are utilised outwith Monday to Friday 9-4pm • Multi agency response to emergencies in severe weather includes GPs and ambulance staff working closely through WIEPEG triaging and responding to appropriate calls
12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*		• The Draft plan will be shared with NHS24 & Highland Hub to gather their views & input.
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*		• Monthly liaising with Acute Service to ensure Acute and Primary Care OOH cover
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*		• IJB coordinates the Winter Plan across health and social care services.

15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic flu and other emergency plans, including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*		• Pandemic Plan has been updated. • Outbreak Plan in place. • 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. • The OOH Emergency Contingency Plan is in place

4	**Prepare for & Implement Norovirus Outbreak Control Measures** *(Assessment of overall winter preparations and further actions required)*	**RAG**	**Further Action/Comments**
1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*		• The IPCT will read the guidance, make it available on their Intranet page and ensure that NHS Western Isles (NHS WI) is optimally prepared. • The IPCT will be responsible for cascading the above information throughout NHS WI three hospital sites and partner organisations. • The guidance will be provided in all Priority Training for nursing and community staff, local Council care home staff and also their home carers.
2	Infection Prevention and Control Teams (IPCTs) will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which nursing and care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*		• NHS WI will support the IPCT to provide education and training to all staff on norovirus. • 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. • The IPCT and HPT will ensure all campaign materials will be cascaded throughout the organisation and partner organisation.

3	PHS 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 and that frontline staff are aware of their responsibilities with regards prevention of infection.		• Current information on HPS Norovirus Control Measures will be available on the IPCT Intranet page. • 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. • 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. • Risk assessment held on Operational Management Group risk register.
4	NHS Board communications regarding bed pressures, ward closures, etc are optimal and everyone will be kept up to date in real time. *Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*		• Outbreak Control Plan (Hospital) is available to all staff via Intranet. • Infection Control Communication Plan available and content known to the whole of the IPCT. • Outbreak Control Team (OCT) will communicate ward closures and any restrictions on hospital visiting as a result of a norovirus outbreak
5	Debriefs will be provided following individual outbreaks or at the end of season to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*		• 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. • The OCT will also write a report with any recommendations in an action plan and disseminate the report to all relevant parties. • NHS WI will ensure the report recommendations are implemented. • NHS WI will share any lessons learned with colleagues in NHS Scotland to prevent similar outbreaks.
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker.		• Weekly Norovirus figures are shared across the organization. • 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.

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.		• Procedures in place throughout NHS WI. • NHS WI 'Team Brief' circulated to all OOH GP's.
8	NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.*		• Infection Control Doctor's on-call 24/7. • HPT on call also 24/7. • Duty, Executive level Manager on call with list of all contacts.
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple bays / wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*		• Procedures are in place across NHS WI. • Outbreak Control Plan would be implemented.
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.*		• 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.
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.		• Embedded throughout NHS WI and IJB. • All Norovirus publicity materials are deployed internally and locally as appropriate • Priority Training session for both Health and Social Care will include information on Norovirus from the ICPT.

12	Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of Covid-19.		• Norovirus restriction notices are communicated to the public via media outlets and social media

5	**Covid-19, Seasonal Flu, Staff Protection & Outbreak Resourcing** *(Assessment of overall winter preparations and further actions required)*	**RAG**	**Further Action/Comments**
1	Staff, particularly those 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 and other staff, as recommended in the CMO's seasonal flu vaccination letter published on 07 Aug 20 https://www.sehd.scot.nhs.uk/cmo/CMO(2020)19.pdf *This will be evidenced through end of season vaccine uptake submitted to PHS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.*		• Seasonal influenza immunisation is being offered to NHS and social care employees directly and involved in the provision of direct personal care. • 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 are in place.
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support*		• 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 promoted and strengthened in season2020/2

	vaccine delivery and uptake. *Vaccine uptake will be monitored weekly by performance & delivery division.*		
3	Workforce in place to deliver expanded programme and cope with higher demand, including staff to deliver vaccines, and resource phone lines and booking appointment systems.		• The National Scottish Immunisation Recall System (SIRS) invitation letter and Flu information leaflet will be distributed to all eligible groups this season. The National Scottish Immunisation Recall System has been adapted to enable call and recall for adult groups locally. Season 2020/21 will see the responsibility for call and recall to be the responsibility of the Board. Co-ordination of call and recalll will be provided via the Primary Care Team. • Coordinated by the Health Protection Team. Delivered by OH, CACT and Dental Services • The expanded programme is being delivered by a Registered Nurse workforce extensively coordinated and delivered from within the Community Nursing establishment with support from additional staff groups primarily bank staff
4	Delivery model(s) in place which: • Has capacity and capability to deal with increased demand for the seasonal flu vaccine generated by the expansion of eligibility as well as public awareness being increased around infectious disease as a result of the Covid-19 pandemic. • Is Covid-safe, preventing the spread of Covid-19 as far as possible with social distancing and hygiene measures. • Have been assessed in terms of equality and accessibility impacts		• 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 2020 until 31st March 2021.However influenza cases start to increase from late November into early December, with a peak in mid to late January therefore, to provide protection of staff and by extension vulnerable patients, the programme focuses on maximising vaccination of the main body of staff from October to mid-November. Pneumococcal vaccination will be available all year round with a concentrated effort being made to vaccinate at the same time as Influenza.

	There should be a detailed communications plan for engaging with patients, both in terms of call and recall and communicating if there are any changes to the delivery plan.		• The vaccination programme will see a mixed model of delivery throughout the Western Isles. Where possible vaccinations will be delivered to eligible groups within their GP practice, however, due to the implications and challenges of COVID-19, centralised clinics will also take place in the localised community setting. There may also be the need for vaccinations out-with normal working hours and provision of a 7 day week service. • This year's 2020/21childhood flu vaccination programme will offer vaccination to the same groups as last year. Specifically: all children aged two to five* (not yet at school) will be invited to attend GP practices for immunisation delivery by the Community Nursing team(*children must be aged two or above on 1 September 2020); and all primary school aged children aged 5 to 11 years will be invited for immunisation by the School Nursing Team for vaccination at school or at clinic (where they are home schooled). • Work will continue for this year to improve uptake rates in the over 65s, as well as for those in the younger 'at risk' groups, and health and social care staff. • The Midwifery service are delivering the immunisation for all pregnant women throught NHS Western Isles. • The Western Isles NHS Board Pandemic Flu Plan will be adapted in accordance with current epidemiological evidence. • 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 immunisation activity and sharing of best practice is undertaken via meetings with local community nurse networks. Networks.
5	The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu		• Information from early spotters utilised • Data is currently week behind and trends are analyses and relevant actions taken

	outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)*		• Major/Adverse Incident – Re-deployment Protocol in place to ensure placement of staff to deal with potential flu outbreak. • Immunisation • Bed Escalation Plan • Staff escalation plan • Service Retraction Plan
6	PHS weekly updates, showing the current epidemiological picture on Covid-19 and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *PHS and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.*		• Yes, in place and cascaded to relevant departments. • Monitoring Uptake • Health Protection Scotland (HPS) will take the lead in monitoring uptake on behalf of the Scottish Government and will provide weeklyuptake data from October 2020 to March 2021. These reports will be circulated by HPS to the Scottish Government and NHS Boards. The Health Board will observe the data and monthly reports are provided on HPS website. If uptake is low the Health Board will contact the Lead Community Nurse or the Head of Midwifery with offer of assistance/ discussion on what can be done to improve.
7	NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows: • Adults aged over 65 • Those under 65 at risk • Healthcare workers • Unpaid and young carers • Pregnant women (no additional risk factors) • Pregnant women (additional risk factors) • Children aged 2-5 • Primary School aged children		• The Board's trajectory for all eligible cohorts has been provided to Scottish Government • The trajectory has been identified against previous years uptakes by eligible cohort, and projections include uptake to 60%, 70% and 75% to align with planned scheduled clinics • Uptake will be monitored on a daily and weekly basis against the identified trajectory • Where delivery is found to be below planned performance, assistance will be offered aiming to increase uptake.

	• Frontline social care workers • 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household • Eligible shielding households The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This will include regular reporting that will commence from the end of week commencing 12th October. We will adopt a the Public Health Scotland model, which is a pre-existing manual return mechanism that has been used in previous seasons with NHS Boards to collate Flu vaccine uptake data when vaccination is out with GP practices.		
8	Adequate resources are in place to manage potential outbreaks of Covid-19 and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*		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 acute 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 given 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 Social Media sites, via media outlets 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 a variety of channels to communicate information to the public and also issues all mail user bulletins to staff/weekly Team Brief/ and Desk Alerts 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.
9	Tested appointment booking system in place which has capacity and capability to deal with increased demand generated by the expansion of eligibility and increased demand expected due to public awareness around infectious disease as a result of the Covid-19 pandemic.		• Booking system in place and capacity for increased demand planned for.
10	NHS Boards must ensure that all staff have access to and are adhering to the national COVID-19 IPC and PPE guidance and have received up to date training in the use of appropriate PPE for the safe management of patients. Aerosol Generating Procedures (AGPs) In addition to this above, Boards must ensure that staff working in areas where Aerosol Generating Procedures (AGPs) are likely to be undertaken - such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) - are fully aware of all IPC policies and guidance		• NHSWI is adhering to the guidance. Regular training takes place. New equipment and procedures and relocation of staffing require continuous training programme. This includes areas where AGP's take place.

	relating to AGPs; are FFP3 fit-tested; are trained in the use of this PPE for the safe management of suspected Covid-19 and flu cases; and that this training is up-to-date. ***Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's 'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013). https://www.hse.gov.uk/pUbns/priced/hsg53.pdf***		
11	NHS Boards must ensure that the additional IPC measures set out in the CNO letter on 29 June staff have been implemented. This includes but is not limited to: • Adherence to the updated extended of use of face mask guidance issued on 18 September and available here. • Testing during an incident or outbreak investigation at ward level when unexpected cases are identified (see point 9). • Routine weekly testing of certain groups of healthcare workers in line with national healthcare worker testing guidance available here (see point 9). • Testing on admission of patients aged 70 and over. Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster. • Implementation of COVID-19 pathways (high, medium and low risk) in line with national IPC guidance. • Additional cleaning of areas of high volume of patients or areas that are frequently touched. • Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September. • Consideration given to staff movement and rostering to minimise staff to staff transmission and staff to patient transmission. • Management and testing of the built environment (e.g.		• NHSWI is in compliance with all highlighted measures.

	water systems) that have had reduced activity or no activity since service reduction / lockdown – in line with extant guidance.		
12	Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf In addition to this, key healthcare workers in the following specialities should be tested on a weekly basis: oncology and haemato-oncology in wards and day patient areas including radiotherapy; staff in wards caring for people over 65 years of age where the length of stay for the area is over three months; and wards within mental health services where the anticipated length of stay is also over three months. *Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-covid-19-healthcare-worker-testing/*		• NHS WI is compliant with existing policy • Day surgery staff covering key specialities are tested weekly

13	The PHS COVID-19 checklist must be used in the event of a COVID-19 incident or outbreak in a healthcare setting. The checklist is available here: https://www.hps.scot.nhs.uk/web-resources-container/covid-19-outbreak-checklist/ The checklist can be used within a COVID ward or when there is an individual case or multiple cases in non-COVID wards.		• Arrangements are in place to deal with a covid incident or outbreak in line with national guidance.
14	Ensure continued support for routine weekly Care home staff testing This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results.		• All arrangements for weekly Care Home staff testing are operational, working effectively and transition plans in place.

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*	**RAG**	**Further Action/Comments**
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**		
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.		• Highland Pathway. • Shared Clinical Guidelines – Respiratory (Intranet).

1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.		• GP Practices hold register of all patients. • 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. • The Hospital at Home service has access to Oxygen concentrators to provide respiratory support (upto 5 litres flow rate) with the service being manned 7 days a week and able to provide same day support (either admission avoidance or facilitated discharge) •
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*		• 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. • Patients will have Emergency Medication information to hand in their self management plan. • Shared Clinical Guidelines on Intranet. • Respiratory Traffic Lights available on Shard Clinical Guidelines. • ACP in place by GP but no access to information by Respiratory Nurse. ▪
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*		• National Campaigns. • Text alert service re: adverse weather. • Twitter. • Facebook. • WIEPCG. • NHSWI Communications Strategy

2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**		
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).*		• Pharmacist/Pharmacy technician training in correct use of inhalers. • Monitor medication at clinics. • Smoking Cessation. • Nutrition advice.
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.		• Pharmacist/Pharmacy technician training in correct use of inhalers. • Monitor medication at clinics.
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**		
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*		• In place. • ACP are generated by GPs via KIS and shared with Out of Hours Practitioners. • Community Unscheduled Care Nurses (CUCN) manage patients in Out of Hours capacity. • To investigate making ACP flag available on Hospital IT systems with alerting made available to key staff.

4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**		
4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*		• In place. Confirmation has been received from Senior Nurse that staff are satisfied that they have access to local equipment. • Emergency plans are in place to enable patient to receive timely referral to home oxygen service. • 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. • Contingency arrangements are in place for clinical staff to access equipment for temporary use.
5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**		
5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*		• A&E. • Shared Clinical Guidelines. • In addition the Primary Care Implementation Board are in a procurement process that should be complete in the next few weeks to provide home self-monitoring for a large proportion of our COPD population •

7	Key Roles / Services	RAG	Further Action/Comments
	Heads of Service		One senior post has recently been appointed. The Chief Officer IJB will take up position at the beginning of January2021. The Nurse/AHP Director/Chief Operating Officer post is vacant. An additional temporary Executive Director is in the process of being recruited for a 3 month period from 23/11/20.
	Nursing / Medical Consultants		Vacancies to the Consultant team are being recruited to or are covered by locum appointments
	Consultants in Dental Public Health		
	AHP Leads		
	Infection Control Managers		
	Managers Responsible for Capacity & Flow		
	Pharmacy Leads		
	Mental Health Leads		
	Business Continuity / Resilience Leads, Emergency Planning Managers		
	OOH Service Managers		
	GP's		
	NHS 24		

	SAS		
	Other Territorial NHS Boards, eg mutual aid		
	Independent Sector		Limited provision of independent sector Care Homes
	Local Authorities, incLRPs & RRPs		
	Integration Joint Boards		
	Strategic Co-ordination Group		
	Third Sector		
	SG Health & Social Care Directorate		