Preparing for Winter 2018/19:
Supplementary Checklist of Winter Preparedness: Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Seasonal Flu**
6. **Respiratory Pathway**
7. **Key Partners / Services**

This checklist supports the strategic priorities for improvement identified by local systems from their review of last winter and includes other areas of relevance.

This list is not exhaustive and local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

NHS Special Boards should support local health and social care systems to develop their winter plans as appropriate.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups can use these checklists to self-assess the quality of overall winter preparations and to identify where further action may be required. This should link to the guidance available for continual provision of service avaible on the associated web links highlighted on the accompanying paper

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

- The following RAG status definitions are offered as a guide to help you evaluate the status of your overall winter preparedness.

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	Lead	Completion Date	Further Action/Comments
1	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose.			GMs, Site Directors, PSSD		Acute and primary care services have been reviewing arrangements which will be complete by September
	Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details.The NHSScotland Standards for Organisational Resilience (2018) sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*			Resilience Officers	Ongoing	NHS, SLC + NLC resilence officers are members of the winter planning group
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.			GMs, Site Directors, PSSD	Completed	
	Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner.			GMs, Site Directors, PSSD	November 2018	A 'desk-top' exercise will be undertaken as part of the site planning in each hospital.
	The partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.			A Robertson, K Wratten, A McMann	Completed	

3	The NHS Board and HSCPs have appropriate policies in place that cover: • what staff should do in the event of severe weather hindering access to work, and • how the appropriate travel advice will be communicated to staff and patients • how to access local resources (including voluntary groups) that can support the transport of staff to and from their places of work during periods of severe weather.Policies should be communicated to all staff 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.*	☒		J White	Completed	The instructions re NHS staff being 'essential' even in times of 'RED' warning have also been emphasised.
4	The NHS Board's and HSCPs websites will be used to advise on travel to appointments during severe weather and prospective cancellation of clinics.	☒		M Waters	Completed	Dedicated page will be provided in First Port.
5	The NHS Board, HSCPs and local authority have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☒		A Robertson, K Wratten, A McMann	November 2018	Additional mortuary capacity has been created. Work ongoing in negotiating arrangements with local undertakers.
6	The effectiveness of winter plans will be tested with all stakeholders by 30 October The final version of the winter plan has been approved by NHS Board and HSCPs	☒		A Robertson, V de Souza, J Hewitt	Completed	AR will develop scenario for desktop test. Date to be agreed. North and South H&SCPs will assist in preparation of final plans and the plan will be considered at the NHS Board by end of October and IJB thereafter.

2	**Unscheduled / Elective Care Preparedness** *(Assessment of overall winter preparations and further actions required)*		RAG	Lead	Completion Date	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.*	☒		Acute Site Directors/ H&SCP Heads of Service	Complete	Site huddles, barometer and escalation measures in place on all acute sites.
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.	☒		Acute Site Directors	Complete	In place
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*	☒		Acute Site Directors/ J Park	Completed	Modelling of elective work has been undertakne. Extra escalation include elective capacity.

	discharged without further delay					
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.*	☒		Acute Site Direcotrs/ H&SCP Operational Heads	Ongoing	Plans assume predicted levels of activity and capacity. It is not possible to guarantee additional resource – either in relation to manpower or finance.
2	**Undertake detailed analysis and planning to effectively manage schedule elective and unscheduled activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**					
2.1	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.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*	☒		Site Direcors	Ongoing	Part of existing capacity plan. Have detailed elective plans as part of wider planning. This will take accont of TTG targets as well as maximising mitigating factors at peak winter period.
2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions and recovery plans to minimise the impact of	☒		Acute Site Directors/ H&SCP Leads	Ongoing	Planning has been undertaken to confirm wher additional surge capacity could be provided if sufficient resources/ staff are

	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.* *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.*					available. There are 24 beds in UHM and a further 17 beds in UHH available as well as an additional 6 beds in receving area in UHW. Work is ongoing at modelling how this capacity should be introduced on a phased basis, only opening beds as required.
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.**					
3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events (e.g.). Hogmanay Street parties on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☒		Site Directors	Ongoing	Each acute site working on this. Similarly, all staff grops across community and social care services have been asked to demonstrate sufficient cover arrangements across the peak holidty period. Review status in October

3.2	Extra capacity should be scheduled for the 'return to work' days after the festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services. The Monday following the festive weekend breaks should not be routinely used as a day off thereby creating a 5 day weekend.	☒		All	Ongoing	Some further work is required in securing all the cover which has been added to existing arrangements to create surge/ additional front door capacity. There is similar attention being given to these services which can assist reducing admissions.
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*	☒		All	Ongoing	Confirmation sought from planning partners to raise awareness of any issues. Also work with Red Crss to support discharges. Productive discussions with SAS has also confirmed access to dedicated ambulance support for the 3 hospitals duringthe winter period and beyond.
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.*	☒		F Brownlie	October 2018	This will form part of the 'Winter Planning Folder'. Regular information also provided to ERC. GPs will also be open on additional days and communicated accordingly see below.

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.*	☒		Site Directors	Ongoing	Regular communication is being undertaken to measure improvement in this area. There will be particular focus given to increasing weekend/PH discharges as well as 'pushing the curve' to the left with earlier discharge times.
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. Pharmacy services should also be avaible to issue timely prescriptions to support discharge. 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*	☒			Ongoing	As above. Trajectories are being produced which seeks to idenitify improvement in the numbers and times of weekend discharges. Additional staff – across all staff groups and agencies – will be available to support the peak winter period patient flow.

	availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.					
4.3	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*	☒		Site Directors	Complete	Utilisation of discharge lounges will also feature as part of the winter plan performance report.
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 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*	☒			Ongoing	Key partners are all involved in wider winter planning process and have been asked to confirm additional staffing to meet anticipated demand
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*	☒		J McCreanor, M Hayward, I Beattie	Ongoing	H&SCP's identifying additional resources to meet agreed trejectories. Additional staff being appointed to manage same.

	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.*					
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. *Paertnerships 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*	☒		V de Souza, J Hewitt, J Knox	Ongoing	Full range of options to be available. Homecare assessment will remain the responsibility of respective social work staff. Additional intermediate care capacity is still being planned across the H&SCP.
5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*	☒		GMs	Ongoing	Existing effective arrangements in place. Work is also progressing to improve sharing of information across other agencies e.g SAS
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.*	☒		GMs	Ongoing	ACP development well advanced accessed via ekis.

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. *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.*	☒		Site Direcotrs/ H&S C Leads	Complete	All partners aware of winter plan requirements and associated access to services. Additional capacity will be available via equimpment stores, SAS, home care, OOH services (see below) and AHP services.
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. *NHS 24 are leading on the 2018/19 'Be Healthwise This Winter' media campaign, and SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around repeat prescriptions', respiratory hygiene, and norovirus are effectively communicated to the public.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather*	☒		C Brown	Ongoing	Plans being updated to relect the various developments and protocols being established. The communications plan will build upn last year's award winning 'meet the expert' campaign. There will also be a 'regional' approach to adverts and public messages via local radio stations.

	events. *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*					

3	Out of Hours Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Lead	Completion Date	Further Action/Comments
1	The OOH plan covers the full winter period and pays particular attention to the festive period. *This should include an agreed escalation process.* *Have you considered / discussed local processes with NHS 24 on providing pre-prioritised calls during the OOH period?*	☒		F Brownlie	Ongoing	Full rostering has been identified and shifts offered to staff. Some work is still required in filling the associated shifts.
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.	☒		GM/ SM OOH	As above	Rosters prepared accordingly. Work is also ongoing in developing a new pilot to allow GP/ consultant call back to a range of patients to assist in off setting demand. The new scheme will start in October and, staff allowing, run through to March 19.
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.	☒		As above	As above	The H&SCPs are offering GPs the opportunity to operate on PHs, thereby reducing demand on OOH and A&e. This is being augmented by offering GPs to open on the first two Saturdays in January – 5/1/19 and 12/1/19.
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*	☒		As above	As above	Work identified in supporting greater numers of paediatric and mental health patients being managed in OOH – away from A&E.

	appropriate?					
5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☒		As above	As above	Access to clinical portal available for mental health and paediatric staff.
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	☒		As above	As above	Pharmacist will be available in OOH service.
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.	☒		GM/ SM	Complete	
8	In conjunction with HSCPs, ensure that there is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☒		Community Dental Service	Complete	Full access to OOH Dental Service is available across all services in Lanarkshire.
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.*	☒		F Brownlie	Ongoing	It is anticipated that thewwe will be good coverage against planned rotas.
10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☒		C Brown	Ongoing	As per communication strategy.
11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered	☒		A Graham	Ongoing	SAS full members of winter planning process and participants in agreed

	through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.					actions.
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.*	☒		C Spence	Ongoing	NHS24 full members of winter planning process and participants in agreed actions. NHS 24 are also participating in the test of change in realtion to OOH services.
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.*	☒		F Brownlie/ Acute Site Directors	Ongoing	Both acute and OOH managers have participated in preparation of the plan.
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.*	☒		H&SCPs	Ongoing	Social work staff are key members of the Winter Planning Group.
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic plan including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*	☒		G Docherty	Ongoing	Public Health staff are members of the Winter Planning Group and Pandemic plans have been previously tested.

4	**Prepare for & Implement Norovirus Outbreak Control Measures** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Lead**	**Completion Date**	**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.*			E Shepherd	Complete	Full representation from Infection Control team at Winter Planning meetings and, in turn, plans developed to ensure effective management of all infection control risks.
2	IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which 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.*			E Shepherd	October 2018	As above. This also includes communication with all care homes in the NHSL area to ensure they are aware of their respective responsibilities in managing issues on site as well as communicating effectively in the event of requirement for hospital admission.
3	HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.			E Shepherd	October 2018	Also linked to dedicated winter plan page on NHSL intranet site.
4	NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*			C Brown	October 2018	As above

5	Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☒			Ongoing	Part of recognised outbreak management
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.	☒		C Cunningham	Ongoing	Weekly dashboard information shared across all partners
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.	☒		Infection Control	Ongoing	
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/ Site Directors	October 2018	On call arrangements will cover entire Festive/winter period
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☒		Infection Control/ Site Directors	Ongoing	
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *This could include the notification of 'tweets', where appropriate, to help spread key message information. HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.*	☒		Infection Control/ Site Directors	Ongoing	

11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message. *This could include HPT supporting schools to have awareness raising prior to norovirus season and the notification of 'tweets', where appropriate, to help spread key message information.*			Infection Control/ Site Directors	Ongoing	Addresses as part of ongoing incidenet management arrangements

5	**Seasonal Flu, Staff Protection & Outbreak Resourcing** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Lead**	**Completion Date**	**Further Action/Comments**
1	Staff working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients, as recommended in the CMOs seasonal flu vaccination letter due to be published in Aug 2018. *This will be evidenced through end of season vaccine uptake submitted to HPS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.*			All	December 2018	This will be a key ambition of this year's plan.
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2018) clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; and that*			K Japp	September 2018	Full programme of staff vaccines already been circulated and will have catch up sessions as well. Work ongoing with Partnership colleagues to ensure positive promotion of flu vaccine messaging.

	senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.					
3	The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required and an agreed protocol is in place with NHS Boards on the use of the contingency stock. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)*	☒		All	Ongoing	Without knowing the strain and associated prevelance/ severity it is difficult to confirm exact capacity requirements.
4	HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Health Protection Scotland and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. HPS produce a weekly influenza bulletin and a distillate of this is included in the HPS Winter Pressures Bulletin.*	☒		All	Ongoing	All data shared routinely with Winter Planning Team.
5	Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective*	☒		All	Ongoing	As per above.

	admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.					

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Lead**	**Completion Date**	**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.	☒		L Anderson/ T/L	October 2018	These will be re-circulated and emphasised to all relevant staff.
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☒		L Anderson/ T/L	November 2018	Rotasa to be confirmed.
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).*	☒		L Anderson/ T/L	Ongoing	Work is ongoing in identifying all pactients with ACP, ensuring these are up to date and that all have been shared with all respective partners/ staff. The current IT systms do not always allow for sharing of content of ACP.
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.*	☒		L Anderson/ T/L	Ongoing	

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).*	☒		L Anderson/ T/L	Ongoing	
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.	☒		L Anderson/ T/L	Ongoing	
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**					
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data, https://www.bo.scot.nhs.uk/. This release estimates an individual's risk of emergency admission.* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☒		L Anderson/ T/L	Ongoing	Work continuing across hospital and community services to ensure creation and awareness of same.

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.*	☒		L Anderson/ T/L	Ongoing	Arrangements in place to access home oxygen
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.*	☒		L Anderson/ T/L	Ongoing	

7	Key Roles / Services		RAG	Further Action/Comments
	Heads of Service	☐		
	Nursing / Medical Consultants	☐		
	Consultants in Dental Public Health	☐		
	AHP Leads	☐		
	Infection Control Managers	☐		
	Managers Responsible for Capacity & Flow	☐		
	Pharmacy Leads	☐		
	Mental Health Leads	☐		
	Business Continuity / Emergency Planning Managers	☐		
	OOH Service Managers	☐		
	GP's	☐		
	NHS 24	☐		
	SAS	☐		
	Territorial NHS Boards	☐		
	Independent Sector	☐		
	Local Authorities	☐		
	Integration Joint Boards	☐		
	Strategic Co-ordination Group	☐		
	Third Sector	☐		
	SG Health & Social Care Directorate	☐		