Preparing for Winter 2021/22: Supplementary Checklist of Winter Preparedness: Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **COVID -19, RSV, Seasonal Flu, Staff Protection & Outbreak Resourcing**
6. **Respiratory Pathway**
7. **Integration of Key Partners / Services**

These checklists supplement the narrative and deliverables identified in your RMP4 and support the strategic priorities for improvement identified by local systems from their review of last winter's pressures and performance and experiences of managing Covid -19.

Your winter preparedness assessment should cover systems, processes and plans which take into account the potential impacts of COVID-19, Respiratory Syncytial Virus (RSV), seasonal flu, other respiratory conditions and severe weather impacts. Plans should recognise that some of these events may occur concurrently and should take into account system wide impacts. Plans should also reflect a strategic as well as operational approach to maintain service resilience and business continuity.

The checklists also include other areas of relevance but are not exhaustive. Local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

NHS National 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 available on the associated web links highlighted on the accompanying paper.

- 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**	**Further Action /Comments**
1	NHS Board and Health and Social Care Partnerships (HSCPs) have clearly identified all potential disruptive risks to service delivery and have developed robust Business Continuity (BC) plans to mitigate these risks. Specific risks include the impact of Respiratory Infections (e.g. Covid, RSV, Seasonal Flu) on service capacity, severe weather and staff absence. Business continuity arrangements have built on lessons identified from previous events, and are regularly tested to ensure they remain relevant and fit for purpose.		Whilst robust arrangements are in place, it is not possible at this stage to be absolute re whether they will be able to mitigate all the concurrent issues recognising the scale and 'never before seen' potential impact of these. These plans are based on previous debrief events and will also take account of experience/lessons learned from 'Winter Breach' planning exercises both this year and previously.
	Resilience officers are fully involved in all aspects of winter preparedness to ensure that business continuity management principles are embedded in Remobilisation / Annual Operating Plans as part of all-year-round capacity and service continuity planning *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.* This guidance Preparing for Emergencies Guidance*sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*		Council and NHS resilience officers are all key members of the winter planning group and also work alongside the wider LRP process. They have also been key to 'testing' the system and organising 'Winter Breach' exercise, currently planned for 28 October, 2021. Opportunity will also be taken to link potential learning from COP26 BCP exercises which would be pertinent to winter planning.
2	BC plans take into account all critical activities across the NHS Board / HSCPs spectrum of activity and include analysis of the risks of disruption and their actual effects and demonstrate that planning has been based upon the likelihood and impact of worst case scenarios.		As above, whilst the BCP process is in place, it is not possible to test it in real terms in relation to worst case scenario re concurrency given the uncertainty of many of the potential issues to be managed. It

			is similarly very difficult to predict the prevalence of Covid and other respiratory disease and therefore the potential subsequent extent of stand down of 'routine' healthcare. It will definitely not be possible to provide 'routine' healthcare – and indeed social care, if there was to be 'worst case scenario' given current staffing and multiple demands on same.
	Risk assessments take into account staff absences including those likely to be caused by a range of scenarios and are linked to a business impact analysis to ensure that essential staff are in place to maintain key services. All critical activities and actions required to maintain them are included on the corporate risk register and are actively monitored by the risk owner. The Health Board and HSC partnership have robust arrangements in place to support mutual aid between local / regional partners in respect of the risks and impacts identified.		Similar message re recognition that we may/will not be able to do everything being asked of the same staff groups – including extended winter staffing – depending on severity of seasonal flu/RSV/infection rates re Covid. There are robust arrangements in place between NHSL and the 2 x H&SCPs. Complexities this year include the shortage of home care staff; continued apprehension by care homes to accept given all the adverse publicity around care homes and Operation Koper. And fewer staff who could be deployed from other roles than was the case last winter when services were stood down/lock down in place. Additionally, this means that where we previously were able to have beds provided to support short term

			stays to support earlier discharge, it is less likely this year.
3	The NHS Board and HSCPs have appropriate policies in place to cover issues such as : • what staff should do in the event of severe weather or other issues hindering access to work, and • arrangements to effectively communicate information on appropriate travel and other advice 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.*		There are appropriate policies in place and these have been refined over the years. This includes regular updates to all staff to reiterate the fact they are essential staff and as such, expected to travel to their work in adverse weather conditions as required. There are also well rehearsed mutual aid arrangements between NHSL, the 2 Councils and SAS re being able to access patients (and occasionally staff) to ensure ability tom make essential journeys to hospital
4	NHS Board/HSCPs websites will be used to advise patients on any changes to service access arrangements or cancellations of clinics / outpatient services due to severe weather, reduced staffing levels etc,		This is covered as part of the adverse weather policy
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.		Consideration has been given and mitigating actions established/ taken.

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 and visibility of other key performance indicators *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.*		Well established processes are in place across the 3 hospital sites and the H&SCPs. This is supplemented by a daily bed state call involving acute and H&SCPs. SAS also join as required.
1.2	Effective communication protocols are in place between clinical departments and senior managers across the whole system, 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 with key actions and timescales assigned to individuals.		Twice daily huddles are held on all sites to ensure any issues identified/resolved. These can be increased as and when pressures escalate.
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, with PDDs*		Modelling and escalation policies in place.

	(planned dates of discharge) visible and worked towards, to ensure patients are discharged without 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.*		Whilst these escalation policies are in place the ability to purchase additional capacity in care homes is limited in the extreme given social care staffing pressures.
2	**Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID-19 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-19 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.*		Systems in place albeit without knowing extent of subsequent demand, it is not possible to be able to confirm that all these services will be able to continue elective work whilst responding to scale of Covid and associated staffing requirements. There will also be significant backlog to catch up following recent and previous stand down of routine elective surgery, meaning modelling will require to give cognisance to priority patients over routine waiting list management and therefore there will be a deterioration in waits.

	NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID-19 surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.		
2.2	Pre-planning created pathways which provide an alternative to admission, and optimised the use of inpatient capacity for the delivery of emergency and elective treatment, including identification of winter / COVID-19 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*		As above, it is unlikely there will be enough staff/beds to manage full extent of Covid requirements without adversely impacting upon elective work.
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,		Rotas are in place, however there are emerging demands on various

	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 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*.		staff groups which require additional staff to be recruited/ diverted from other tasks to manage same, e.g. additional surge beds, ICST and home care capacity challenges.
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.		Staff rotas in place to manage same – with same proviso as 3.1
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.*		Full involvement of wider partners as part of LRP/winter planning processes.
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.*		All staff aware of alternative treatment destinations, This will be supported by the creation of the urgent care flow hub.
	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 hospital 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 viable appointments / timeslots at A&E services. The impact on health-inequalities and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.		The new Urgent Care Flow Hub will build upon the success of the previous ERC to be able to redirect as many people to alternative treatment resources as possible and where necessary, direct patients to the most appropriate care flow.
	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.		
4	**Optimise patient flow by proactively managing Discharge Process utilising PDD (Planned Date of Discharge) and associated discharge planning tools such as – Daily Dynamic Discharge, to shift the discharge curve to the**		

	left and optimise in day capacity,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.*		All sites and H&SCPs now have PDD fully embedded and working to minimise delays. As noted above, issues still exist around admissions to care homes. It would be helpful if there was some change in the management of AWIs given the inability of courts to respond timeously to demand and the subsequent significant delays of people who do not need to be in hospital being discharged from hospital.
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.*		Social Work/discharge staff cover has been secured for weekends and public holidays throughout the winter period. This includes associated AHPs.
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*		
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.*		As 3.3.
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.*		Whilst close partnership working is in place, it is not possible to confirm that all staff will be in place recognising pressures around prevalence of Covid, national lack of social care staff and other staff demands.

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.*		As indicated above, whilst the service will be there in both community and inpatients, there is reluctance across both care at home and care home providers to take patients without 2 negative tests.
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.*		There is a cohort of 'high resource' individuals followed up in this way. It is not all who are on SPARRA registers.
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.*		Advice has been issued to all areas to ensure ACPs are up to date as well as respective KIS.

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.		FNC mainstream GMS and A&E now integral to Covid pathway.
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.*		
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 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.*		A dedicated winter comms campaign is being launched. This follows on from previous year's campaigns which have won national awards.

	The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events. *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*		

3	Out of Hours Preparedness *(Assessment of overall winter preparations and further actions required)*	RAG	Further Action/Comments
1	The OOH plan covers the full winter period and pays particular attention to the festive period 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?*		All planning in place and rotas developed to recognise anticipated increased demand over peak weekends and public holidays. As highlighted at 9 below however, it is not possible at this stage to be able to predict fill rates.
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.		As above. The plan is there, but little certainty re staff availability.
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.		All calls are now subject to a senior clinician 'call back' to ensure best possible option re treatment delivery. This will include use of Pharmacy First, mental health team etc.
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?*		OOH will also feature as part of the redesign work associated with the Urgent Care Flow Hub.

5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.		
6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa.		
7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.		
8	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.*		
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.*		Staffing in the OOH service has been very fragile in recent months and whilst work is ongoing in securing additional staff with the associated skill set, e.g. ANPs, this is set against other areas demanding the same staff as well as there not being services stood down as previously had been the case.
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.*		As per 6.2 above.

11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.		
12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*		
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*		
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*		
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic 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.*		

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.*		
2	IPCTs and HPTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their IPCTs and Health Protection Teams (HPTs) are supported to undertake the advance planning to ensure that Norovirus outbreaks in hospitals and care homes are identified and acted upon swiftly. Boards should ensure that there are sufficient resources to provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*		In 'normal' times, the IPCT would be involved in this, however this year, we will utilise what is already in existence recognising that the IPCT is fully committed in responding to Covid outbreaks in all respective settings.
3	PHS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff.		
4	How are NHS Board communications regarding bed pressures, ward closures, kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*		
5	Debriefs will be provided following significant outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*		

6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker.		
7	Are there systems in place that would ensure appropriate patient placement, patient admission and environmental decontamination post discharge in ED and assessment areas.		As per item 2 above.
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.*		
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.*		This will be undertaken alongside management of Covid patients and may result in different planning than in previous years.
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.		
11	Are there systems in place to deploy norovirus publicity materials information internally and locally as appropriate.		

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.		As per 6.2 above.

5	**COVID -19, RSV, 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 CMOs seasonal flu vaccination letter published on Adult flu immunisation programme 2021/22 (scot.nhs.uk) and Scottish childhood and school flu immunisation programme 2021/22 . Further CMO letters will be issued before the flu season begins to provide further details on aspects of the programme, including the marketing campaign and details of education resources for staff administering vaccinations.		Plans are in place to allow all staff to have both flu and covid vaccines, however it will be later in the programme before we are able to confirm extent of coverage recognising it is not mandatory. There is however plenty of scope for all such staff to be vaccinated.
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*		Plans in place for various staffing groups.

	preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake. Vaccine uptake will be monitored weekly by performance & delivery division		
3	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 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. SG procures additional stocks of flu vaccine which is added to the stocks that Health Boards receive throughout the season, which they can draw down, 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 co-ordinated and issued by the Vaccinations Strategy Division.)*		Whilst the plan takes account of the potential for additional demand due to seasonal flu, it is not possible to say that there will be adequate resources to deal with it internally to NHSL depending on other pressures which may be in the system concurrently.
4	PHS weekly updates, showing the current epidemiological picture on COVID-19, RSV and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Public Health Scotland and the Vaccinations Strategy Division 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.*		
5	Adequate resources are in place to manage potential outbreaks of COVID-19, RSV 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.*		Without being able to predict the extent of either, it is not possible to state whether the resources would be adequate. Depending on severity and possible concurrence, it may be necessary to stand down non-urgent service delivery.

6	Ensure that sufficient numbers of staff from high risk areas where aerosol generating procedures 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, FFP3 fit-tested and trained in the use of PPE for the safe management of suspected COVID-19, RSV 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***		
7	Staff in specialist cancer & treatment wards, long stay care of the elderly and mental health (long stay) will also will be required to continue to undertake asymptomatic weekly testing for COVID-19 throughout this period. We are actively reviewing the current asymptomatic Healthcare Worker testing Operational Definitions to ensure they are still fit for purpose.		
8	Ensure continued support for care home staff asymptomatic LFD and PCR testing and wider social services 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. *Enhanced care home staff testing introduced from 23 December 2020 . This involves twice weekly LFD in addition to weekly PCR testing review of enhanced staff testing underway. PCR testing - transition to NHS lab complete. Good level of staff participation in PCR testing. Testing has been rolled out to a wide range of other social care services including care at home, sheltered housing services.*		

9	NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2021/2022) 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 • 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 day 1 of the programme utilising automated data collection methods for performance monitoring. Public Health Scotland will report weekly.		It is anticipated plans will be able to deliver against JCVI guidelines and respective Soct Gov asks. Further guidance is awaited in relation to timing of covid boosters to allow seasonal flu and covid booster to be able to be delivered concurrently.

10	**Low risk** – Any care facility where: a) triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact who have isolated/shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the test date OR b) Individuals who have recovered from COVID-19 and have had at least 3 consecutive days without fever or respiratory symptoms and a negative COVID-19 test OR c) patients or individuals are regularly tested (remain negative) **Medium risk** Any care facility where: a) triaged/clinically assessed individuals are asymptomatic and are waiting a SARSCoV-2 (COVID-19) test result with no known recent COVID-19 contact OR b) testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR c) asymptomatic individuals decline testing **High risk** Any care facility where: a) un-triaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals who decline testing So all emergency admissions where COVID-19 status is unknown/awaited will fall into the medium risk pathways until testing can be undertaken to allow them to transition into green.		
11	All NHS Scotland Health Boards have provided assurance that all emergency and all elective patients are offered testing prior to admission. *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.*		

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 mid-February 2021, the scope of the LFD testing pathway was expanded further to include patient facing primary care staff (general practice, pharmacy, dentistry, optometry), hospice staff, and NHS24 and SAS call handlers. Some hospice staff had been included in the original scope where staff worked between hospitals and hospices, so this addition brought all patient facing hospice staff into the testing programme.* *On the 17 March Scottish Government announced that the scope of the HCW testing pathway would be further expanded to include all NHS workers. The roll out is currently underway and we expect that all Boards across Scotland will have fully implemented the roll-out of twice weekly lateral flow testing to eligible staff by the end of June 2021. This will include staff who may have been shielding or working from home and is in line with national guidance.* *Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-COVID-19-healthcare-worker-testing/*		

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*	RAG	**Further Action/Comments**
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**		
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.		
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.		There is not a 7 day home respiratory service available.
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).*		Respiratory staff are aiming to ensure all ACPs in place, however are currently having to prioritise managing Covid inpatient and outpatient activity. GPs have been asked to ensure PC led respiratory patients have ACPs in place**.**
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*		

2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**		
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).*		
2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.		
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**		
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*		As 1.3 above.

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

7	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 / Resilience Leads, Emergency Planning Managers		
	OOH Service Managers		
	GP's		
	NHS 24		
	SAS		
	Other Territorial NHS Boards, eg mutual aid		
	Independent Sector		
	Local Authorities, incLRPs & RRPs		
	Integration Joint Boards		
	Strategic Co-ordination Group		
	Third Sector		
	SG Health & Social Care Directorate		

COVID-19 Surge Bed Capacity Template **Annex A**

		Baseline ICU Capacity	Double Capacity and Commitment to deliver in one week	'Triple plus' Capacity Commitment to deliver in two weeks	ICU Max Surge Beds	Y - Correct / N Incorrect with comment	Please list assumptions & consequences to other service provision to meeting these requirements
PART A: ICU	Please confirm that your NHS Board can deliver the stated level of ICU Capacity in the time periods set out						

PART B: CPAP	Please set out the maximum number of COVID-19 patients (at any one time) that could be provided CPAP in your NHS Board, should it be required		
PART C: Acute	Please set out the maximum number of acute beds that your NHS Board would re-provision for COVID-19 patients (share of 3,000 nationally), should it be required		

Annex B

Infection Prevention and Control COVID-19 Outbreak Checklist

(Refer to the National Infection Prevention and Control Manual (NIPCM) for further information http://www.nipcm.hps.scot.nhs.uk/)

This COVID-19 tool is designed for the control of incidents and outbreak in healthcare settings. **Definitions: 2 or more confirmed or suspected cases of COVID-19 within the same area within 14 days where cross transmission has been identified.** **Confirmed case: anyone testing positive for COVID-19** **Suspected case: anyone experiencing symptoms indicative of COVID (not yet confirmed by virology)** **This tool can be used within a COVID-19 ward or when there is an individual case or multiple cases.**						
Standard Infection Control Precautions; **Apply to all staff, in all care settings, at all times, for all patients when blood, body fluids or recognised/unrecognised source of infection are present.**						
Patient Placement/Assessment of risk/Cohort area **Date**						
Patient placement is prioritised in a suitable area pending investigation such as for a single case i.e. single room with clinical wash hand basin and en-suite facilities						
Cohort areas are established for multiple cases of **confirmed** COVID-19 (if single rooms are unavailable). Suspected cases should be cohorted separately until confirmed. Patients should be separated by at least 2 metres if cohorted.						
Doors to isolation/cohort rooms/areas are closed and signage is clear (undertake a patient safety risk assessment for door closure).						
If failure to isolate, inform IPCT. **Ensure all patient placement decisions and assessment of infection risk (including isolation requirements) is clearly documented in the patient notes and reviewed throughout patient stay.**						
Patient placement is reviewed as the care pathway changes. NB: Patients may be moved into suspected or confirmed COVID-19 cohorts or wards to support bed management.						
Personal Protective Clothing (PPE)						

1. PPE requirements: PPE should be worn in accordance with the **COVID 19 IPC addendum** for the relevant sector: • **Acute settings** • **Care home** • **Community health and care settings** 2. All staff should wear a FRSM in accordance with the updated guidance on face coverings, which can be found **here**.					
Safe Management of Care Equipment					
Single-use items are in use where possible.					
Dedicated reusable non-invasive care equipment is in use and decontaminated between uses. Where it cannot be dedicated ensure equipment is decontaminated following removal from the COVID-19 room/cohort area and prior to use on another patient.					
Safe Management of the Care Environment					
All areas are free from non-essential items and equipment.					
At least twice daily decontamination of the patient isolation room/cohort rooms/areas is in place using a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl.).					
Increased frequency of decontamination (at least twice daily)is incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g. “frequently touched" surfaces such as door/toilet handles and locker tops, over bed tables and bed rails.					
Terminal decontamination is undertaken following patient transfer, discharge, or once the patient is no longer considered infectious.					
Hand Hygiene					
Staff undertake hand hygiene as per WHO 5 moments: using either ABHR or soap and water					
Movement Restrictions/Transfer/Discharge					
Patients with suspected/confirmed COVID should not be moved to other wards or departments unless this is for essential care such as escalation to critical care or essential investigations. Discharge home/care facility: Follow the latest advice in COVID-19 - guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.					
Respiratory Hygiene					
Patients are supported with hand hygiene and provided with disposable tissues and a waste bag					
Information and Treatment					
Patient/Carer informed of all screening/investigation result(s).					

Patient Information Leaflet if available or advice provided?						
Education given at ward level by a member of the IPCT on the IPC COVID guidance?						
Staff are provided with information on testing if required						