Annex A:

National Unscheduled Care Programme: Preparing for Winter 2014/15

Self-Assessment Checklists

1. **Resilience**
2. **Unscheduled / Elective Care**
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These self-assessment checklists should be read in conjunction with the letter from the Director for Health Workforce & Performance entitled **'National Unscheduled Care Programme: Preparing for Winter 2014/15'** issued on 23 September 2014

- NHS Territorial Boards should consider all of these checklists, in detail, as part of their winter planning preparations.
- NHS Special Boards should review these checklists to identify the actions most applicable to their own area of operations.
- Special Boards should also consider how they can best support Territorial Boards across the full complement of actions and initiate supportive partnership working where required.

Self-Assessment Checklists - Guidance

The following self-assessment checklists have been developed in consultation with Unscheduled Care Executive Leads to support NHS Boards refine their winter plans. These checklists should be used by internal governance groups to assess the quality of your Boards winter preparations and ascertain where further action might be required. There is no requirement for these checklists to be submitted to the Scottish Government; however, Executive Unscheduled Care Leads should regularly review progress.

The following RAG status definition table is offered as a guide to help you evaluate the status of your Board's winter preparedness against each activity.

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.	Active Monitoring & Review
■ **Red**	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	Resilience		RAG	Further Action/Comments
1	The Board has robust business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans.*	☒ ☒	Amber	All wards and departments have business impact analyses (BIA) and recovery plans. • All services with BC plans have been requested to review their plans by 27 October to provide reassurance for the Winter Plan and to consider exercise of their plans. Services had been requested to identify single points of failure - a report on this will be submitted to the BGH Resilience Group for review and consideration of risk. The Resilience Manager is undertaking 1:1 training sessions with all on call managers to ensure awareness of responsibilities and plans/tools in on call packs. **A progress report on this will also be submitted to the BGH Resilience Group.** The NHS Borders Resilience Manager is a member of the Winter Planning Group.

2	The Board's business continuity (BC) plans take into account the organisations critical activities, analysis of the effects of disruption and the actual risks of disruption and develop plans based on risk-assessed worst case scenarios. 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 will be regularly monitored by the risk owner. The Board has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	☒ ☒ ☒	Amber	This is taken account of in BIA and recovery plan development and review. The Joint Executive Team is reviewing critical services priorities and these are being aligned with IT resilience plans. BIAs includes these. Further discussion is required on links with the risk register. A mutual aid agreement is in place with South East and Tayside NHS Boards in the regional planning partnership. A Mass Casualties mutual aid agreement is in final draft for approval by the Chief Executives Group.
3	The Board has HR policies in place that cover: • what staff should do in the event of severe weather hindering access to work, • how the appropriate travel advice will be communicated to staff and patients *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.*	☒	Green	The NHS Borders Adverse Weather Policy outlines what staff are required to do in the event of severe weather. The Board's Severe Weather plan sets out arrangements for managing services and staff in the event of severe weather. The Board's crisis management group includes HR, Resilience and Communications representation and there are close links with the LRP. Appropriate messages are communicated to all staff.
4	The Board's website will be used to indicate advice on travel to hospital appointments during severe weather.	☒	Green	NHS Borders will use its website and other forms of communication (including Social Media) to provide advice on whether to travel to Hospital appointments during periods of severe weather.
5	NHS Boards and local authorities are working together to create a capacity plan to manage increased demand for mortuary services over the winter period, including liaison with funeral directors.	☒	Green	The East Regional Resilience Partnership's Mass Fatalities Group has plans in place and the Resilience Manager is linked to this group.

6	The Board will test its winter plan by 30 Nov with stakeholders to ensure that they are effective and that they are convergent with the relevant plans of Local Authorities and other key partner	☒	Amber	There are plans in place to test a number of elements of the Winter Plan: • PSAU Stand Up as Inpatient Ward – TBC • Escalation Plan – 04 November & 20 November • Severe Weather transport Office – 25 November

2	**Unscheduled / Elective Care**		**RAG**	**Further Action/Comments**
1	**Agree and test escalation policies for management of in-patient capacity across the whole system.**			
1.1	Escalation policies are focused around in-patient capacity across the whole system. *Pressures are often due to an inability to discharge patients who have not yet been identified for discharge but who no longer require acute care*	☒	Green	The NHS Borders Escalation Policy has a focus on inpatient capacity across the system. The Policy has been updated and now includes a decision making flow to support managers when it looks as though surge beds will be required. The Board Executive Team (BET) has agreed that the document should not be signed off yet remains under consistent review and updated as and when required. The policy was tested on 04 and 20 November and will be presented to the Resilience Committee on 18 December

1.2	Escalation policies are well defined, clearly understood, and well tested. *Clear thresholds and authorities for triggering, and standing down, escalation plans should be established and clearly communicated.*	☒	Amber	The policy was tested on 04 and 20 November and will be presented to the Resilience Committee on 18 December. A familiarisation plan will be required for all those not involved.
1.3	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. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☒	Amber	The Escalation policy has considered all elements of potential capacity including Community, Mental Health and Social Work. The policy is under constant review and as additional opportunities are identified they are built in.
1.4	Escalation policies 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.*	☒	Green	Elective activity is looked at on a daily basis, where cancellations are deemed necessary because of bed pressures all issues are considered e.g. cancer patients, Treatment Time Guarantee, previous cancellations, ITU requirements etc… before deciding which patients need to be cancelled. This information will be considered at the Patient Flow Action Team (PFAT). The policy includes a section on 'Golden Rules' have been built which outlines the hierarchy to be followed when bed availability becomes an issue.
2	**Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity. This has specifically taken into account the surge in activity in the first week of January.**			

2.1	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. *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/backloading activity for autumn and spring.*	☒	**Amber**	Elective activity will continue to be scheduled in advance as normal over the winter period with a reduction in elective services over the festive period. However unlike previous winter periods there will be no stand down of elective services in early January as activity levels over the past few years have dictated that this isn't necessary Elective demand is looked at on a daily basis as is predicted emergency activity. Where cancellations are deemed necessary, the urgency of the patients procedure (e.g. to treat a cancer) and TTG are key elements of the decision making process. NHS Borders has a number of surge beds that could be stood up if required, however the organisation is looking to deliver the required capacity differently by reducing the number of unscheduled admissions through testing an Assessment Unit with the aim of turning patients round before they become inpatients and getting patients to their next stage of care when they no longer require acute treatment through purchasing additional care home beds. An Elective Plan has been developed to help reduce the risk and impact of elective cancellations.

2.2	Pre-planning and modelling has been undertaken around elective activity to plan responses, escalation and recovery to minimise the impact of winter peaks in demand on the delivery of routine elective work. *A set of clear actions should be developed based on a firm understanding of demand and capacity, prediction and management of variation.* *In the event of severe weather impacting significantly on elective activity, NHS Boards, should contact SGHSCD Access Support Team to discuss arrangements for cancelling and rescheduling activity.*	☒	**Amber**	An Elective Plan has been developed to help reduce the risk and impact of elective cancellations. The plan continues to build on work the Waiting Times Team has been taking forward throughout the year in order to help improve waiting times and reduce the risk of target breaches e.g. building head room into each specialties.
2.3	Planning and analysis will facilitate the Board to maintain the 95% 4 Hour Emergency Access target, to eliminate 12 hour breaches whilst avoiding 8 hour breaches, and maintain the delivery of all elective care. *Boards should ensure that they meet the interim 95% emergency access target for year ending Sept 2014 as an absolute minimum level of performance.* *Boards are expected to maintain performance against all HEAT standards, while recognising that clinical decision making in the interests of all patients is paramount.*	☒	**Amber**	NHS Borders continues to develop its patient flow improvement work considering all aspects of the system and how each contributes to ensuring patients are treated and discharged or admitted within their 4 hour window. BGH and P&CS look at predicted emergency and elective activity levels 7 days ahead and attempt identify issues and plan on this basis Additional resources such as additional ENPs funded through the LUCAP were put in place last year to improve the resilience of the Emergency Department.
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities such as MDTs, and projected peaks in demand. These rotas should include services that support the management of inpatient pathways, (e.g.) diagnostics, pharmacy, phlebotomy, AHPs, IPCT, etc.**			

3.1	Consultant (Medical and Surgical) cover along with multi-professional support teams, including IPCT cover, will be planned to effectively manage predicted activity and discharge over the festive holiday periods, by no later than the end of October. *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*.	☒	Green	The NHS Borders Winter Plan outlines in detail the staffing that will be available over the festive period. There will be additional ED, Hospital @ Night and BECS staff on at key dates where demand is expected to be higher. Each working day outwith the public holidays staffing levels will for the most part be as per a normal working day. Weekend cover will be in place on the first public holiday each week with increased levels of staffing on duty (including senior medical staff) on the second public holiday so as to mitigate the impact of the 4 day weekend.
4	**Optimise patient flow by implementing Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of discharge, ensuring there are no delays in patient pathways.**			
4.1	Discharge planning will commence at the point of admission or at pre-admission assessment using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.*	☒	Amber	Estimated Date of Discharge (EDDs) are routinely used across the BGH and P&CS. The daily multidisciplinary board rounds consider the EDDs each day and what actions are required to facilitate the patients discharge. Work to improve the accuracy of the EDDs continues.
4.2	There will be on-going engagement with the SAS to effectively plan patient transport when it is known, or anticipated, that patients will require transport home or to another care setting.	☒	Amber	Using data from previous years as an indicator for expected demand we are negotiating with the Scottish Ambulance Service (SAS) and if required the voluntary sector to provide the anticipated levels of patients transport.

4.3	Multi-disciplinary Ward Rounds will be embedded to proactively manage the patient journey and prepare for discharge detailing the estimated date of discharge. *This should be displayed visually for the care team to see and should be the focus of all daily ward rounds and bed meetings.*	☒	■ **Green**	Multidisciplinary Team meetings are held in certain areas of the BGH including Stroke, DME and in each of the Community Hospitals. These are well embedded; however we continue to look at potential improvements in the process. Daily Multidisciplinary Board Rounds in the BGH are now well embedded. A daily Senior Charge Nurse is also now well embedded. Although the focus is at a higher level, this is often a good tool for identifying and resolving blocks to getting patients discharged. An afternoon forward planning meeting to help improve forward planning specifically around discharges has been tested over recent weeks and is showing signs of a positive impact. All of these supporting structures will continue over the festive period.
4.4	Regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, including over weekends, and should involve key members of the multidisciplinary team, including social work. *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 early on the estimated date of discharge.*	☒	■ **Green**	As above

4.5	Predictive data will be used to assess the hourly demand for beds allowing for discharges to be scheduled to optimise flow. *Boards should consider evaluating the accuracy of EDD to help improve the discharge process.*	☒	■ Green	Bed states are updated routinely by the bed managers and circulated at key points during the day (0700, 1130, 1530 & 1930 hrs. More often if the situation dictates). These bed states include predicted emergency activity and discharges and look forward to the bed position at midnight. Work continues to improve the accuracy of this information
5	**Ensure that senior clinical decision making capacity is available for assessment, care planning, MDTs and discharge and that AHP rotas are structured, to facilitate the discharging of patients throughout weekends and the fortnight in which the two festive holiday periods occur in order to maximise capacity.**			
5.1	There is adequate medical cover across both, the festive holiday period, and over weekends to conduct assessments, plan effective care programmes and perform dedicated discharge rounds. *Nurse, or criteria-led discharges, should be put in place wherever possible.*	☒	■ Amber	Detailed in Winter Plan. Key points are: In Medicine on-call Consultant cover will be provided on the 25 December and 01 January bank holidays. Increased levels of Consultant cover will be available in the Hospital on the 26 December and 02 January bank holidays to provide senior decision making support prior to the weekend periods. In Surgery and Orthopaedics on-call Consultant cover will be provided on each of the public holidays and weekends. We are currently negotiating and increase on the second public holidays.
5.2	Key partners will be able to provide pharmacy, transport and social care services to support the discharge process.	☒	■ Green	Detailed in Winter Plan. Key points are: Social work (START) will be available on the second public holiday each week with an increased presence over the weekends.
6	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise**			

	intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge.			
6.1	There is close partnership working with local authorities and the third and independent sector to ensure that adequate care packages are in place in the community to meet predicted discharge levels. *This will be particularly important over the festive holiday periods.*	☒	**Amber**	Difficulties remain with homecare provision. Different models of care and support are being trialled to help improve the issue including: Commissioning a second Fast Reaction team to respond to facilitate discharge. Use of care home beds in flexible way to ensure a person does not have to remain in hospital Working closely with all providers Consideration is being given to purchasing blocks of hours in anticipation.
6.2	Ongoing and detailed engagement between local partners around the capacity of social care services to accommodate predicted discharge levels will start no later than October.	☒	**Green**	Engagement between the Partners is ongoing – there is an awareness around the difficulties that are being experienced in sourcing homecare and the plans in place to try and rectify this
6.3	The Board and their respective local authorities have put in place a joint escalation plan resolve issues that might arise. *Consideration should be given to developing local agreements on the direct purchase of homecare by ward staff.*	☒	**Green**	The NHS Borders Escalation Policy is cross system including Acute, Community, Mental Health and Social Work
6.4	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised, where possible. *Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*	☒	**Green**	Intermediate beds are in place and are flexed to support discharge and prevent admission. Work is ongoing with the managers of these care homes to ensure they can meet demand
6.5	Host NHS Boards and local authorities are taking the discharge requirements of patients who	☐		

	are receiving treatment at the Golden Jubilee National Hospital into account.			
6.6	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge.	☒	■ Green	The Key Information Summary (KIS) and anticipatory care plans are being accessed by the OOH service when available. Work is ongoing in P&CS on engaging with practices to fill in anticipatory care forms and also using the KIS – the population targeted is those in the 20% - 60% risk category. (This is part of the QOF. The numbers of people of will have these plans is small at present, however the target will be increasing year on year.
6.7	All plans for anticipatory care planning will be implemented, as outlined in LUCAPs in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances.	☒	■ Amber	To date all information in the anticipatory care forms is used by OOH staff. We are adapting access rights to ensure that OOH reception staff can see them so that information can be passed to GPs out in cars (NHS Borders does not have computers in the cars) – Position to be confirmed
7	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
7.1	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as soon as they occur, and that escalation procedures are invoked at the earliest opportunity.	☒	■ Green	Service pressures are communicated to Operational/Service Managers then to the BGH/P&CS General Manager and the Chief Operating Officer via the daily Sit Rep. The Escalation Policy includes triggers for system pressures and actions to take which includes communication requirements.

7.2	Demand, capacity, and activity plans across emergency and elective provision are fully integrated. *Collaboration between partners, including NHS 24, CHPs, Scottish Ambulance Service, 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.*	☒	Amber	The Winter Plan was developed with input from service areas across and outwith NHS Borders. Demand and Capacity has been considered and additional capacity identified to help meet the demands of unscheduled care whilst protecting elective care.
7.3	Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector. *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.*	☒	Green	As part of the winter planning process a daily service snapshot is produced outlining service availability across the festive period and contact details if required. This historically has been shared around the Health Board, however this year it will be circulated to partners
7.4	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *NHS 24 are leading on the 2014/15 'Be Ready for Winter' media campaign, and SG Health Workforce & Performance 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.* *On 21 October the SG will launch its Resilience Campaign, in partnership with the British Red Cross, and other organisations to highlight the risks and consequences of all kinds of severe weather and the simple practical ways people can reduce these risks. This year there will an enhanced emphasis on community resilience and messages will continue to be targeted at more vulnerable and harder to reach people in our communities.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.*	☒	Green	A detailed communications plan has been developed which includes the use of a number of mediums including radio, internet, social media plasma screens etc. The plan will relay the key winter messages as well as the 'know who to turn to' messages. Communications is also built into our severe weather plan so the public are kept well informed and advised during periods of service disruption

3	Out of Hours		RAG	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 around NHS24 providing pre-prioritised calls during the OOH period?*	☒	■ Green	The BECS rotas are worked out several weeks in advance and incorporate additional staffing for key dates over the festive period as well as dates where an increased call volume is predicted. Escalation of staffing issues takes place as earlier as possible to ensure there is adequate time to resolve the issues.
2	The plan clearly demonstrates how the Board will manage the predicted and unpredicted demand of triaged and untriaged calls from NHS 24, particularly on Saturdays and public holidays throughout the winter, and especially over the festive period.	☒	■ Green	Rotas have been adjusted and staffing levels increased for dates where a high workload is predicted (Identified through local knowledge and liaison with NHS 24). As a rule all NHS24 calls arrive triaged although if the service is quiet they may request that NHS 24 to send through untriaged calls.
3	There is evidence of innovation (or of innovation considered but rejected for stated reasons) around how the Board will deal with pressures on public holidays/Saturday mornings. *For example, does the plan mention arrangements for open access. Has the Board considered the possibility of GP surgery openings at any time?*	☒	■ Green	As a result of staffing issues the BECS service went through a process of redesign at the beginning of 2014. The service has reported improved response times since the change was made
4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs)? Are efforts being made to encourage greater use of special notes, where appropriate?*	☒	■ Green	The existing redirection process between BECS and ED continues to work effectively. All walk-in patients at Minor Injury Units are dealt with by PGDs following a strict criteria for nurse led care or for referral to BECS/ ED.
5	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	☒	■ Green	Pharmacists requiring GP advice can contact the service via the professional line.

6	Clear arrangements are in place to ensure that effective mental health services are in place such as enhanced mental health nurse provision to A&E especially at the festive period.	☒	Green	Existing service procedures will continue to be utilised if access to mental health services is required. This procedure applies on a daily basis and not only to the winter months.
7	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.*	☒	Green	Walk-in dental patients who are not a medical emergency are initially seen by the BECS GP. NHS24 are the first contact for all dental emergencies out of hours, weekends and public holidays. This applies to Borders registered patients and unregistered patients from the health board and independent dentists. Borders Emergency Dental Service will operate an emergency clinic over the weekend periods, based in Out Patients between 1300-1600hrs
8	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 Boards believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*	☒	Amber	Festive period cover is reasonably good; however there are a few key gaps still to fill for GPs, Reception and Drivers. Work is ongoing to resolve these: The following actions have been taken to support cover over the festive period: • suspension of annual leave requests during the festive season and • liaising with Salaried and Sessional GPs.

9	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 of PCECs etc.*	☒	Green	NHS Borders has a detailed communication plan which includes reference to out of hour's services, when they are available and how they should be contacted.
10	There is evidence of joint working with the SAS in preparing this plan, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☒	Amber	The overall winter plan has included specific liaison with the SAS re patient transport.
11	There is evidence of joint working with NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☒	Green	The BECS Team have provided NHS 24 with all required information and use the information provided by NHS 24 to inform staffing levels.
12	There is evidence of joint working with the acute sector and Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units, including covering the contact arrangements.*	☒	Green	BECS continues to support ED during busy periods and where clinically appropriate, this is an ongoing arrangement. BECS is available to MIUs for advice and support.
13	There is evidence of working with social work services 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.*	☒	Green	Normal service procedures continue to apply.
14	There is evidence of 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.*	☐	Red	TBC

4	Prepare for & Implement Norovirus Outbreak Control Measures		RAG	Further Action/Comments
1	Infection Prevention and Control Teams (IPCTs) have read the HPS Norovirus Outbreak Guidance 2014 to ensure that the Board is optimally prepared.	☒	Green	Complete
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 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 care homes.*	☒	Green	Community Infection Control Nurse has established links with care homes and provided advice and guidance.
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. *Staff should be reminded of the need to remain absent for 48 hours post last symptom of Diarrhoea and vomiting. Where staff are prevented from returning to work NHS Boards should refer to the guidance note issued in 2010 relating to staff absence and infection control.*	☒	Green	Policies and key messages for staff available on Infection Control microsite. Additional reminders and information circulated to staff at start and throughout Norovirus season including requirement and process for excluding symptomatic staff for 48 hours.
4	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.*	☒	Green	During 2013/14 Norovirus season, NHS Borders established high profile communications for patients, staff, visitors and the wider public with daily updates. This has already started in 2014/15
5	Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks.	☒	Green	Norovirus Preparedness Group is convened outwith Norovirus Season to review learning from recent outbreaks and progress actions to reduce the risks of future outbreaks
6	IPCTs will ensure that the Board is kept up to date regarding the national norovirus situation.	☒	Green	Weekly Norovirus surveillance circulated across NHS Borders

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. *The SG HAI team has contacted the HOAG to request that they liase with the SMVN to reach consensus around testing procedures for patients that have been in the vicinity of norovirus outbreaks.*	☒	■ **Green**	In 2014, HPS will alert Boards 1 month before the start of Norovirus season. After receiving that alert, the Infection Control Team will work with MAU and ED departments.
8	Arrangements are in place to provide IPCT 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 might wish to consider their local IPC arrangements.	☐	■ **Green**	The Infection Prevention and Control Team Control provide a full weekday/daytime service as well as Consultant Microbiologist cover 24/7 (accessed via the BGH switchboard) should advice and support be required during weekends, public holidays or out of hours.
9	The 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.*	☒	■ **Green**	The Infection Control Plan and The NHS Borders Escalation Plan will support the Board if/when occurrences like this arise. There are a number of additional inpatient (surge) beds identified within the plan which can be used to off-set the loss of inpatient capacity
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.	☒	■ **Green**	NHS Borders ICPT and ICT work very closely with the additional benefit of the Community Infection Control Nurse supporting care homes, schools and nurseries
11	The Board 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.	☒	■ **Green**	The Infection Control Plan includes a robust communications plan which has been developed to keep patients well informed of what to do prior to and during a norovirus outbreak.

5	Seasonal Flu, Staff Protection & Outbreak Resourcing		RAG	Further Action/Comments
1	At least 50% of all staff working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients, as recommended in the CMO Letter (2014)12 . *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. Uptake of vaccine in 2013/14 was still significantly below target, at 34.7% (compared to 33.5% in 2012/13).*	☐		The staff vaccination programme publicity commenced in September 2014 with the actual vaccination programme commencing on 1 October 2014. In addition to specific flu clinics that will be held and the Occupational Health Service going on-site to high risk wards and departments to immunise staff in-situ a more robust network of peer vaccinators has been introduced. The national target is 50% uptake, NHS Borders has set itself a stretch aim of vaccinating 60% of all staff in 2014/15 Previous uptake: 2012/13 – 42% 2013/14 – 38% 2014/15 – 40% Week 5
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2014)12 clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *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 senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake,*	☒	■ **Green**	The Occupational Health Service has met and agreed that senior charge nurses and charge nurses will work as flu champions to encourage and improve uptake. In addition to specific flu clinics that will be held and the Occupational Health Service going on-site to high risk wards and departments to immunise staff in-situ a more robust network of peer vaccinators has been introduced. Clinics have been arranged covering early, late and night shifts, at convenient locations throughout the Board area.

3	The winter component of our LUCAP 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, Health 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 Health 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)*	☒	**Amber**	Our LUCAP has no specific action related to flu related activity. The NHS Borders Escalation Policy provides detail of additional capacity available and actions to take if there is a surge in inpatient activity. As always the seasonal flu campaign will provide free vaccine for at risk groups i.e. over 65s, fewer than 65 with long term conditions and pregnant woman along with Health and Social Care staff and unpaid carers.
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.*	☒	**Green**	Public Health will alert NHS Borders management of any communicable disease outbreaks which may impact on service provision.
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 admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☒	**Amber**	The Winter Plan provides details of plans for increasing inpatient capacity over the winter period including the recruitment of additional staffing.

6	Respiratory Pathway		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.	☒	Amber	The COPD manual is displayed on the Respiratory Microsite advises of relevant pathways. This is currently out-of-date and with work on-going to up-date it.
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☒	Red	**TBC**
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).*	☒	Amber	Selected patients with respiratory diseases have agreed self management plans in place. This includes end of life planning and support where appropriate. This is not in place for all patients. Additionally, palliative plans are agreed for those patients where specialist involvement is required for pain and/or symptoms management is more complex.
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 intercurrent illness can reduce the risk of exacerbation and hospitalisation.*	☒	Green	Part of key winter messages
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).*	☒	■ **Green**	Our specialist respiratory nursing teams identify patients with known respiratory disease at the point of admission, and will ensure that patients are reviewed, and self management plans assessed and amended as appropriate. The specialist teams will also support wards with discharge planning and any patient education that may be required.
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.	☒	■ **Green**	Again Specialist Nursing teams are proactively identifying respiratory patients at the point of admission and ensuring that medications on admission and discharge are reviewed, with appropriate follow up arranged as required. All patients have access to specialist advise during the normal working week should they required a discussion in relation to any aspect of their management plan.
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, http://www.bi.nhsnss.scot.nhs.uk/ . This release estimates an individual's risk of emergency admission in the period 1st August 2014 to 31st July 2015.* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☒	Amber	The respiratory nursing team service are reviewing self management plans for those identified as 'at risk' of admission, or with a recent pattern of admission to ensure that additional support is available aimed at supporting patients at home, and highlighting to admission teams agreed plans for management where and as appropriate.
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. 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.*	☒ ☒ ☐	Amber	There is a national contract for the provision of home O2, and a locally agreed pathway that is now well established for the assessment and prescribing of home 02 support where clinically indicated. This is routinely available at all emergency and unscheduled care points of contact. Details of procedures for obtaining Oxygen support are detailed on the Respiratory Microsite
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.*	☒	■ Green	This is routinely available at all emergency and unscheduled care points of contact.

7	Management Information		RAG	Further Action/Comments
1	Admissions data will be input to the System Watch predictive modelling system as close to real time as possible.	☒	■ Green	Completed weekly by Planning & Performance Department
2	Effective reporting lines are in place to provide your Scottish Govt contact with routine weekly management information and any additional information that might be required on an exception / daily basis. In cases where 4 hour emergency access performance deviates significantly from agreed LUCAP trajectories, or where 12 hour waits occur, processes are in place to provide your Scottish Government contact with explanatory narrative outlining the reason for the deviation / wait and detailing any actions that have been taken to recover performance and ensure quality of care. This narrative should accompany the weekly performance data return. *Over the winter period we will be augmenting the weekly management information we currently collect on an all-year-round basis, and we will continue to share this information across NHSScotland to help Boards compare and benchmark performance. Detailed guidance on this year's reporting arrangements will be sent to Unscheduled Care Leads in October.*	☒ ☒	■ Green	There is an agreed process for submitting the routine weekly management information including details of any significant deviation from performance or where 12 hour breaches are reported. This is managed through Planning & Performance. Should any daily information be required e.g. service closures during periods of adverse weather this will be coordinated through a single point of contact.
	Where SAS or NHS 24 peformance is significantly below agreed performance standards, processes are in place to provide your Scottish Government Performance Management Team with explanatory narrative detailing any actions that have been taken to recover performance and maintain services. *Significant deviations from performance standards will be agreed with the SG Performance Mgt Team and additional information will be requested as and when required.*	☒	■ Green	Information will be provided as and when required and in the format advised by the Scottish Government

3	Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise. *Any exception reporting should be set within the context of planned / actual capacity and demand activity.*	☐	■ Green	Normal escalation processes will be followed up to the Chief Operating Officer predominately via the Daily Sit Rep. The Scottish Government will be advised should any significant pressures arise.

8	Sign Off		RAG	Further Action/Comments
1	The Chief Executive will discuss the winter plan at board meetings and personally sign off and publish the plan on the Boards website by the end of November at the latest.	☒	■ Green	The Board were updated on progress re Winter Planning on 06 November. The Chief Executive has since signed off the Winter Plan and it will be taken back to the Board for final comment on 04 December 2014.
2	A summary of the winter plan will be published on the Board website by the end of November.	☒	■ Amber	Will be done after Board meeting on 04 December.
3	Arrangements are in place to include governance of winter planning within local Unscheduled Care Management Groups or other relevant management groups as appropriate. *Membership of these groups should include Unscheduled Care Managers where applicable.*	☐		

9	Key Roles / Services Integrated into Planning Process		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	☐		
	CHP Managers	☐		
	OOH Service Managers	☐		
	GP's	☐		
	NHS 24	☐		
	SAS	☐		
	Territorial NHS Boards	☐		
	Independent Sector	☐		
	Local Authorities	☐		
	Integration Joint Board Interim Chief Officers (where appointed)	☐		
	Strategic Co-ordination Group	☐		
	Third Sector	☐		
	SG Health & Social Care Directorate	☐		