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	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather, EU Exit and Covid-19 resurgence. These arrangements have built on the lessons learned from previous events, and are regularly tested to ensure they remain relevant and fit for purpose. ☐ Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. ☐ *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The Preparing for Emergencies Guidance sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*			NHS Borders business continuity plans were signed off in March 2020 on a new web-based planning and management system. Services were requested to review and update these in the light of Covid-19. 90% of reviews are complete. The remainder are due for completion by mid-November 2020. The services were requested to take account of the lessons identified in the response to and recovery from Covid-19. 90% of reviews are complete. The remainder are due for completion by mid-November 2020. The Board's Major Incident plan is under review to take account of Covid-19 pathways, systems and Covid-19 resurgence service changes.
2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios, including Covid-19 reasonable worst case scenarios. ☐ Risk assessments take into account staff absences including those likely to be caused by a range of scenarios including seasonal flu and/or Covid-19 as outlined in section 5 and a business impact analysis so that essential staffing requirements are available to maintain key services. ☐ The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner. ☐			The business impact analyses (BIAs) for the BC plans undertake impact analysis on five criteria, assuming total catastrophic loss of service and unacceptable downtime is identified. The assessments include staff absence consequence with recovery strategies. Critical activity reports are prepared on the recovery time objectives for each service. Mapping of the business continuity system and the risk register is being undertaken in 2020 to ensure that risks are identified and monitored.

	The Health Board and HSC partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.			Mutual aid arrangements - NHS Borders works closely with other NHS Boards in the east region, Scottish Borders Council (SBC) and other partners on the resilience partnership in a mutual aid capacity as required in risk scenarios. This includes severe weather transport by SBC, other category 1 responders and the third sector.
3	The NHS Board and HSCPs have appropriate policies in place should winter risks arise. These cover: • what staff should do in the event of severe weather or other issues hindering access to work, and • how the appropriate travel and other advice will be communicated to staff and patients • how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*	☐		NHS Borders Severe Weather Plan and the HR Adverse Policy detail management and staff roles and responsibilities in the event of severe weather. These include travel advice sources and communication arrangements for staff and patients. A staff transport office is set up when the Severe Weather Plan and severe weather management group are invoked. Communications to staff are undertaken in advance of a severe weather event and daily during invocation of the plan.
4	The NHS Board's and HSCPs websites will be used to advise on changes to access arrangements during Covid-19, travel to appointments during severe weather and prospective cancellation of clinics.	☐		NHS Borders website and social media are employed to provide appropriate information to patients and the public in severe weather events.
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.	☐		NHS Borders and Scottish Borders Council has a capacity plan, along with the Local Resilience Partnership and funeral directors to ensure adequate mortuary capacity during the Covid-19 and winter period. Daily monitoring of mortuary

			RAG	
				capacity is undertaken by hospital and council officers.
7	The NHS Board and HSCPs have considered the additional impacts that a 'no deal' EU withdrawal on 1 January 2021 might have on service delivery across the winter period.	☐		NHS Borders EU-Exit group which reports to the Executive Team is assessing the impact of 'no deal' on service delivery and ensuring adequate contingency planning is in place, along with the Regional and Local Resilience Partnerships. This remains a risk and is therefore rated as amber due to a number of issues outwith of our control.

2	**Unscheduled / Elective Care Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity. *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		Clear operational management structures in place including acute site management. Fortnightly meetings include Acute Services and IJB colleagues. Weekly Whole System Winter Operations meetings being established for second year to review system flow measures and take corrective actions.

1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked.	☐		Safety brief, patient flow meetings and escalation plan
1.3	A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.* *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*	☐		Safety brief and patient flow meetings, disseminated to ward level and all other business units, separate ICU escalation plan also in place
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.*	☐		Clear escalation plan for Acute Services. We have step down facilities in place and we require further capacity. The Community plan is being further developed and will address this issue.
2	**Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID activity (both short and medium-term) based on forecast emergency and elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.*	☐		Daily bed requirements from October to March 2021 have been modelled and bed and community capacity have been projected against this to ensure sufficient capacity. COVID-19 capacity plan has been developed alongside this.

	Weekly projections for Covid demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity. *Plans in place for the delivery of safe and segregated COVID care at all times.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*			Weekly COVID-19 projections reviewed at Executive and Operations levels. Non-COVID-19 model is being added to this for single demand projections on a weekly basis. Plan in place for separate COVID-19 pathways beyond front door areas.
2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter / COVID surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work. *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution.* *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.* *Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical*	☐		See 2.1

	prioritisation and planning assumptions			

3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.**			
3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including 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.*	☐		Rosters and rotas in place 6 weeks in advance, management team work with nursing staff and medical staff to allocate festive holidays to ensure resilience in the system. Recruitment ongoing for a winter consultant and nursing staff but will not be concluded by 31st October. Management team have sight on core services to ensure these are covered. Staff resourcing and recruitment for winter plan is in place and annual leave plans are in place for social work and social care. There is senior management on-call rota for every day including the festive and new year period. Multi-disciplinary locality teams will meet according to the RAG rating for services and public health pressures/ delayed discharges. An operational and senior management governance has been established around delayed discharges to ensure pro-active approach.

				Trusted Assessment Scheme is enabled to ensure that AHP can facility discharge to assess more effectively to assist patient flow as identified. Resilience plans have been requested from Care Homes and Care at Home service providers with daily/weekly reporting to quickly respond to COVID19 related outbreaks. System wide reporting is in place to allow the social work service to flex according to the unplanned absences that impact social work and social care services. This reporting is shared across HSCP to enable senior management to take quicker demand/ resource/response decisions.
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.	☐		Follows on work above Social Work and Social Care have staff rota's in place for the festive period and beyond. SBC have allowed untaken annual leave to be increased from 5 days to 10 days to flatten demand for annual leave at year end.
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*	☐		Discussions have been held with SAS and our own BGH Transport Hub relating to winter and the festive period. Cover is agreed and will be implemented for BGH Transport and requests for cover on the Mon PHs over festive period to have

	any change in service provision from partner organisations			Patient Transport however, SAS cannot commit to this as it requires staff volunteering to come in as PHs are not part of their contract. Extra provision will be provided by BGH transport Hub to try to provide as much service as possible. The Third Sector are represented on the Winter Planning Board and opportunities are being explored to ensure support during peak periods.
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.*	☐		In place A Winter Communications and Engagement Strategy has been developed containing our objectives and key messages."- **Be aware of GP surgery and pharmacy closures on public holidays and plan ahead to ensure you have adequate stocks of prescribed medication** **Be prepared for winter** **Seek the right treatment at the right place from the experts in the community** **Only attend the Emergency Department in an emergency** These messages to the public will be reinforced consequent to the development of the Borders Urgent Care Centre and the introduction of a flow navigation process that will introduce the scheduling of patients currently seen in the Emergency Department. This new service is part of a local Reshaping Urgent Care Project and an internal communications plan will support the

		launch of the new service. NHS Borders will raise awareness of public holiday dates and inform all stakeholders and the public of service cover in place throughout this period.

Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of healthcare associated infection and crowded Emergency Departments.

Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.

To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate. Referrals to the flow centre will come from: • NHS 24 • GPs and Primary and community care • SAS • A range of other community healthcare professionals. If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide visable appointments / timeslots at A&E services.	☐	Plans are being developed to implement this service by the date now specified 1st Dec, we are working to recruit the senior decision maker for the flow navigation centre, progressing IM&T infrastructure Funding allocation does not meet requested amount.

	The impact on health-inequalties and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.			
	Professional to professional advice and onward referral services should be optimised where required Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission.	☐		In place
4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge to shift the discharge curve to the left and ensure same rates of discharge over the weekend and public holiday as weekday.**			
4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☐		

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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.*	☐	🟧	Ongoing work regarding supporting teams for morning discharges, daily dynamic discharge refresh but there is still work to be done to fulfil. Weekend capacity will be enhanced to support discharge. We have arrangements for care homes to admit 7 days a week and we can do care packages 7 days a week.
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*	☐	🟩	The Discharge lounge will be open in line with modelled demand; discharges will be direct from the wards when closed. Site Assistants will be on duty at weekends to facilitate moves throughout the Site. They work under the Direction of the Site Manage to prioritise patient flow. The discharge Lounge will be open on Monday 28th December, Friday 1st Jan and Monday 4th Jan, public holidays.
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	☐	🟧	BGH Pharmacy have maintained a 7 day service and extended staff working hours Mon-Fri since March. We will aim to sustain this over the winter period. A number of pharmacist posts have been out to advert over the summer without successful recruitment. We have managed to recruit some

				technical resource.
	There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes			Pharmacy will prioritise dispensary services, vaccine services, chemotherapy production and ward stock management (where applicable) – but this is likely to mean a reduced presence on wards. BGH Pharmacy is dependent on clear communication from wards on destination for discharge for patients in order to minimise any delays to discharge. The demand for weekend pharmacy services is dependent on what other weekend services are in place (e.g. additional ward rounds; social care etc) – we therefore need organisational direction on this to determine our capacity requirements Discussions have been held with SAS and our own BGH Transport Hub relating to winter and the festive period. Cover is agreed and will be implemented for BGH Transport and requests for cover on the Mon PHs over festive period to have Patient Transport however, SAS cannot commit to this as it requires staff volunteering to come in as PHs are not part of their contract. Extra provision will be provided by BGH transport Hub to try to provide as much service as possible. Social care capacity will be in place at weekends.
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.*	☐		Recruitment in place for reablement teams. Additional post in Rapid Response Team is being appointed. Capacity Modelling is being led by NHS awaiting information this would need additional resource if capacity above current levels is indicated.
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*	☐		In place
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.*	☐		Whilst no formal process in place OOH and GPs do use SPARRA- this will be explored on a more formal basis but not completed this winter. All care home residents have an Anticipatory Care Plan in place. An education and supportive programme is in place to further develop COVID ACP for all residents. The current GP Local Enhanced Service includes the completion of ACP for all care home residents and the Pharmacy Enhanced Service also supports regular polypharmacy review of ACP. As part of the supportive improvement programme for care

				homes development is underway to identify methods of sharing care home paper based ACP with Community Nursing and GP records.
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.*	☐		General Practice and Out of Hours Care currently utilise the KIS and ACP. A recent review has highlighted improvement measures to further utilise the KIS as part of the work underway within the Older Peoples Pathway and assessment and referral to Community Discharge Pathways such as Discharge to Assess, Intermediate Bed Based Care, step down beds, community hospitals and care homes. See above for care home residents. It has been identified that very few clients in Homecare have ACPs' and this is something we want to progress through district nurses and GPs.
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.			NHS Borders is reliant on the implementation of a regional hub in NHS Lothian.
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.*	☐		Communication processes with key partners for both planning and operations are well established

	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.* *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*	☐		Winter Communication Plan in draft and due for finalisation within next month

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?*	☐		Long standing escalation process in place.
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.	☐		Staffing sought to provide additional cover during expected periods of high demand.
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.	☐		GP Sessional rates increased on key dates to minimise risks in respect of shifts not being filled and ANPs scheduled to provide additional resilience.
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?*	☐		ED and OOH work closely in sometimes providing cross cover and/or patient redirection and the clinical administration supporting this practice is being strengthened consequent of the work around reshaping urgent care.
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.	☐		This is a normal operational requirement and will be further developed as part of the new patient flow navigation system within the redesign of urgent care project.
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	☐		In place.
7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly	☐		In place.

	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.*	☐		This is part of the Dental Winter Plan.
9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*	☐		The plan assumes staff availability, however as is the case throughout Scotland GP OOH cover remains a challenge. The Board is actively considering options in respect of how this risk can be minimised ways of
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.*	☐		Annual arrangements apply. This year there will be additional guidance around scheduling of unscheduled care in respect of which national guidance is sought. Board reps engaging in the national discussions.
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.	☐		In Place
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.*	☐		NHS Borders fully engaged in discussions around reshaping urgent care i.e. scheduling unscheduled care.

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.*	☐		NHSB has a single system winter planning process. The local Reshaping Urgent Care Project membership involves representation for across the system.
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☐		NHS Borders Winter Planning Process refers.
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.*	☐		Completed pre-covid and now being updated

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.*	☐		Staff can access national infection control guidelines through NHS Borders intranet and the daily hospital safety brief is also used to remind staff of key messages. Compliance with infection control guidelines is monitored on a monthly basis in all wards.
2	Infection Prevention and Control Teams (IPCTs) will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which nursing and care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*	☐		The Infection Prevention and Control Team (IPCT) is represented on the Care Home Oversight Operational Group which meets three times a week. The IPCT is resourced to provide advice and support to care homes.
3	PHS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards and that frontline staff are aware of their responsibilities with regards prevention of infection.	☐		There is a direct link from NHS Borders intranet home page to the infection control micro site which contains key messages and guidelines.
4	NHS Board communications regarding bed pressures, ward closures, etc are optimal and everyone will be kept up to date in real time. *Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☐		The Communications Team are always invited to attend Problem Assessment Group (PAG) and Outbreak/Incident meetings and communications is a standing agenda item for these groups.

5	Debriefs will be provided following individual outbreaks or at the end of season to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☐		An outbreak report including learning is written at the end of each Norovirus season and progressed through the NHS Borders governance structure.
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.	☐		Links to the national Norovirus activity data will start to be included in the regular infection control reports from November 2020.
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 IPCT are available and visible to frontline staff throughout the year and routinely attend the daily Hospital Safety Huddle. Advice is regularly sought from the IPCT to support clinical prioritisation of the limited single rooms that are available as well as control measures to implement when it is not possible to isolate individual patients.
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.*	☐		IPCT cover is available 24/7 through the Consultant Microbiologist rota. IPCT annual leave has also been managed to provide on-site cover with the exception of 25th and 26th Dec and 1st and 2nd Jan.
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.*	☐		NHS Borders has a clear surge plan for increasing system capacity in response to pressures.
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.*	☐		The IPCT and HPT have frequent liaison to facilitate clear communication and updates and avoid overlap/duplication.

| 11 | The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus. | ☐ | | Messaging relating to Norovirus is included in the Winter Communications Strategy. |
| 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. | ☐ | | The Communications Team are always invited to attend Problem Assessment Group (PAG) and Outbreak/Incident meetings and communications is a standing agenda item for these groups. Suspension of routine visiting with associated communications is considered during these meetings. |

5	Covid-19, Seasonal Flu, Staff Protection & Outbreak Resourcing *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	Staff, particularly those working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients and other staff, as recommended in the CMO's seasonal flu vaccination letter published on 07 Aug 20 https://www.sehd.scot.nhs.uk/cmo/CMO(2020)19.pdf *This will be evidenced through end of season vaccine uptake submitted to PHS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.*	☐		Robust staff vaccination plan in place- 51% uptake as at 28/10/20
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake. Vaccine uptake will be monitored weekly by performance & delivery division.*	☐		Plans in place with extensive use of peer vaccination
3	Workforce in place to deliver expanded programme and cope with higher demand, including staff to deliver vaccines, and resource phone lines and booking appointment systems.			In place

4	Delivery model(s) in place which: • Has capacity and capability to deal with increased demand for the seasonal flu vaccine generated by the expansion of eligibility as well as public awareness being increased around infectious disease as a result of the Covid-19 pandemic. • Is Covid-safe, preventing the spread of Covid-19 as far as possible with social distancing and hygiene measures. • Have been assessed in terms of equality and accessibility impacts *There should be a detailed communications plan for engaging with patients, both in terms of call and recall and communicating if there are any changes to the delivery plan.*			In place for flu vaccination Work ongoing for COVID-19 workforce model
5	The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)*	☐		Flu activity anticipated as part of winter capacity plans. Vaccination programme underway with target delivery higher than previous year.
6	PHS weekly updates, showing the current epidemiological picture on Covid-19 and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *PHS and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.*	☐		We are currently building our winter Early Warning scorecard. This will include tracking on influenza rates and norovirus rates from the syndromic surveillance section of Systemwatch as well as other PHS data and reporting. The scorecard will include triggers for response, which feed into clinical services risk status action plans and will be reviewed at least bi-weekly alongside Covid early warning reporting.

| 7 | NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows:

• Adults aged over 65
• Those under 65 at risk
• Healthcare workers
• Unpaid and young carers
• Pregnant women (no additional risk factors)
• Pregnant women (additional risk factors)
• Children aged 2-5
• Primary School aged children
• Frontline social care workers
• 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household
• Eligible shielding households

The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This will include regular reporting that will commence from the end of week commencing 12th October. We will adopt a the Public Health Scotland model, which is a pre-existing manual return mechanism that has been used in previous seasons with NHS Boards to collate Flu vaccine uptake data when vaccination is out with GP practices. | ☐ | | Being finalised

Risk associated with the availability of vaccine |

8	Adequate resources are in place to manage potential outbreaks of Covid-19 and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☐		Plans are established to manage and mitigate the impact of COVID-19, Flu and Norovirus outbreaks. The Winter Transport plan is under review and there will (as usual) be a robust Festive Weekend plan for both weekends.
9	Tested appointment booking system in place which has capacity and capability to deal with increased demand generated by the expansion of eligibility and increased demand expected due to public awareness around infectious disease as a result of the Covid-19 pandemic.			In place from a board point of view limiting factor would be availability of actual vaccine
10	NHS Boards must ensure that all staff have access to and are adhering to the national COVID-19 IPC and PPE guidance and have received up to date training in the use of appropriate PPE for the safe management of patients. Aerosol Generating Procedures (AGPs) In addition to this above, Boards must ensure that staff working in areas where Aerosol Generating Procedures (AGPs) are likely to be undertaken - such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) - are fully aware of all IPC policies and guidance relating to AGPs; are FFP3 fit-tested; are trained in the use of this PPE for the safe management of suspected Covid-19 and flu cases; and that this training is up-to-date. **Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's *'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013).***	☐		Staff have been provided with COVID-19 IPC guidance including PPE use along with practical training. The guidance and training covers AGPs and non-AGP activity.

	https://www.hse.gov.uk/pUbns/priced/hsg53.pdf			
11	NHS Boards must ensure that the additional IPC measures set out in the CNO letter on 29 June staff have been implemented. This includes but is not limited to: • Adherence to the updated extended of use of face mask guidance issued on 18 September and available here. • Testing during an incident or outbreak investigation at ward level when unexpected cases are identified (see point 9). • Routine weekly testing of certain groups of healthcare workers in line with national healthcare worker testing guidance available here (see point 9). • Testing on admission of patients aged 70 and over. Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster. • Implementation of COVID-19 pathways (high, medium and low risk) in line with national IPC guidance. • Additional cleaning of areas of high volume of patients or areas that are frequently touched. • Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September. • Consideration given to staff movement and rostering to minimise staff to staff transmission and staff to patient transmission. • Management and testing of the built environment (e.g. water systems) that have had reduced activity or no activity since service reduction / lockdown – in line with extant guidance.	☐		NHS Borders has fully implemented and is compliant with all of these bullet points with the exception of the following:- Additional cleaning of areas of high volume of patients or areas that are frequently touched. This is in place in our hospitals and some primary care facilities. Recruitment is progressing to increase capacity in locations where this is not currently achieved. Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September. Physical distancing and public signage is incorporated into NHS Borders remobilisation processes. However, it has not been possible to implement improvements to the physical distancing within inpatient areas due to constraints of our premises. In accordance with the CNO letter of 22 September, this has been risk assessed.

12	Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf In addition to this, key healthcare workers in the following specialities should be tested on a weekly basis: oncology and haemato-oncology in wards and day patient areas including radiotherapy; staff in wards caring for people over 65 years of age where the length of stay for the area is over three months; and wards within mental health services where the anticipated length of stay is also over three months. *Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-covid-19-healthcare-worker-testing/*	☐		NHS Borders complies with national guidance in relation to staff screening in relation to incidents and outbreaks and also weekly screening of key health workers.
13	The PHS COVID-19 checklist must be used in the event of a COVID-19 incident or outbreak in a healthcare setting. The checklist is available here: https://www.hps.scot.nhs.uk/web-resources-container/covid-19-outbreak-checklist/ The checklist can be used within a COVID ward or when there is an individual case or multiple cases in non-COVID wards.	☐		NHS Borders uses the PHS guidance and checklist.

| 14 | Ensure continued support for routine weekly Care home staff testing This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results. | ☐ | | Work is progressing to facilitate a smooth transition of care home staff testing from NHS Lighthouse to NHS Lothian via NHS Borders. |

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.	☐	(green)	Algorithm available in respiratory section of intranet for advice/pathway re exacerbations. National guidelines followed. A/E protocol also available Pathway implemented by SAS – for patients having an exacerbation of COPD.
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☐	(red)	Service is a Monday to Friday service, this is a development we want to progress but unlikely to be in place this winter
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)	COPD patients have self management plan, (rescue medication will be suggested as appropriate).Asthmatics have Personal asthma action plan (PAAP) both inclusive of relevant contact numbers for emergency care/support and advice. EKIS (key information summary) under ECS on intranet includes resuscitation status, anticipatory care plan information (updated regularly in primary care). Anticipatory care planning and RESPECT forms currently in use across all services. Advice can be sought by telephone to RSN service or via Respiratory inbox.

					Inhaler advice/technique and prescribing support also available on intranet.
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.*	☐			Local and national guidance/press releases (inclusive of general health advice/vaccination requirements). National charities – CHSS and BLF literature and advice. Current initiative being investigated is CHSS offer "chesty voices" training for COPD patients to keep well/improve quality of life. Current Covid guidance available on national news/social media.
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*	☐			All Respiratory patients referred to RSN team will be assessed, a plan initiated and evaluated with discharge plan documented. Assessment will include medication review/inhaler technique/changes to treatment as appropriate, and compliance/concordance.

	review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).			Education and advice/self management. Referral to local support group (if appropriate), referral for pulmonary rehabilitation (currently virtual or on 1-1 basis due to Covid risks). Smoking cessation if required. Appropriate follow up arrangements agreed and documented. 0xygen assessment (if required). All discharge planning supported by use of COPD discharge bundle**.**
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.	☐		If reviewed by RSN team follow up arrangements will be documented in notes as part of discharge plan, immediate discharge letter will confirm re follow up arrangements.
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.*	☐		The respiratory team inputs information in to anticipatory care plans/update as circumstances change via liaison with primary care/palliative care colleagues. The Respiratory Specialist nurses have undertaken training on completing the RESPECT documentation in collaboration with our Respiratory patients. The Respiratory team are aware of patients who have frequent admissions and those on Long term oxygen therapy at home, and offer additional ongoing support for this group of patients through home visits/telephone

				support/clinic review.
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.*	☐ ☐ ☐ ☐		Oxygen therapy is currently prescribed in NHS Borders by the Respiratory team; the current supplier of all 02 equipment is Dolby Vivisol. The current method of requesting is electronic prescriptions (SHOOF). Currently we have 02 concentrators available in all community hospitals – under ongoing review/process in place to increase numbers as winter/pandemic dictates. We have 3 portable 02 concentrators, 1 each held by the Respiratory nurses/palliative care and lung cancer nurses. We also currently hold a "pandemic" stock of 18 x 02 concentrators – (supplied by Dolby Vivisol) Referrals are made via sci-store, Respiratory inbox, or by direct contact with respiratory team.

				02 prescribing guidance available for both emergency and long term use on the intranet, 02 flow charts also available in all medical wards. National guidelines also available via BTS website. Palliative care guidance available on intranet – 02 section.
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.*	☐		All emergency care points will have access to pulse oximetry, All RSN nurse have an oximeter (for use on domiciliary visits). RSN team have data base detailing patients found to be "02 sensitive", alerts are in place via, GP/ EMIS &Scottish Ambulance Service, OOH, Documented as alert in medical notes and on TRAK. Patients are issues with COPD alert cards x2 and appropriate 02 mask/cannulae.

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