APPENDIX 2

Health & Social Care
Winter 23/24 Preparedness Checklist

The Winter Preparedness Checklist sets out key areas of resilience preparedness to provide both local systems and Scottish Government with an understanding of the level readiness of winter plans.

If there are any areas within this checklist that have not been considered, it remains the responsibility of the respective Board /HSCP to develop an action plan to ensure that appropriate action is taken to improve resilience.

As a further line of defence, local systems may wish to engage internal audit in the review of this checklist.

Return due: 22-Sep-23

NHS Scotland Chief Operating Officer
Director for Social Care Resilience and Improvement

6th September 2023

Dear Colleagues,

WINTER PREPAREDNESS CHECKLIST

Ahead of our Winter Plan for health and social care in Scotland, we are taking a *state of readiness* check across systems, Health Boards, and Health and Social Care Partnerships for service resilience, similar to the approach we have taken in previous years.

The **Winter Preparedness Checklist** (this document) sets out key areas against which we asked you to provide an assessment of preparedness for your local systems.

We are taking a further step this year in that preparedness view through a whole-system approach. We have reflected a number of health and social care assurance statements throughout the document, albeit there are health-specific sections as per previous years. We will continue to develop this approach each year.

For 2023/24, we are asking that this checklist is **completed as a collaboration** between Health Board and associated Partnerships.

For Health Boards, we will seek to align follow-up of the checklist responses with the quarterly ADP reviews (covering Q1 and Q2) to avoid duplication where possible. This will be further supported by regular meetings between Directors of Planning and the Health Planning Team.

Boards will receive funding letters this week for unscheduled care, which should be targeted towards improvement measures that support delivery of the Four Hour Target. This includes measures which will support winter resilience and implementation of the actions outlined in the checklist.

For partnerships, we are aware that this ask comes alongside other returns such as the quarterly Whole System Discharge Planning Self-Assessment Tool that will be issued this week. In

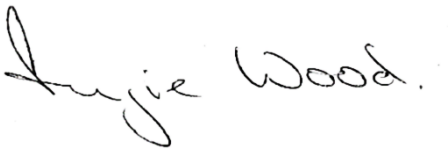
recognition of this we have extended the return date of the self-assessment to 6th October. We also want to offer reassurance that these returns will be considered holistically and not in isolation.

If there are any areas within this checklist that have not been fully considered, it would be expected that Boards and local systems develop an action plan to ensure that appropriate action is taken to maintain and improve resilience.

We request all areas return the completed checklist **by 22-Sep-23,** for review and engagement with you, as appropriate, over the course of October.

If you have any questions, please contact the Health Planning team at healthplanning@gov.scot

Yours sincerely



John Burns
NHS Scotland Chief Operating Officer

Angie Wood
Director for Social Care Resilience and Improvement

The Winter 23/24 Resilience Priorities

The winter resilience priorities are consistent with last year: key system resilience areas for supporting patients, citizens and staff through seasonal increase in demand. The delivery and implementation is year-round improvement and development to support ongoing resilience and capacity across the systems, alongside targeted prevention and early-intervention work.

1. **Where clinically appropriate, ensure people receive care at home, or as close to home as possible.**
2. **Through clear and consistent messaging, we will have a strong focus on prevention and give people the information and support they need to better manage their own health and care, and that of their families.**
3. **Support delivery of health and social care services that are safe and sustainable.**
4. **Maximising capacity and support wellbeing of our workforce to meet demand.**
5. **Protect planned care with a focus on continuing to reduce long waits.**
6. **Prioritise care for the most vulnerable in our communities.**
7. **Work in partnership to deliver this Plan.**

Completing the Self-Assessment Winter Checklist

There are four sections to the self-assessment checklist:

1. **Overview of Preparedness & Business Continuity**
2. **Urgent & Unscheduled Health and Social Care, Planned Care**
3. **Primary Care, Mental Health and Social Care**
4. **Health and Social Care Workforce and Staff Wellbeing**

Whole System Response

As outlined at the recent Winter Summit, the approach we are taking is to strengthen our whole-system planning. Please complete the checklist as a joint response between Board and Partnerships. It is appreciated that for some areas this requires increased logistics; please be in touch with the team if this is not possible. Where necessary, supplementary information can be provided that outlines your Board/Partnership position.

Financial Note

Boards have submitted financial plans for 2023-24 and this would have included costs over the winter period. All areas in this document are assumed to be included already in plans and no further funding is anticipated, unless otherwise stated.

As noted above, Boards will shortly receive funding letters for unscheduled care which should be targeted towards improvement measures that support delivery of the Four Hour Target. This includes measures which will support winter resilience and implementation of the actions outlined in the checklist.

Checklist statements

For each assurance statement, please provide a current state level of readiness alongside a short statement on the rationale for that classification. The statement should be high-level and concise. Statements which are showing as ‘Yes’ (or green in the Excel format) will be assumed to require no further action. Areas showing as ‘Partial’ or ‘No’ may require a follow-up discussion to gain greater understanding of the classification and any mitigations that can be put in place.

Current level classification

There are four possible responses; this provides a high-level status for the readiness statement.

Classification	***Definition***
Yes	The statement is true for your Board / Partnership
Partial	The statement is mostly true for your Board Partnership; minor issues still to be resolved but it is estimated that this area will be ready ahead of winter
No	This statement is not true for your Board / Partnership; major issues still to be resolved and it is estimated with current plans this area will not be ready for winter
n/a	This statement is not applicable for your Board / Partnership

Example

The table below provides an example of classification with associated response statement.

1.1 There are sufficient mechanisms in place to support the collaboration and co-operation with other Boards and Partnerships in the delivery of health and care.	
Yes	*Our health board and HSCP has regular meetings with a joint winter plan.*
Partial	*Our health board is part of our regional winter readiness group which is working across our partnerships; it has not met yet to agree plans yet.*
No	*Our health board and HSCP has not yet met to discuss winter and we have no meeting scheduled.*
n/a	*Our health board does not have formal partnership agreements.*

Deadline and return of form

Please return the completed checklist by 22-Sep-23.

We have provided an Microsoft Excel version of the return responses to support completion of the checklist; this has dropdown boxes and summary dashboard. **Excel is the preferred return format.** However, if you would prefer a Word version, please contact the team.

The Excel has a “Submit Return” button which will automatically generate an email to return. To manually send the return, please send to healthplanning@gov.scot

Section 1: Overview of Preparedness & Business Continuity

* Indicates additional information provided.

Subsection	#	Readiness Statement
Overarching principles	1.1	There are sufficient mechanisms in place to support the collaboration and co-operation with other Boards and Partnerships in the delivery of health and care.
	1.2	Plans have been developed through joint working between the Board, associated HSCPs, and other key partners (i.e. Primary Care practitioners, SAS, Scottish Prison Service, care at home and care home providers etc.). It is clear to all parties how plans will be delivered through joint mechanisms.
	1.3*	Winter Planning includes demand, capacity, and activity plans across all health and care delivery (including urgent, unscheduled, social care and planned care provision).
	1.4	Planning for winter reflects identification of surge capacity to ensure capacity is made across the health and care system to allow new emergency admissions to be accommodated.
Resilience preparedness	1.5	***Business Continuity Management*** arrangements are in place and regularly reviewed, exercised, and updated. These are in accordance with Civil Contingencies Act 2004 for Category 1 and 2 organisations and other guidance including: • NHS Scotland Standards for Organisational Resilience 2018. • Preparing For Emergencies: Guidance for Health Boards in Scotland.
	1.6*	Plans have identified potential disruptive risks to service delivery and associated mitigation responses. These incorporate lessons identified from Winter 2022/23 in addition to concurrent risks. Resilience Teams are involved in winter preparedness to ensure that business continuity management principles are embedded as part of year-round capacity and service continuity planning.
	1.7*	Business Continuity plans take into account critical activities across the NHS Board / HSCPs spectrum of activity and include analysis of the risks of disruption and their actual effects and demonstrate that planning has been based upon the likelihood and impact of worst-case scenarios.
	1.8*	Business continuity plans include response(s) if a clinical system outage occurs and the steps required to ensure continuity of services.
Communications	1.9*	***Local communication plans:*** A review has been undertaken of communication channels to ensure that key messages about winter planning are clearly and consistently delivered to all parties, involved. This includes : a) Key partner communication protocols b) OOH information including four day festive period c) Surgery hours & access arrangements General practices contingency plans for respiratory disease outbreaks d) Signposting to Scottish Government assistance for households struggling to meet their energy bills.
Step up / Step down care	1.10*	Boards and HSCPs can evidence plans to increase the provision of intermediate care to impact positively on patients and services over the winter; and work towards building sustainability for the future.

Section 2: Urgent & Unscheduled Health and Social Care, Planned Care

* Indicates additional information provided.

Subsection	#	Readiness Statement
Urgent and Unscheduled Care	2.1*	To ensure Right Care is provided in the Right Place, a 24/7 Health Board Flow Navigation Centre is in place to offer rapid access to a senior clinical decision maker as well as the option of appointments via Near Me.
	2.2*	Effective communication protocols are in place to support whole-system situational awareness of emerging pressures. Monitoring of key indicators across the system forms the basis of huddle discussions. This 'early warning system' should highlight areas of concern and drive action to maintain or regain a balanced system.
	2.3*	Robust communication processes are in place across each hospital site, following Discharge Without Delay (DWD principles) including morning hospital-safety huddles, focusing on the day's activity and current status, and afternoon huddles, setting Planned Date of Discharge and using this to predict capacity and demand for the next day.
	2.4	Emergency Physician in Charge (EPIC), Flow Co-Ordinator roles are in place where possible to provide dedicated leadership in Emergency Departments. A Discharge Co-ordinator is in place in each ED to act as a single point of contact (SPOC) to arrange rapid discharge from ED and take responsibility for co-ordinating community support.
	2.5*	Pathways are in place which provide care closer to home through pathways such as Hospital at Home for Older People; Respiratory Rapid Response and Out-patient Parental Antibiotic Therapy (OPAT); and supported by appropriate digital interventions such as Remote Consultation by phone and Near Me and Remote Monitoring, call before convey with SAS and flow navigation hub working to maximise virtual/remote Monitoring.
	2.6	Boards and Partnerships have effective organisation of care across between primary and secondary care so that patients receive high-quality care and the best use is made of clinical time and resources in both settings. This could be through a mechanism such as an Interface Group.
	2.7*	Escalation procedures are directly linked to a plan which encompasses the full use of step-down community facilities.
	2.8	Boards and HSCPs have additional festive arrangements, over the four-day public holiday, planned in collaboration with partner organisations such as Local authorities, Police Scotland, SAS and the local Voluntary Sector and in line with recommendations from the Four Day Public Holiday Review.
	2.9	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.
	2.10*	Processes are in place to enable patients with respiratory conditions and those who are frail are given the opportunity to have an anticipatory or future care plan. There should be a system in place for identifying these individuals and it should be clear which professional clinical groups will take a lead on having these care planning conversations depending on the persons circumstances.
	2.11*	Pathways are in place for patients who are identified as 'frail' and those with respiratory or cardiac exacerbations, and these are embedded within primary care services, in and out of hours, as alternatives to admissions.
	2.12*	People living with a respiratory condition have access to a respiratory team 7 days a week, should they become unable to self-manage their condition from home. People with heart failure and those who are living with frailty should be given the opportunity to have an anticipatory or future care plan.

	2.13	Care Homes will be supported with timely access to professional support and clinical advice to enable admission prevention and more planned interventions to keep residents safe in their own home. This includes proactive contact on at least a weekly basis to discuss any residents the care home staff are concerned about and agree a plan of care and interventions if these should be required. Remote consultations via phone or Near Me video consultation should be available.
	2.14*	For Health Boards with Major Trauma Centres (Grampian, GGC, Lothian, Tayside), to incorporate into their winter surge plans, assurance of sufficient safe staffing on MTCs (both adult and paediatric) to ensure Scottish Trauma Network MTCs will continue to deliver high quality, integrated, multi-speciality care to severely injured patients. Further consideration is also required for those Boards with Major Trauma Units to similarly support safe staffing.
	2.15	Where admission is necessary, ensure there is a mechanism and/or agreements in place with primary care and secondary care clinicians to minimise delays in pathway, and avoid multiple discussions that can lead to delays; recognising that in periods of increased demand, general practice may not have the functional capacity to follow the usual processes such as pathways for admission.
Planned Care	2.16*	Plans are in place to maintain activity over winter for planned care, including outpatients and inpatient / daycase, diagnostics, imaging and cancer, with plans considering the impact of increased unscheduled admissions on planned care activity. Planned care activity will not be paused or cancelled routinely – **if Health Boards need to consider this as part of their business continuity / escalation plans it needs to be discussed and agreed in advance with Scottish Government.**
	2.17	Health Boards are considering opportunities to maximise capacity through Pooled Lists - locally for high volume specialties and pooled lists regionally / nationally for those patients waiting the longest.
	2.18	Health Boards are making use of the National Elective Coordination Unit (NECU) to support admin and clinical validation.
	2.19	For those Health Boards with National Treatment Centres (NTCs), plans are in place to enhance and maximise use of the NTCs through winter and beyond.
	2.20*	***Discharge*** – close partnership working is in place, including the third and independent sector, to ensure that adequate care packages are in place in the community to meet all discharge levels.
Digital assets	2.21	Plans are in place to support the availability of Near Me video consultations to optimise estate and workforce capacity.

Section 3: Primary Care, Mental Health and Social Care

* Indicates additional information provided.

Primary Care: Primary Care Independent Contractors (including General Practice, Dentistry, Optometry and Pharmacy and including Health Board provided Primary Care Services e.g. 2C practices and Health Board employed MDT).

Subsection	#	Readiness Statement
Primary Care	3.1*	Plans are in place to support General Practice (and where necessary other independent contractors) to manage provision of core General Medical Services (and sustainability more widely) over the winter period. Specific reference should be made to contingency arrangements where practices are unable to open (or provide General Medical Services) due to staffing or other reasons. Health Boards and HSCPs should ensure that where services are

		reduced or unavailable they support the practice with communications to patients including alternative arrangements.
	3.2*	**Maximising Multi-Disciplinary Teams (MDTs)** Plans explicitly reference the use of MDTs within OOH services; indicate where increased use of MDTs are in place. This includes increasing capacity of senior clinical and non- clinical leadership, use of multidisciplinary teams and availability of professional-to-professional advice across acute and community.
	3.3	**Executive level overview and oversight for Out of Hours (OOH)** A Primary Care OOH winter plan has been signed off at Executive level, with clear escalation processes in place. There is Board Executive level oversight of OOH to support resilience, explore other operational solutions and agree appropriate escalation plans during the winter period given its essential role as a "front door" service
	3.4*	**Link with wider winter plans and engagement with SAS and NHS 24 to improve system resilience.** The plan puts Primary Care OOH within the context of winter readiness preparedness, as part of the urgent/unscheduled care landscape and whole system local planning, including community and social care responses through urgent care resource hubs/flow navigation centres (FNCs), or equivalent.
	3.5	NHS Board Directors of Dentistry engage with NHS 24 to ensure they have sufficient capacity in place to meet any potential increased demand for out of hours care during the winter period
	3.6	**Provision of OOH dental services** Plans reference provision of dental services; 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.
	3.7	**Working with mental health services** HSCPs should have clear arrangements in place to enable access to mental health crisis teams/services 24/7, including availability of professional to professional advice for out of hours services, particularly during the festive period.
	3.8	**Increased level of professional-to-professional advice** Boards and HSCPs have increased, where possible, the availability of professional to professional advice across acute and the community to ensure the patient receives right care in the right place at the right time.
	3.9	**Working with social care** OOH Plans demonstrate consideration to social care services and where possible close links are in place for emergency respite, community alarm services and home care provision. OOH Plans will identify how Care Homes will be supported with timely access to professional support and clinical advice (particularly in the OOH period) to enable admission prevention and more planned interventions to keep residents safe in their own home.
Mental Health	3.10*	Winter readiness plans consider the needs of those living with a mental health, learning disability, neurodiverse or dementia diagnosis, including the needs of carers.
	3.11	Plans to ensure appropriate staffing levels include consideration of mental health services and the need to maintain support for service provision and patient

		rehabilitation (such as suspension of detention), including for forensic mental health patients.
	3.12	The discharge partnership working plans include consideration of those requiring mental health supports and/or being discharged from a mental health setting, including the unique support package needs of those leaving forensic inpatient settings or with complex care needs.
	3.13	Plans ensure continued access to dementia diagnosis services for both inpatients and those in the community, ensuring people have care and treatment appropriate to their needs and any potential dementia-related issues are recognised and addressed.
	3.14*	Plans are in place to ensure data is available to monitor the performance of mental health services throughout the winter.
Prisons	3.15	Plans are in place to ensure that the delivery of prison healthcare, including mental healthcare, is maintained and that that there are appropriate levels of healthcare staff in prisons to deliver efficient and effective patient care.
Social care	3.16	Care at home assurance boards and care home assurance arrangements are in place to ensure all risks in care provision are recorded and appropriate mitigating actions are put in place.
	3.17	Capacity to deliver key public protection functions is in place e.g. child and adult protection, MAPPA (Multi Agency Public Protections Arrangements)

Section 4: Health and Social Care Workforce and Staff Wellbeing

* Indicates additional information provided.

Subsection	#	Readiness Statement
Workforce	4.1	Appropriate steps are being taken to support recruitment of staff on an ongoing basis within recognised financial parameters, utilising the full range of potential contractual arrangements including (but not limited to) Permanent, Sessional Worker, Bank or Fixed Term contracts (or a combination of these). Work undertaken with local college and HEI student workforce to offer holiday shifts and regular part time contracts can be evidenced.
	4.2	Boards and HSCPs are continuously deploying the range of tools available to them to support efforts aimed at staff retention. For Boards, this is including but not limited to those set out through DL (2022) 30: DL(2022)30.pdf (scot.nhs.uk) to enable those staff who have retired to return to work on a part time basis should they wish to do so.
	4.3	Plans are in place for appropriate levels of staffing across the whole system to facilitate efficient and effective patient care, ensuring consistent effective discharge planning takes place over 7 days and the holiday periods. This requires sufficient senior medical and other senior clinical decision makers to facilitate decision-making, and pharmacists to prepare timely discharge medications. For HSCPs, this includes sufficient social work staff and others associated with discharge planning.
	4.4	A strategy is in place for the deployment of volunteers over winter, making appropriate use of established local and national partnerships. Investment in and funding of local voluntary and third sector organisations to support care@home teams and provide practical support to people who are ready for discharge, and across the wider community can be evidenced.

	4.5	Staff are appropriately supported to access the range of available local and national staff wellbeing resources. This includes Primary Care independent contractor staff.
	4.6	In relation to potential adverse weather, Boards and Partnerships have contingency plans in place covering staff disruption to manage the impacts – for NHS this is specifically according to DL(2022)35.pdf (scot.nhs.uk). Staff are fully aware of the contingency plan.
Seasonal outbreak	4.7	**COVID -19, RSV, Norovirus, Seasonal Flu, Staff Protection & Outbreak Resourcing** All patient-facing Health and Social Care Staff (and this includes Primary Care independent contractor staff) have easy and convenient access to the Covid-19 and seasonal flu vaccines and that: i. clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. ii. drop-in clinics are also available for staff unable to make their designated appointment. iii. peer vaccination is facilitated, where possible, to bring vaccine as close to the place of work for staff as possible. iv. information and guidance is provided to staff on how to book appointments via the online portal or the National Vaccination Helpline. v. Information and guidance/ promotional materials are provided to staff specific to the benefits for HC staff in receiving the vaccine.
	4.8*	Plans take into account the predicted surge of Covid-19 as well as other viruses including seasonal flu, RSV and Norovirus activity that can happen between October and March and have adequate resources in place to deal with potential outbreaks and the impact these have on services (health and social care inclusive of primary care) across this period.
	4.9*	Adequate resources are in place to manage all potential increases in Covid-19 including possible new variants with increased severity, RSV and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. Debriefs should be undertaken following significant outbreaks or end of season outbreaks to identify lessons and ensure system modifications to reduce the risk of future outbreaks
	4.10	To help detect early warnings of imminent surges in activity, Boards routinely monitor PHS weekly publications, showing the current epidemiological picture on COVID-19, RSV, Norovirus and influenza infections across Scotland, and PHS Whole System Model Winter outputs.
	4.11	Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings

Additional Notes

Section 1 Overview of Preparedness & Business Continuity	
1.3	These projections are reviewed at least weekly to assess fullness and drive balancing actions across the whole system to prevent overcrowding and maintain safe front-door pathways.
1.6	Concurrent risks include but not exclusive to: i. Industrial Action, including risk of strike action in other services, such as public transport and/or education, and risk of concurrent action across the public sector. ii. Power Outage (national, localised, planned) iii. Severe Weather iv. NHS Supply Chain v. Cyber security attack and plans in place to mitigate any impact of an attack
1.7	Risk assessments account staff absences including those likely to be caused by a range of scenarios and are linked to a business impact analysis to ensure that essential staff are in place to maintain key services. Critical activities and actions required are included on the corporate risk register and are actively monitored by the risk owner and the Executive Team.
1.8	Plans include process, equipment and staffing to operate under Business Continuity.
1.9	Consideration is given to highlighting: • www.readyscotland.org as one stop shop for information and advice on how individuals and communities can prepare for and mitigate against the consequences from a range of risks and emergencies. • The Met Office National Severe Weather Warning System for information on the localised impact of severe weather events. • Use of NHS Inform to support people to look after themselves and identify alternative pathways for care. Communications plans a) Effective communication protocols are in place between key partners, particularly across unscheduled and planned care provision, local authority housing, equipment and adaptation services, Mental Health Services and the independent sector. b) Information about OOH services is routinely available to the public at evenings and weekends, and includes community pharmacy NHS Pharmacy First, optometry first port of call and, information on advance planning for the 4-day Festive Periods, including pre-stocking of repeat prescriptions. c) There is a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc. Arrangements are in place to ensure that general practices have robust contingency plans in place for outbreaks of respiratory diseases.
1.10	Plans include: • continued implementation of the following to enable step up and step down care and prevent admission: Home First, Discharge without Delay, Discharge to Assess and effective End of Life pathways to prevent an increase in patients who are delayed in the health and care system • increase in community capacity to enable patients to be discharged to their own home (or as homely a setting as possible) as the default ambition. This increase in capacity will be context specific according to need and be a mixed model of an increase in health and care community services, and/or bed based services dependent on patient and service need. Continued and swift mobilisation of their local voluntary and third sectors to maximise support to community services enabling people to be discharged and avoid readmission. This increase will also have to consider the role of General Practice and primary care out of hours services, in providing supporting services and their capacity to do so.
Section 2: Urgent & Unscheduled Health and Social Care, Planned Care	
2.1	This is staffed by a multi-disciplinary team, optimising digital health where possible in the clinical consultation, and should have the ability to signpost to available local services, such as MIU, Ambulatory Emergency Care, General Practice (in and out of hours), mental health services, pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate. If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide viable appointments / timeslots at EDs
2.2	Actions should be explicit around role and responsibility as part of a whole-system escalation plan which sets out 'levels' of response and is stepped up, and stepped down, as part of a 24/7 operating framework. This should include communication of potential interface issues and pressures to Primary Care Independent Contractors where appropriate. Plans should be in place to support Primary Care Independent Contractors in this situation.
2.3	Attendance and participation in the huddles includes pro-active involvement of HSCPs and Primary Care. Where HALOs are on site they are included to ensure focus on turnaround times for ambulances and SAS role in discharge etc. Winter planning includes volunteer transport as a component of discharge plans.
2.5	Pathways in place to ensure discharge to assess are in place from the front door.

	Consideration should also be given to: • General Practice rapid access to hospital investigation to maintain elderly patients at home, (for example chest x-rays) with ambulance transfer to and from hospital in a timely manner so they can be dealt with during the working day. • Faster and enhanced access for general practice to a suite of investigations such as CT scans which would decrease the demand for admission and outpatient referrals. Self-referral pathways for patients, such as physiotherapy.
2.7	If necessary, plans will consider any requirement to purchase additional capacity over the winter period.
2.10	A summary of any care plans should be on the Key Information Summary, and there should be a system in place to regularly update and review these.
2.11	Regular MDT meetings are in place to discuss patients with severe COPD.
2.12	Patients are provided with information on action to take/who to contact in the event of an exacerbation, including direct phone lines where possible.
2.14	This includes the provision of rehabilitation to enable patients to be discharged to their own home as soon as is practicably possible.
2.16	Plans are in place that focus on the reduction of long waits including diagnostic endoscopy or radiology. Systems are in place for the early identification of patients who are fit for discharge, with PDDs (planned dates of discharge) visible and worked towards to ensure patients are discharged without delay.
2.20	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) Key partners such as: pharmacy, transport and support services, including social care services, 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.
Section 3: Primary Care, Mental Health and Social Care	
3.1	In particular plans should reflect that: • Measures are in place to identify and resolve issues in accessing general practice appointments (with GPs and wider multi-disciplinary team members) as soon as possible. Reference should be made to the General Practice Access Principles (to be published late Summer 2023). • To ensure issues are identified and resolved at the earliest opportunity an appropriate process to escalate issues must be established. • Specific reference should be made to contingency arrangements where practices are unable to open due to staffing or other reasons. • Any involvement of GP practices in vaccination programmes is based on the assurance that practices will continue to deliver essential primary medical services. Plans should involve Local Primary Care Leads and Cluster Leads, and where appropriate the GP Subcommittee/LMC or other independent contractor representatives.
3.2	Plans also include the requirement of HSCPs to ensure access to mental health crisis teams/services 24/7 to cover addiction and mental health needs including availability of professional to professional advice for out of hours services, particularly during the festive period. Greater use of Pharmacy First is being promoted. Sufficient community pharmacy services are open and accessible including during public holiday periods. Availability of these services is well known and information for the public is current.
3.4	This will have included engagement with SAS, NHS 24 and Primary Care OOH services and to consider what more could be done collaboratively to improve continuity of care. The plan also 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. There is reference to direct referrals between services.
3.10	Plans support continuity of community services for those with a mental health, learning disability, neurodiverse or dementia diagnosis to keep people well and reintegrate them into the community following any inpatient stay.
3.14	This includes bed occupancy, delayed discharges, waiting lists, staffing, staff absences and bespoke system pressures data as required. Please confirm if this data is, or will be, shared with Scottish Government to assist with national planning.
Section 4: Health and Social Care Workforce and Staff Wellbeing	
4.8	If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards will consider undertaking targeted immunisation. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals co-ordinated and issued by the Vaccinations Strategy Division).
4.9	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 is in place to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of planned admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.