Item No: 14

Meeting Date: **Wednesday 30th November 2022**

Glasgow City Integration Joint Board

Report By: **Susanne Millar, Chief Officer**

Contact: **Stephen Fitzpatrick, Assistant Chief Officer (Older People and South Operations)**

Phone: **0141 427 8372**

Winter Planning 2022/23

Purpose of Report:	To update the Integration Joint Board on the winter planning arrangements for 2022/23.

Background/Engagement:	Guidance has been issued by the Scottish Government to all NHS, IJB Chairs and Local Authorities setting out the expectations for Winter 2022/23. The HSCP has contributed to the development of the plan for Greater Glasgow & Clyde, as have other HSCPs, and work is in hand to implement the actions outlined in the plan.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☒ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☐ Not Applicable ☐

Recommendations:	The Integration Joint Board is asked to: a) note the contents of this report.

Relevance to Integration Joint Board Strategic Plan:

Winter planning, particularly for unscheduled care, forms a significant part of the IJB Strategic Plan.

Implications for Health and Social Care Partnership:	
Reference to National Health & Wellbeing Outcome(s):	Relates to a number of outcomes, including supporting people to live independently and at home or in a homely setting in their community; keeping people who require to use health and social care services safe from harm; and, the efficient and effective use of resources in the provision of health and social care services.
Personnel:	Contingency plans include upscaling staff capacity, revising staff rotas and management of annual leave.
Carers:	All planning is in keeping with the HSCP's Carer Strategy and national guidance set out in the Carers (Scotland) Act 2016: implementation plan 2021-2023.
Provider Organisations:	Contingency plans include scope to increase use of purchased services such as Care Home places to meet additional need through the winter period.
Equalities:	In preparing the winter plan the equalities implications will be taken into account to ensure adequate access to a range of services to support people over the festive period and the winter as a whole.
Fairer Scotland Compliance:	None.
Financial:	This will be funded from within existing IJB budgets including the funding which was provided and approved by the IJB on 1st December 2021 to funds to support the health and social care system over the winter period and to provide longer term improvement in service capacity across our health and social care systems.
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None

Risk Implications:	There are risks that the IJB's performance in certain areas (e.g. hospital discharges) might be adversely affected depending on the additional pressures in the system over the winter period. All efforts will need to be made to minimise the potential risks over the winter period.

Implications for Glasgow City Council:	Potential increased demand for NHS services during the winter period may create additional demand for social care services provided by the Council during that period.

Implications for NHS Greater Glasgow & Clyde:	Potential increased demand for health and social care services during the winter period may impact significantly on the accessibility and performance of NHS services during that time.

Direction Required to Council, Health Board or Both	
Direction to:	
1. No Direction Required	☒
2. Glasgow City Council	☐
3. NHS Greater Glasgow & Clyde	☐
4. Glasgow City Council and NHS Greater Glasgow & Clyde	☐

1. Purpose

1.1 To update the Integration Joint Board on the winter planning arrangements for 2022/23.

2. Background

2.1 Winter planning commenced in early September 2022 and has incorporated subsequent guidance from the Scottish Government to NHS Boards, IJBs and local authorities on expectations for Winter 2022/23 (Appendix 1). Bringing together numerous stakeholders including independent and third sector colleagues, the plan reflects the significant anticipated challenges this winter;

- Fluctuating levels of COVID-19 and its enduring impact on service delivery, including the requirement to further vaccinate staff and vulnerable citizens.
- Risk of industrial action in the NHS and related services.
- Recruiting challenges across the health and care sector.
- A cost of living crisis that is exacerbating health inequalities.

2.2 The plan has been internally ratified by NHS GG&C, with the accompanying assurance checklist submitted to the Scottish Government. To remain output focussed, specific actions are identified and assigned in each chapter. The chapters relating 'community' are attached at Appendix 2. The key elements relating to HSCP responsibilities include:

- Reduction in delayed discharge numbers.
- Improvement of flow into intermediate care and residential care.
- Reduction in unscheduled admissions through initiatives such as Hospital at Home, the Home First Response Service and NHSGG&C Community Falls Pathway.
- Maximising virtual capacity through community contribution to multi-disciplinary teams.
- Vaccination rollout within communities.
- Maintaining care at home services and other initiatives to maximise independence and alternatives to residential care.
- Maintenance of safe staffing levels and staff wellbeing.

3. Recommendations

3.1 The Integration Joint Board is asked to:

a) note the contents of this report.

Appendix 1

Cabinet Secretary for Health and Social Care
Humza Yousaf BPA/MSP
Cabinet Secretary for Social Justice, Housing and Local Government
Shona Robison MSP

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To: Local Authority Leaders,
Chairs & Vice Chairs Integration Joint Boards
Chairs NHS Boards

CC: Local Authority Chief Executives & Directors of Finance;
Health and Social Care Partnership Chief Officers
NHS Territorial Boards Chief Executives;
NHS Territorial Boards Directors of Finance;
COSLA Chairs; Chief Social Work Officers;
NHS Territorial Boards Nurse Directors;

via email

12 October 2022

Dear Colleagues

Supporting our Health and Social Care System

You will no doubt be as concerned as we are about the pressures currently being experienced by the NHS and Social Care system across Scotland. We are in a precarious position and must make every effort to maximise capacity to ensure resilience of these services, as we head into winter. We know this is a shared concern and we are very keen to get in the room with key COSLA and Solace representatives to work together on this collectively, as a matter of urgency. However, given the urgency of situation we feel there are a number of actions we have already identified as necessary.

In conversations with health and social care partnerships, we have heard many examples of good practice and are aware of a range of interventions being applied across the country to address these challenges. However, we are also aware that these evidence based good practices are not yet being applied consistently, and we now need to see an acceleration in spreading and scaling these evidence based good practices across the country.

Therefore, my officials have reviewed interventions and activities already being implemented in part by Health Boards, Local Authorities and Health and Social Care Partnerships; the Winter Pressures Funding Quarterly Key Performance Indicator returns; and wider improvement work across Scotland. The interventions set out in **Annex A** have been shown to have a positive impact.

We must now redouble our efforts and we ask for your support in immediately implementing all of the listed actions, to tackle the challenges that are being faced.

Funding to support the demands of winter pressures, particularly in supporting capacity for Social Care, are set out in **Annex B**.

Assurance and Oversight

We recognise both the need to support each other, and the importance of good information to support our actions. For this reason, we want clearer assurance of the readiness of local planning and resourcing and evidence that winter pressures funding has had any significant impact on system pressures is unclear. In particular, we seek assurance that all possible action is taken to ensure a rapid reduction in the number of patients delayed in hospital who no longer have a clinical need to be there.

An invitation to attend a meeting will be issued in the coming weeks, which will offer an opportunity for us to meet with you to collaboratively gain the necessary assurances that these actions are being effectively implemented across the country. These meetings will also offer opportunity to agree how we can work together to identify solutions to the pressures being faced.

In addition, we ask for your support in ensuring that that social care data relating to outstanding assessments and hours of unmet need at Local HSCP level are made public. This reasoning behind this release of data, currently classified as "management information" is threefold:

a) The data is regularly shared internally and is FOI-able, and pro-active publication is always preferable;
b) If we are looking at pressures across the whole system, the lack of social care data hampers decisions about where investment is required to ease patient flow;
c) It will assist Integration Joint Boards and Local Authority Leaders' understanding of the risks being carried at a local level.

A programme of work is underway to review these data in more detail with Health and Social Care Partnerships and Public Health Scotland, to improve the quality, completeness, accuracy and consistency of these data.

The current situation requires immediate action to minimise the increasing the impact of pressures on the NHS and Social Care system. By working collaboratively, we can seek to ensure that the system has capacity to serve the people of Scotland approaching winter.

Yours sincerely,

HUMZA YOUSAF **SHONA ROBISON**

ANNEX A

All Health Boards, Health and Social Care Partnerships and Local Authorities **must renew their focus on the following actions**:

- Home First
- Discharge without Delay (Use of Planned Date of Discharge [PDD] compulsory)
- Criteria Led Discharge
- Hospital to Home transition teams with re-ablement focus / Discharge to Assess
- Hospital at Home
- Anticipatory Care Plans
- Effective End of Life pathways in strong collaboration with our Hospice colleagues.

Additional Measures to support improved flow.

In addition, we will require **Discharge co-ordination to be extended to all Emergency Departments.** It is our view that placing a Discharge Co-ordinator, as a single point of contact (SPOC) to arrange rapid discharge from ED, enables ED staff to focus on seeing and treating patients in the department. This co-ordinator role will take responsibility for co-ordinating community support to enable swift decision making at the front door to prevent admission where it is safe to do so. Arranging discharges from ED can take considerable clinical time, which will be released by having a focussed Discharge Co-ordinator on site.

Support for Care Homes: Building on the successful support provided to care homes during the pandemic; Care Homes must be supported by having 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. 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. This prevents unnecessary ED attendances, which are distressing for residents.

Increase care and support in community by increasing / supplementing workforce:

- Work with local **college and HEI student workforce** to offer holiday shifts and regular part time contracts, Medical students as support workers for medical teams (NHSAA example);

- **Invest in and fund 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. This practical support (previous home help role for example) is not the provision of personal care, which would be inappropriate for volunteers. This support

will release time for care@home staff. Some HSCPs have already focussed on this intervention with good impact.

Increase capacity in social work teams, including retirees. There is an urgent need to focus on assessments and reviews in order to ensure people are receiving the right level of support and release potential capacity in the care system. This includes the wider MDT and key staff such as OTs and OT assistants, and MHO roles to focus on AWI / guardianship processes.

Commission beds in care homes as NHS beds to support transfer of care from hospitals to release capacity. This must be supported by re-ablement so that people move on to their correct destination. Some HSCPs have already addressed this and will have learning for others, which we will document and share across the system. Identify designated beds within current footprint. This would enable focussed care for patients experiencing delays with a different model of staffing to meet their care needs, including a focus on re-ablement using OT assistants. This could reduce the care@home demand in the longer term.

Streamline processes for patients on the AWI / Guardianship pathway. There are opportunities to streamline this pathway and ensure that all elements of the process are completed in a timely manner. Discussions are currently under way with the Director of Mental Health that will enable guidance to be given describing the required practice to move any patient from a hospital bed. Guidance is targeted at those areas with the highest AWI delayed discharges. SG officials will continue to meet with these areas to pinpoint and offer assistance in easing their particular difficulties, which differ in each area. A decision to move under AWI MUST be focussed on the individual and each patient must have their own assessment, which agrees the move is in their interests (jointly by MHO and clinician).

The use of NHS commissioned / procured beds may be possible. This was attempted a few years ago by NHS GGC, resulting in reversal of their position following a court case brought by the Equality and Human Rights Commission (EHRC), with the support of the Mental Welfare Commission (MWC). The support of the EHRC and the MWC will be essential to ensure the rights, will and preferences of the person are respected. Officials will be meeting both organisations to explore this.

ANNEX B

Funding

In addition to the £300m allocated in 2021/22, additional funding has continued to be allocated to support the demands of winter pressures, particularly in supporting capacity for Social Care.

This funding for 2022-23 is aimed at the following measures:-

- £124 million to enhance care at home;
- £20 million to support interim care arrangements;
- £40 million to enhance multi-disciplinary teams;
- £30 million for Band 2-4 recruitment;
- £144 million for the full year impact of the pay uplift to a minimum of £10.02 per hour in adult social care commissioned services;
- A further £200 million in 2022-23 to uplift adult social care pay in commissioned services to a minimum of £10.50 per hour, as well as providing non ring-fenced additional support to the sector.

You will be aware that the UK Government held a fiscal event on 23 September 2022. Scottish Government has committed to reviewing the 2022/23 budget in light of this and will follow up with more detail on this in the coming weeks.

It is crucial that you review the available funding allocation to consider how it can be appropriately directed to alleviate the current pressures, including targeted recruitment to the sector. The funding must be used for the purpose in which it was awarded and must not be redirected to other pressures, which do not meet the aims of increasing capacity in the community, reducing delayed discharge, or increasing care at home services.

I appreciate that some Authorities may have concerns over the impact of recruiting, when a recruitment freeze exists in other areas of your Authority. I reiterate that local recruitment freezes or delays must not inhibit recruitment to the Social Care sector. All mechanisms for recruitment should be utilised, including collaboration with your Local Employability Partnership and cross partnership working with other Authorities.

Purpose of Funding

The funding is part of measures being put in place to support current system pressures. It is expected that NHS Boards, Integration Authorities and Local Authorities will work collaboratively to ensure a whole system response. In particular, this funding is available for the following purposes:

i. standing up interim care provision to support significant reductions in the number of people delayed in their discharge from hospital;
ii. enhancing multi-disciplinary working, including strengthening Multi-Disciplinary Teams and recruiting 1,000 band 3s and 4s;
iii. expanding Care at Home capacity; and
iv. expanding support for unpaid carers.

The spend will be monitored against the above measures in the form of expected quarterly reports using outcomes and Key Performance Indicators contained in the Schedule 1-3 attached to this letter. A template was provided to enable this to be done consistently and as easily as possible.

Ministers are seeking significant reductions in delayed discharge, with an early return to the levels that were sustained in the nine-month period up to August this year.

Distribution of Funding 2022-23

The £20 million for interim care and £124 million to enhance care at home capacity were made available to support permanent recruitment and longer term planning. This additional funding was distributed to local authorities via the 2022-23 Scottish Local Government Finance Settlement on a GAE basis, with a requirement to be passed in full to Integration Authorities.

The £40 million to enhance multi-disciplinary teams and £30 million for Band 2-4 recruitment is to cover the period from 1 April 2022 to 31 March 2023 and will be distributed via NHS Boards.

It will be up to Chief Officers, working with colleagues, to ensure this additional funding meets the immediate priorities to maximise the outcomes for their local populations, according to the most pressing needs. The overarching aim must be managing a reduction in risks in community settings and supporting flow through acute hospitals.

Appendix 2

NHS GG&C WINTER PLAN – COMMUNITY

6.6 HSCP Community Teams

Admission prevention is key to our service delivery, particularly during Winter. The Home First Principle, “if not home, why not?” continues to be embedded in our approach. We have reviewed the reablement approach across all HSCPs to share best practice and maximise each individual's reablement potential. Lessons learned have been disseminated ahead of winter to maximise the opportunity for admission avoidance and supported discharge. Partnership effort during the Autumn to establish a number of dashboards monitoring ED attendance and admissions is already paying dividends by allowing increasingly data driven targeting of rehab, telecare, care at home and intermediate care services. This is being continually reviewed to ensure best practice is disseminated and partnerships are focussed on the most effective actions to prevent admission.

The Home First Response Service is a priority development during this winter to support admission avoidance activity. This hub and spoke model delivers a new pathway for those patients screened as frail where there is an opportunity to avoid admission or reduce LoS. Comprising virtual multidisciplinary teams of Advanced Practice Frailty Practitioners, Pharmacists, AHPs and Frailty Support Workers this service will prevent admission to hospital for those frail patients who can be cared for and supported in the community. Recruitment challenges have slowed implementation however a phased launch of the Home First Response Service launches in November 2022. The impact of this revised pathway will be monitored during November and December, with learning transferring over to the launch in January with the enhanced resource.

The GGC Community Falls Integrated Pathway was launched in Sep 22. This pathway is already delivering reduced conveyance to ED of those individuals who have fallen and do not require urgent conveyance and who can be cared for and supported within the community. Via the GGC Administration Hub we offer a single point of contact for SAS crew members to refer patients to the community team for multifactorial assessment following a fall, the pathway also offers advanced clinical triage communication with the Flow Navigation Centre. Following this clinical discussion and if appropriate, fallers can access planned care, reducing pressure on EDs. As of October 2022, the pathway is pan GGC with an increasing trend of referrals month-on-month.

The full ambition of this GGC Community Falls Integrated Response Pathway includes an extension to the operating hours to include 10pm-10am response, this requires resource to be implemented. Further development of this concept would see a pathway direct to Partnership Falls Responder teams to assist non-injured fallers. This is planned for operationalising as of December 2022.

Community nursing and AHP teams continue to be under pressure, supporting patients in their homes and meeting demands generated by the prior restriction of routine services in primary and secondary care and the resulting evidence of patient deconditioning. HSCPs have implemented a number of initiatives to create the capability and capacity required to maintain individuals in their own home/homely setting this Winter and to prevent admission to hospital and support early discharge. Both East Dunbartonshire and Renfrewshire HSCP Community Advanced Nurse Practitioners have been directly aligned with District Nursing services to enhance clinical care and decision-making, allowing the team to manage highly complex patients within the community and prevent avoidable hospital admissions while improving patient outcomes. Most recently East Dunbartonshire have implemented an extension of a local DN core service to include the evening (5pm – 10pm) period. This development is already increasing continuity of care and increasing ability to support complex patients, reducing need to call GP OOH's and prevention of admission. Additionally, the formation of a Winter Response Team focussed on delay and admission prevention is facilitating real time response to pinch points in the system.

Applying an integrated approach to admission avoidance, Renfrewshire HSCP has increased the number of Social Workers within their locality services aiming to respond to support the increased demand of case management in the community. Further, Glasgow City has invested in the development of integrated first contact arrangements for the HSCP across both social care and health services to improve the service delivery with experienced practitioners addressing complex needs/risk adopting trauma informed approaches at point of contact.

Recruitment within community teams continues to be challenging, with a number of vacancies across the teams. Staffing levels are the primary consideration, COVID vaccination will be offered to staff in the autumn to mitigate this. Business Continuity Plans are being reviewed. All HSCPs have invested in community recruitment of clinical support workers to support professional grade staff to support people to remain at home as long as possible. Recruitment to Professional Grade posts across nursing and AHPs is ongoing to support the Home First Response Service.

6.7 Discharge Management

Delayed discharges continue to pressure our system, occupying approximately 150 beds a day in comparison to pre COVID levels of 120 per day. Daily HSCP/Acute Senior Manager meetings provide the opportunity for stronger scrutiny and closer working. The newly established Rapid Assessment and Acute Discharge High Impact Change areas within the Scottish Government Urgent & Unscheduled Care Collaborative with Improvement Resource will provide further opportunity to explore improvement ideas within the acute ward setting and interface with community teams using Discharge without Delay (DwD) as fixed anchor point.

For **Discharge without Delay**, HSCP teams including "Focused Intervention Team" (West Dunbartonshire), "Hospital to Home" (East Renfrewshire), "Home 1st" (Inverclyde) and "Home for me" (East Dunbartonshire) are equipped with dedicated multi-disciplinary teams including AHPs, Elderly Care Advanced Nurses or Specialist

Nurses continue to proactively reach in to hospital ward to prevent unnecessary delays and manage early support discharge.

All HSCPs continue to develop the use of local data to understand and project demand, complexities of need to inform local responses around recruitment, re-alignment of resources and use of local intermediate care facilities offering a step up/step down approach. The use of interim beds across GG&C will increase over the winter period including Bonnyton intermediate care facility (East Ren), 6 additional care beds provided in Inverclyde, new IMC contract being tendered in Glasgow City (75 beds).

The 'Discharge to Assess' policy introduced last year continues to be improved upon to and will continue to deliver the following in the community through Winter;

- Establish early in-reach and acute identification of the need for community support.
- Early engagement of individuals and families by HSCP teams to expedite discharge.
- Completion of full assessment out of hospital and provision of community rehabilitation via new localised pathways.
- Strengthen links with Commissioning Teams to support transfers to appropriate settings.

For **Adults With Incapacity** the use of 13ZA legislation continues to be used where appropriate ensuring people can be moved to an alternative place of care. Embedding an MHO within the East Renfrewshire Home from Hospital team to expedite progress has also evidence a positive impact. Renfrewshire HSCP has also increase MHO capacity to support increased demand for mental health assessment processes and Guardianship applications to supporting community placements and discharge processes. AWI trackers are being used within community teams to support management of the AWI process with a view to minimising delays. Robust AWI improvement plans are also in progress across partnerships. A review of current practice in relation to AWIs to ensure consistency and shared learning, with additional legal resources allocated is planned. This will take place October – December 2022. We continue to actively explore other ways to ease pressure and free up bed capacity, for this Winter we will explore the potential to use on or offsite facility with staffing from a provider for DD patients to move them from acute wards.

6.8 Care Homes

Across GGC we have 187 care homes with 9,287 residents and approximately 15,000 staff. Maintaining the effective running of this system is critical and residents and staff continue to be prioritised for vaccination programmes. Governance structures and arrangements have been strengthened over the last year with systems now in place within care homes and at system level. Clear reporting lines are in place to the Board and council Chief Executives as well as Scottish Government.

A **Discharge to Assess** Huddle approach has been developed during the pandemic to support prioritisation of hospital discharges as appropriate. This dynamic approach to bed occupancy will be maintained over the winter period. The Multidisciplinary Support to Care Homes Team is now established and is working in tandem with our local care homes to enable management of those residents with more challenging and complex health and care needs, preventing admission, as well as enabling them to support more complex hospital discharges. Additional spot purchase of Care Home placements continues to allow timeous discharge to an appropriate homely setting and is evident across a number of HSCPs. As previously mentioned, we will increase the number of intermediate beds available for the winter period through the use of interim beds.

Last winter a proof-of-concept of the **Care Home Falls Pathway** was implemented. This new pathway offers Homes the opportunity to directly contact the GGC Flow Navigation Centre Advanced Nurse Practitioners for triage and if necessary, consultation via Near Me technology. The aim to reduce conveyance to ED for those residents who can be safely managed within the Home and turn unplanned care to a planned care response, when possible. This was successful and during this year the roll out across the GGC Nursing/Care Home estate has continued allowing this pathway to be added to the Homes' toolkit. Now an established process the Pathway will continue to reduce the requirement for admission through Winter.

Workforce planning includes an active recruitment campaign, while staffing levels will require to be maintained throughout the winter and festive/public holiday periods. This is essential to comply with safe staffing levels for care home environments. Services continue to be challenged by staff absence and work closely with Human Resources to monitor this, while supporting staff to return to work.

6.9 Care at Home

Care at Home has a history of prioritising Delayed Discharges and as such, we continue to prioritise planning for discharges into the winter months and beyond. The Care at Home sector continues to be under significant pressure to respond to the ever-increasing demands, some of which are a result of the COVID pandemic and the resultant deconditioning and increasing complexity evidenced across the ageing population. To support this increase in demand for care packages focussed recruitment drives have been underway across some partnerships in advance of the winter period, targeting local areas.

Numerous initiatives are underway in individual Partnerships;

- East Dunbartonshire HSCP has secured resource to enable the provision of overnight care at home for those who require this to support them to remain at home where there is a requirement for more intensive support for a short period to manage change in presentation or circumstances.

- Within East Renfrewshire, local engagement event arranged for October to progress collaborative commissioning and increase use of third sector and creative support options. A key focus of this will be to support people to live well at home, reducing hospital admissions and discharge without delay.

- Glasgow City Care at Home has recovered to pre pandemic levels of with over 5,000 service users a day being supported with in excess of 91,000 visits a week. The HSCP has continued to prioritise hospital discharges and it has projected a 7% increase in referrals to home care from October 2022 to March 2023. Referrals are expected to peak in excess of 190 a week in December 2022. Staffing levels remain a significant challenge, with absence levels between 12 – 15% in August and September 2022. Plans are in place to continue with an aggressive recruitment campaign to maintain home care capacity in the winter months.

- Renfrewshire HSCP investment of winter monies has allowed Care at Home to revise their establishment and increase the management and frontline support across the service. Recruitment of Senior Home Support Workers, Service Coordinators, and Management roles aims to strengthen the staffing position to meet current demand. This funding aims to strengthen the overall management of the service on out of hours, whilst presenting the opportunity to support developments of home first response services, overnight services and generally increasing the management at all operating hours of this service. The HSCP has also embedded a recruitment and absence team to support focus on recruitment and retention, whilst supporting enhanced approaches to absence and recruitment.

- Sharing of best practice from the HSCP activity highlighted to support winter planning across care at home will be co-ordinated and disseminated across all partnerships with the opportunity to highlight areas with highest impact with a view to spreading the activity across all partnerships.