Item No: 8

Meeting Date: **Wednesday 29th November 2023**

Glasgow City Integration Joint Board

Report By: **Stephen Fitzpatrick, Assistant Chief Officer, Older People's Services and South Operations**

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Unscheduled Care Winter 2023/24 Update

Purpose of Report:	To update members on developments in the delivery of the HSCP's Unscheduled Care agenda ahead of Winter 2023/24 and seek approval for the Care Home Call Before Convey test-of-change for Winter 2023/24.
Background/Engagement:	At its meeting in March 2022 the IJB received an update report on the Unscheduled Care Design and Delivery Plan for the period 2022/23 to 2024/25. Subsequently the NHS GGC Board and HSCP Chief Officers have adapted to the requirement for Scottish Government assurance through refinement of the governance structure for Urgent and Unscheduled Care.
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 content of this report; and

	b) approve the Care Home Call Before Convey test-of-change for Winter 2023/24 (Para 4.5).

Relevance to Integration Joint Board Strategic Plan:

Integration Authorities have responsibility for strategic planning, in partnership with the hospital sector, of those hospital services most associated with the emergency care pathway, alongside primary and community health care and social care. This is known as unscheduled hospital care. The objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome(s):	The unscheduled care program contributes to all nine national outcomes and in particular is fundamental to the delivery of outcome 9 that resources are used effectively and efficiently in the provision of health and social care services.
Personnel:	None
Carers:	None
Provider Organisations:	None
Equalities:	None
Fairer Scotland Compliance:	None
Financial:	The legislation requires the IJB and Health Board to put in place arrangements to support set aside arrangements for unscheduled care, and is subject to external assessment. The Unscheduled Care Commissioning Plan delivers a joint strategic commissioning approach to unscheduled care which will deliver on the intentions of the legislation. The IJB's budget for 2023/24 includes a "set aside" amount for the commissioning of acute hospital services within scope (e.g., accident & emergency services). This is currently £240.7M for Glasgow City. Funding of £266,000 has been made available from NHS Greater Glasgow and Clyde to support the test for change of Call before Convey for Care Homes.
Legal:	The integration scheme for the IJB includes specific responsibilities for the strategic planning of certain acute hospital services.
Economic Impact:	None.

Sustainability:	None.

Sustainable Procurement and Article 19:	N/A

Risk Implications:	NA

Implications for Glasgow City Council:	None.

Implications for NHS Greater Glasgow & Clyde:	The approach outlined will have implications for the planning and delivery of acute hospital services for all 6 GGC HSCPs.

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 This report provides the mid-year update to the IJB on how Glasgow City and other Greater Glasgow & Clyde (GGC) HSCPs are working with Health Board colleagues to deliver whole system change against our urgent and unscheduled priorities to minimise the impact of unscheduled care during Winter 2023/24. The report seeks approval for the Care Home Call Before Convey test-of-change for Winter 2023/24.

2. Background

2.1 Unscheduled care work across GGC is directed by the Unscheduled Care Design and Delivery Plan 2022/23 to 2024/25. Ratified by all 6 IJBs, this detailed how HSCPs would seek to operate in conjunction with acute sector colleagues to meet the unprecedented levels of unscheduled care across NHSGGC and meet the continuing challenges of an aging population with increasing complex care needs. This plan will be refreshed and brought back to IJBs in 2024.

2.2 As noted in the most recent update to IJBs on unscheduled care in January 2023, national improvement work and reporting on unscheduled care has been organised into High Impact Change Areas (HIC) whilst improvement work remains true to the actions detailed in the Design and Delivery Plan. GGC partnerships are participating actively in three HICs.

- HIC 3 – Virtual Capacity
- HIC 7 – Discharge without Delay
- HIC 8 – Community Focussed Integrated Care

3. Trends in Unscheduled Care

3.1 **Presentations.** Figure 1 below shows the rate of presentation across all facilities in GGC. Seasonal patterns of attendance are being observed for 2023 and thus far attendance numbers are down 7% on 2019 figures. This could be attributed to the significant efforts within community and Primary Care on early intervention, prevention and signposting of service users to planned care. Glasgow City closely follows the wider GGC trend. Despite the decrease in numbers, anecdotally from front-line staff there is an increase in the complexity of the patients who are attending, which may explain the increased average length of stay (Para 3.3). A breakdown of attendances per HSCP by 100,000 of population is included at Figure 2.

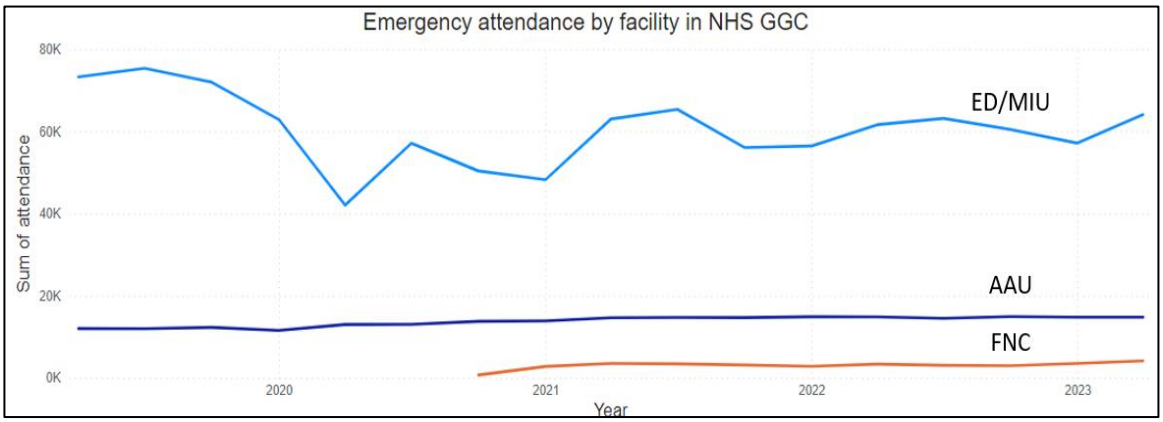

Figure 1. Quarterly counts of attendances to Emergency department (ED)/ Minor Injury Unit (MIU), Acute Assessment Units (AAU) and Flow Navigation Centre from 2019 to 2023. Source: NHS GGC Emergency Department dataset.

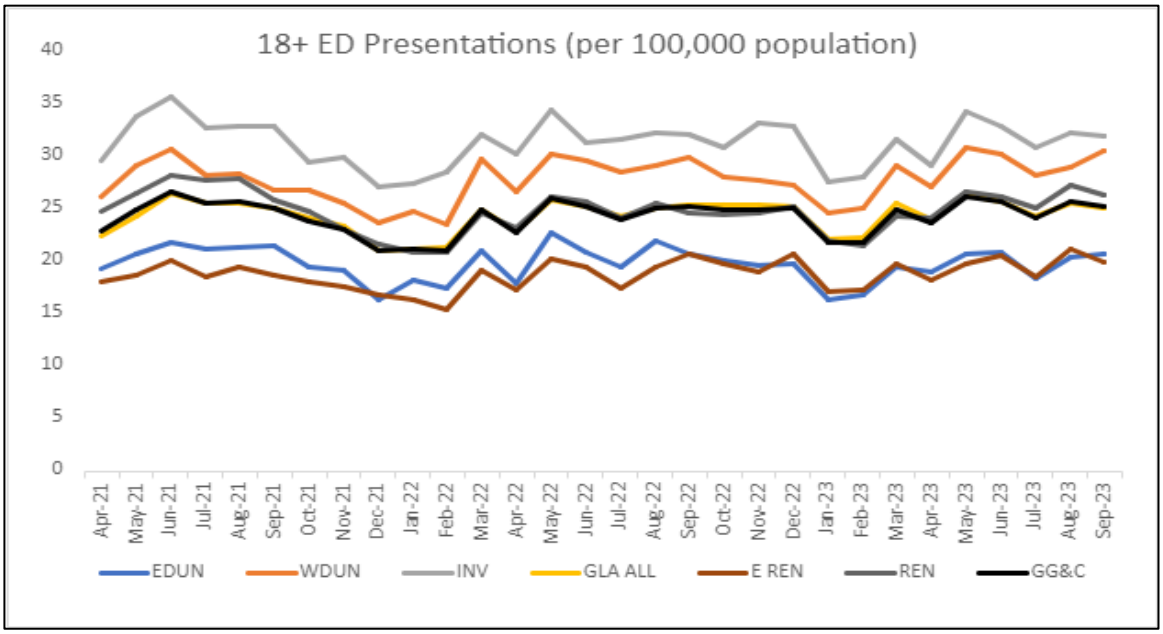

Figure 2. ED/MIU attendances per 100,000 population. Source: NHS GGC Microstrategy

3.2 **Admissions.** Emergency admission rates appear to have stabilised post-pandemic with GGC admission rates closely following Scottish rates overall. Admission rate per 100,000 population by HSCP is shown at Figure 3.

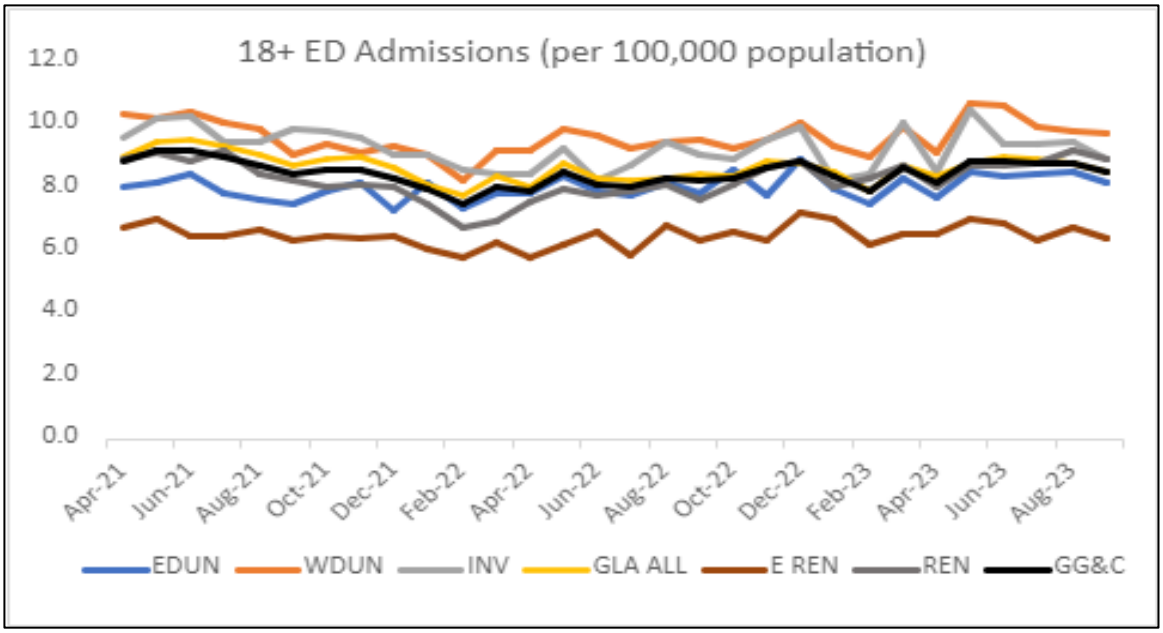

Figure 3. ED/MIU admissions per 100,000 population. Source: NHS GGC Microstrategy

3.3 **Average Length of Stay**. Overall, mean length of stay in NHS GGC has increased from 8.3 days in 2019 to 10.2 days in 2023 (January to June only). This has remained above the Scottish average throughout the time-period (9.0).

The distribution of lengths of stay is not uniform. As can been seen in Figure 4, over half (53.5%) of admissions from January to June 2023 lasted four days or less. There is however a notably large proportion (17.3%) of stays lasting fifteen days or more.

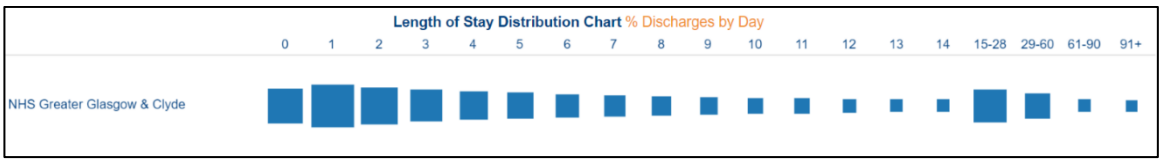

Figure 4. Breakdown of length of stay by day for inpatient stays. Source: PHS

3.4 **Predictive modelling.** HSCPs enlisted the support of Public Health Scotland to predict A&E attendances and emergency admissions through Winter 2023/24. Using logistic regression modelling predicted values have been determined with a range of 95% certainty. This information has informed HSCP and acute demand and capacity planning and workforce measures in advance of Winter.

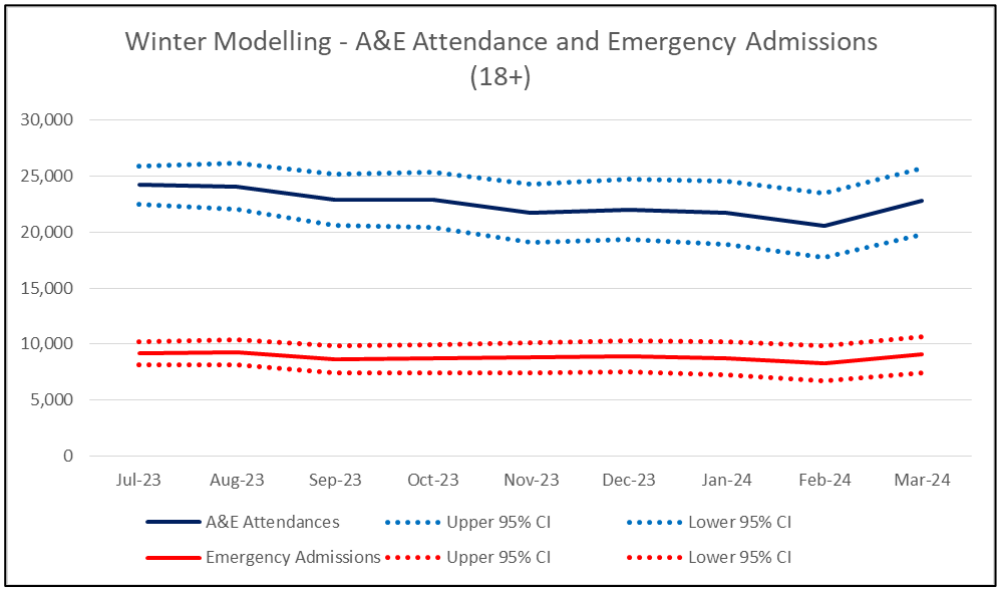

Figure 5. Predicted GGC A&E attendance and Emergency Admissions with 95% confidence intervals. Source: PHS Scotland – MSG Data

4. Unscheduled Care Intervention Progress

4.1 The following key interventions led by HSCPs are now live across GGC. A summary of interventions across acute and community services can be found at Appendix 1.

4.2 **Hospital at Home**. The Hospital at Home (H@H) service continues to provide acute level care to individuals in their own home who would otherwise be admitted to hospital. This is currently provided in the South and North West localities of GCHSCP using a Nursing Midwifery & Allied Health Professional (NMAHP) model with support from a wider multi-disciplinary team, hosted by GCHSCP. During 2023 the service has expanded from 10 to 20 beds with ambition for further scale up, with 40 beds as an initial aimpoint, subject to future IJB approval. Negotiations are underway with Scottish Government and the NHS Board & Partnership Chief Officers to identify revenue funding options for the scale up of the service. This will be the subject of a future report once funding has been confirmed.

4.3 **Home First Response Service.** This service has been established for a year within the Queen Elizabeth University Hospital and Royal Alexandra Hospital. Delivering an augmented multi-disciplinary team approach composed of community staff (Frailty Practitioners, Allied Health Professionals, Pharmacy and Frailty Support Workers) embedded and working alongside the acute team to identify, assess and turn around patients at the earliest opportunity, up to 72 hours post-admission. The service is routinely turning around over 50% of individuals diagnosed with frailty at the Emergency Department (ED) front door, with a threefold increase in community rehab referrals that is expected to continue into Winter. This work aligns with preventative measures such as the development of HSCP Frailty Pathways to support prevention/early intervention activity and anticipatory care planning to maintain individuals at home for longer, reducing risk of admission to hospital.

4.4 **Falls Pathways.** Work is ongoing to reduce the number of conveyances to ED following a fall.

- **Community Integrated Falls Pathway** in collaboration with the Scottish Ambulance Service (SAS) has a focus on referral to community teams for multifactorial assessment for those patients who are not conveyed, with a same day or next day follow up from HSCP team. Referrals from SAS are increasing incrementally with a recent review demonstrating the HSCP prevention and early intervention activity following referral to minimise the risk of further falls.
- **Care Home Falls Pathway**. Linking SAS crews with senior clinical decision makers through calls into the Flow Navigation Centre (FNC) to minimise conveyances with a resulting reduction on pressures in ED. Results so far have shown that 62% of calls to FNC resulted in a non-conveyance.
- **Care Home Falls Test-of-Change**. Following a successful test-of-change in Glasgow City, training has been rolled out to Glasgow's 61 Care Homes, connecting Care Home staff with clinical decision makers. Using 'Near Me' video technology, a livestream consultation takes place between the FNC and the care home resident resulting in the formation of an action and treatment plan, which helps avoid an unscheduled and potentially lengthy attendance to the Emergency Department. For residents that still may require attendance to hospital as an emergency, the FNC will facilitate referral and ambulance transfer. An audit of Care Home Wi-Fi connectivity across GGC has been implemented with a view to expanding this intervention into all HSCPs.

4.5 **Call before Convey for Care Homes.** On average 420 care home residents attend ED each month across GGC. Whilst the GGC Care Home Falls Pathway gives homes access to Flow Navigation Centre clinicians it only covers falls and no other reasons for attendance, which are predominantly respiratory and urinary issues. Building on the experiences of Ayrshire & Arran and East Dunbartonshire and the recommendations within the My Health, My Care, My Home framework published in 2022 a test-of-change for Winter 2023/24 is proposed subject to IJB approval. Funded through delegated NHS GGC funding to support care homes through Winter, the test will give care homes access to a senior clinical decision maker who can provide remote clinical assessment. This will provide timely contact with the potential to avoid delays experienced at NHS24 and the FNC thus reducing the likelihood of a call to 999. Access to senior clinical decision makers varies across the HSCP. This has resulted in variation in the models being proposed. Glasgow City HSCP is seeking IJB approval to implement a weekend approach similar to a successful scheme in East Dunbartonshire HSCP with dedicated District Nurse support to care homes. We are also exploring providing dedicated GP locum support to specific care homes in the North East, using new telehealth equipment provided to these homes to enable virtual assessment.

4.6 **Anticipatory Care Plans (ACP)**. GGC's ACP programme was aligned with Unscheduled Care Programme in 2022 and the diligent work of implementation sub-groups across all HSCPs and in Care Homes, Hospice and Secondary Care continue to demonstrate success through the exponential rise in ACPs available on Clinical Portal, with over 5000 as of October 23 (Figure 6).

Glasgow City will achieve its ACP targets for 2023. In addition to raw numbers, work is on-going to improve the quality of ACPs available to support decision making. Lessons learned from the first cycle of improvement activity has been shared with all HSCPs and cycle two is underway. Additionally, Scottish Government have announced a national re-brand of ACP activity as Future Care Planning. This new terminology will be adopted across GGC with the ACP materials and website being amended to reflect this change.

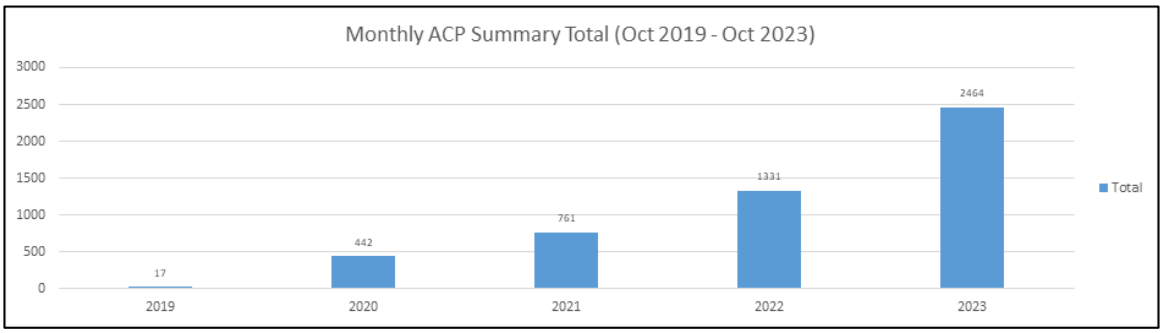

Figure 6. Monthly ACPs completed across GGC. Source: Clinical Portal

5. Recommendations

5.1 The Integration Joint Board is asked to:

a) note the contents of this report; and
b) approve the Care Home Call Before Convey test-of-change for Winter 2023/24 (Para 4.5).

Direction from the Glasgow City Integration Joint Board

1	**Reference number**	291123-8
2	**Report Title**	Unscheduled Care Winter 2023/24 Update
3	**Date direction issued by Integration Joint Board**	29 November 2023
4	**Date from which direction takes effect**	29 November 2023
5	**Direction to:**	NHS Greater Glasgow and Clyde only
6	**Does this direction supersede, revise or revoke a previous direction – if yes, include the reference number(s)**	No
7	**Functions covered by direction**	Residential Care for Older People
8	**Full text of direction**	NHS Greater Glasgow and Clyde is directed to implement the Call before Convey for Care Homes test of change for Winter 2023/24, as outlined in section 4.5 of the report.
9	**Budget allocated by Integration Joint Board to carry out direction**	Funding of £266,000 has been made available from NHS Greater Glasgow and Clyde to support the test for change of Call before Convey for Care Homes.
10	**Performance monitoring arrangements**	In line with the agreed Performance Management Framework of the Glasgow City Integration Joint Board and the Glasgow City Health and Social Care Partnership.
11	**Date direction will be reviewed**	November 2024

Appendix 1

Pre-hospital UUC changes	**Intended high-level outcomes**
Flow Navigation Centre	Divert activity away from ED via virtual front door service
Mental Health Assessment Unit	Improved access to acute mental health support and reduction in mental health attendances to ED
GP Out of Hours workforce stabilisation	Ensure staffing levels sustainable and appropriate to population need
Call before Convey	Reduce unnecessary ambulance conveyances to hospital
Consultant Connect	Improve access to timely specialist advice and decrease hospital referrals from primary care
Interface Care	Outpatient Antibiotic Therapy: Reduce need for hospital admission due to antibiotic therapy Heart Failure Integrated Care: Reduce admissions due to heart failure Respiratory Integrated Care: Reduce admissions due to respiratory conditions (primarily COPD)
Hospital at Home	Reduce admissions to hospital where care could be provided instead in patients' own homes
In-hospital UUC changes	
Signposting and Redirection	Ensure patients are directed to most appropriate care and reduce unnecessary hospital waits / resource use
Rapid Acute Assessment	Reduce length of stay by facilitating rapid access to senior clinical decision-makers and medical investigations Improve patient flow (Continuous Flow Model)
Discharge without Delay	Reduction in delayed discharges by implementation of Discharge without Delay bundle
Home First Response Service	Reduction in admissions and stays less than 48 hours for frail patients who present at ED or AU