Item No: 11

Meeting Date: **Wednesday 27th November 2024**

Glasgow City Integration Joint Board

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Unscheduled Care Winter 2024-25 Update

Purpose of Report:	This report provides the annual update to the IJB on how Glasgow City and other GGC HSCPs are working with health board colleagues to deliver whole system change against our urgent and unscheduled priorities.
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. The next iteration of the Design and Delivery Plan will be presented for approval to the IJB in Q1 2025.
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.

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 at this stage.
Carers:	NA
Provider Organisations:	N/A
Equalities:	N/A
Fairer Scotland Compliance:	N/A
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 2024/25 includes a "set aside" amount for the commissioning of acute hospital services within scope (e.g. accident & emergency services). This is currently £240.3M for Glasgow City.
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:	N/A

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 an annual 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.

2. Background

2.1 Unscheduled care work across GGC is driven by the Unscheduled Care Joint Commissioning Plan, a 10-year strategy that was approved by IJBs 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. Its successor plan for 2025-2028 is in draft refresh, and will be brought to IJBs in early 2025 for approval.

3. Trends in Unscheduled Care

3.1 **Attendances.** Cumulative unscheduled care demand (Figure 1) across GGC remains higher than pre-COVID levels with a 5% increase in total activity in 2024 to date vs 2019 figures, opposed to only a 1% increase in population. Figures for in-person attendance at Emergency Departments (ED) and Minor Injury Units (MIU) are broadly stable and remain lower than 2019 levels, as more attendances are diverted into our alternative pathways such as the Flow Navigation Centre. Thus far, seasonal patterns of attendance are being observed for 2024 and Glasgow City closely follows the wider GGC trend (Figure 2).

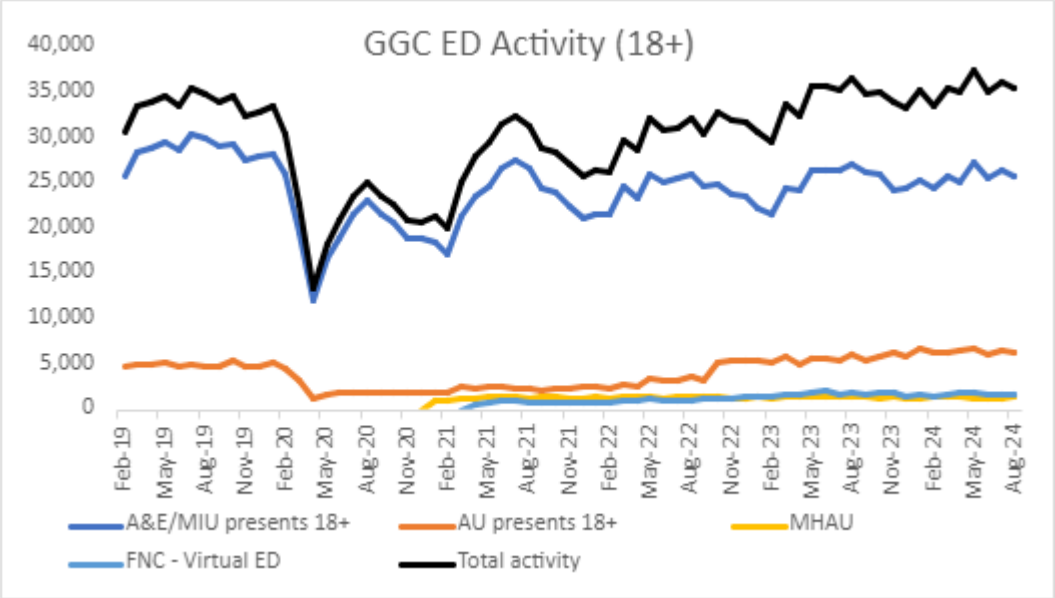

Figure 1. Monthly counts of attendances to Emergency Department (ED)/ Minor Injury Unit (MIU), Acute Assessment Units (AU). Mental Health Assessment Units (MHAU) and Flow Navigation Centre (FNC) from 2019 to 2024. Source: GGC Emergency Department dataset.

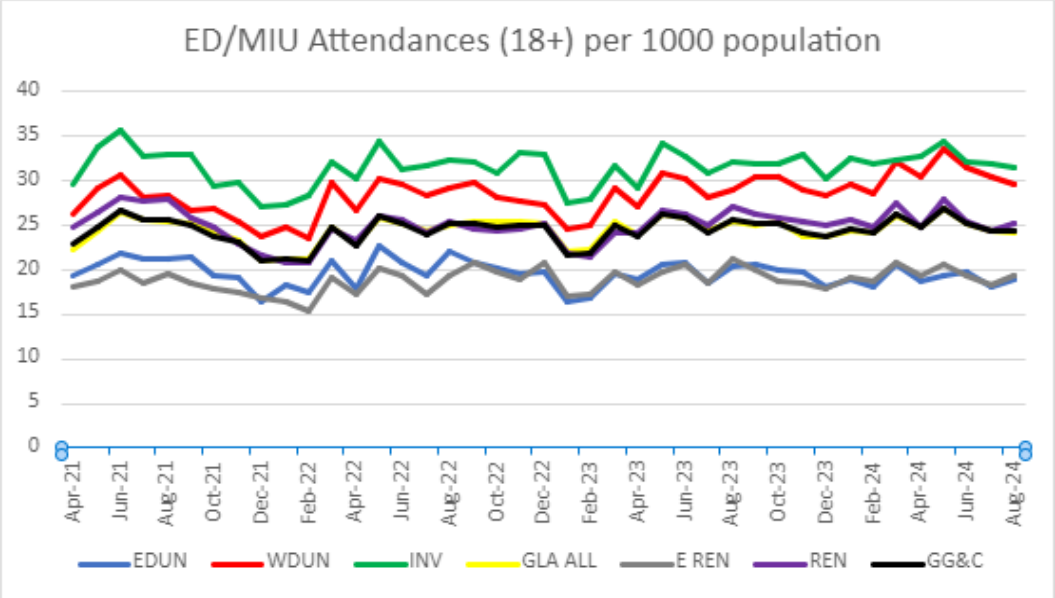

Figure 2. ED/MIU attendances per 1000 population. Source: NHS GGC Microstrategy

3.2 **Admissions.** Emergency admission rates appear to have stabilised post-pandemic with GGC admission rates closely following Scottish rates overall. Variation between HSCPs follows understood patterns attributed to variances in deprivation. Admission rate per 1,000 population by HSCP is shown at Figure 3.

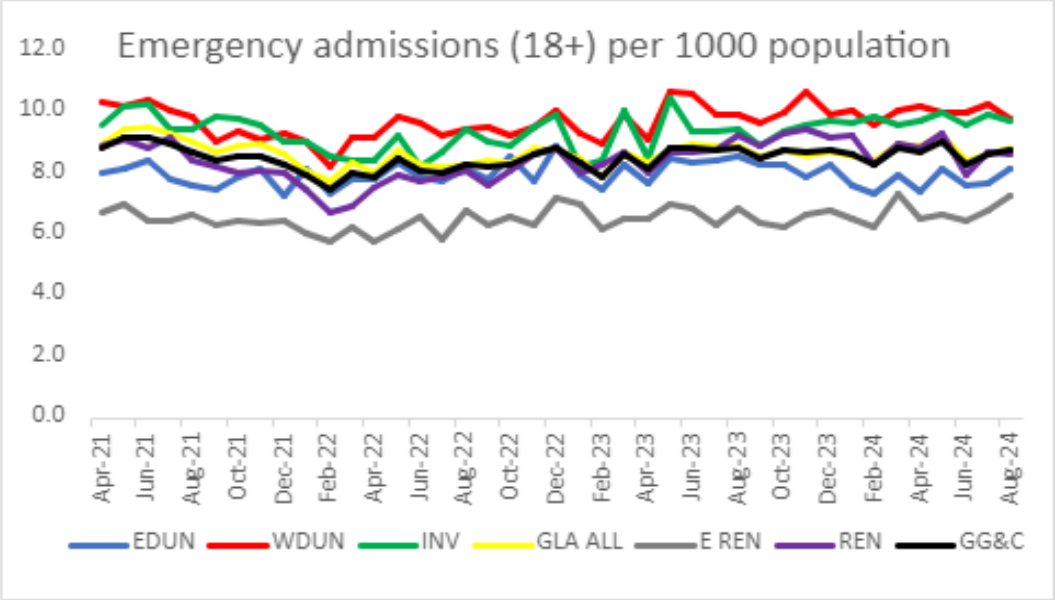

Figure 3. ED/MIU admissions per 100,000 population. Source: NHS GGC Microstrategy

3.3 **Length of stay (LOS)**. Mean length of stay for non-elective admissions in NHS GGC is currently 9.0 days, this has remained above the Scottish average of 7.5 days throughout 2024. The hypothesis for this difference is the compounding longer-term effects of the COVID-19 pandemic on GGC's more deprived population. In our over 65 population, since January 2024, the mean length of non-elective stays was 13.4 days. Trends post-COVID show stability in the mean LOS, however this is despite considerable efforts to reduce length of stay to the minimum clinically appropriate level.

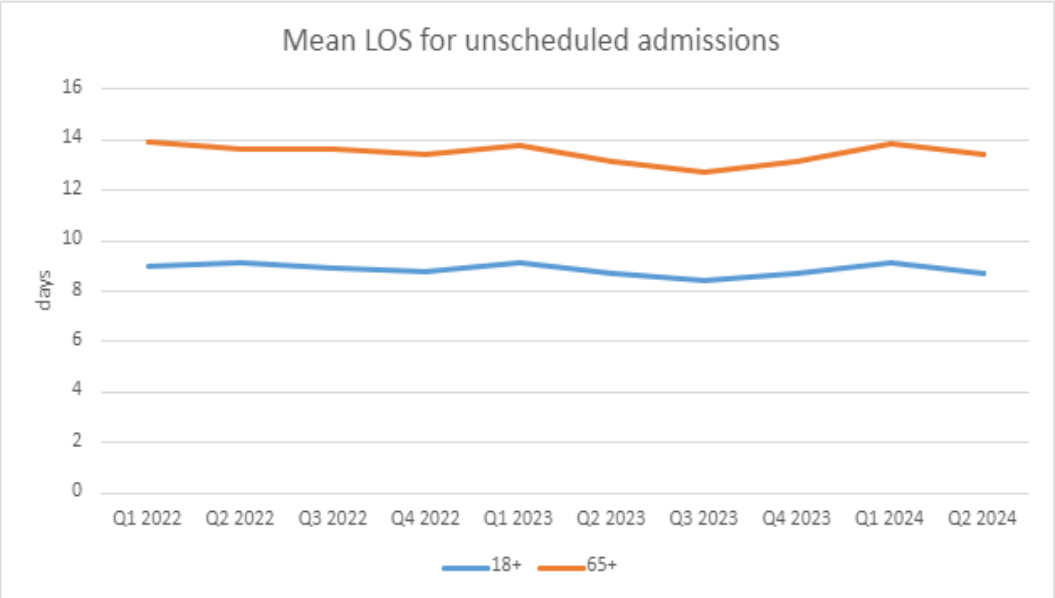

Figure 4. Mean length of stay for unscheduled admissions (65+). Source: GGC Microstrategy

3.4 **Unscheduled Care Bed Days.** Use of unscheduled bed days is following a stable seasonal pattern that has reestablished itself since early 2022. This is exhibited in 18+ and 65+ cohorts (Figure 5). Unscheduled bed day consumption remains higher than in 2019 and this trend is extant even with the removal of delays from the analysis. The increased consumption of unscheduled bed days is attributed to the general increase in complexity in the population as previously discussed.

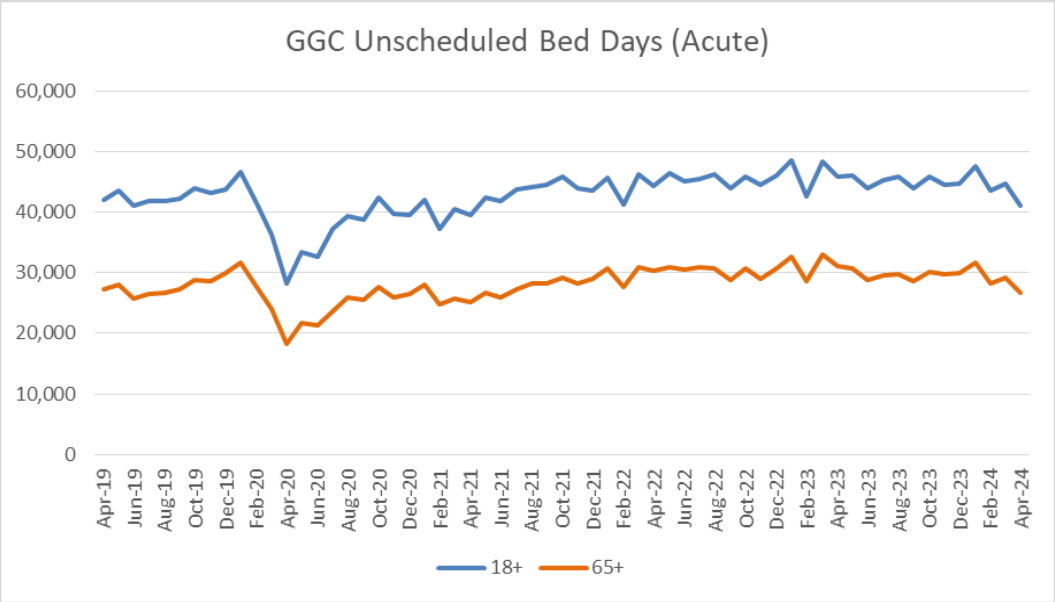

Figure 5. Unscheduled Bed Day use (Acute specialities) Source: PHS Source

4. Unscheduled Care Intervention Progress

4.1 **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 parts of Northwest localities of GCHSCP. The service has demonstrated innovation with new interventions such as an IV antibiotic protocol, a point-of-care capillary blood gas system, and a blood transfusion process. The pharmacy team's contributions have led to savings, improved compliance, and better communication post-discharge. Efforts are ongoing to integrate remote monitoring and digital technologies for further efficiencies. Service achievements for 2023/24 include saving 4,492 bed days for 628 patients, an average length of stay of 4 days and a low rate of onward acute admissions (17%). Evaluations reflect significant satisfaction from referrers and patients and continuous learning from the model. As agreed by the IJB in August 2024, the current service will cease in November 2024 and will be replaced by a new community led service that will deliver against both the aims of the original Hospital @ Home and Glasgow's Care Home Call Before You Convey test-of-change from Winter 2024.

4.2 **Community Care Home Call Before You Convey (CB4YC).** In advance of winter 2023/24, opportunities to reduce unscheduled activity from Care Homes across Greater Glasgow & Clyde were explored. Local evidence suggested that on average 53% of Care Home residents who are conveyed to an Emergency

Department are not admitted. The aim was to avoid unnecessary conveyance of residents to EDs across NHSGGC, recognising the poor outcomes and experience for residents and families when unnecessary conveyances and admissions occur. From December 2023, a test-of-change (ToC) was implemented in all 6 HSCPs with the common aim to significantly reduce the numbers of care home residents conveyed to the emergency department, resulting in a better experience and outcome. East Dunbartonshire HSCP had implemented a ToC during winter 2022/23 with a positive impact reported.

This ToC covered 59% of the older adult care homes across GGC accounting for 57% of the bed base for this population within the homes. There has been a total of 1,345 calls to the community CB4YC pathway from December 2023 to March 2024. n561 residents were triaged and assessed as at high risk of admission, with community intervention these were avoided. With an average LoS of 17 days, this has potentially saved 9,573 bed days. A further n635 residents were of concern triggering homes to follow this alternative pathway to NHS 111. A high number of those without the community input to prevent further deterioration could have results in an ED conveyance within a short time period. These could have been admissions with the potential to have saved a potential 10,795 bed days. Scale up models have been devised to provide support via this pathway to as many care homes as possible across GGC in advance of Winter 2024/25.

There have been 164 calls to the pathway for Glasgow City between December 2023 and March 2024, with 50 patients being maintained in the home, a further 102 patients of concern supported to manage risk of deterioration and only 4 patients conveyed to ED. Glasgow City's model was paused in March 2024, however, it has been agreed that the Glasgow City CB4YC will be reinstated within the 7 Care Homes who were involved in the initial test-of-change. A case for baseline funding will be made to Scottish Government following evaluation of the service to February 2025.

4.3 **Home First Response Service.** This service has been established since 2022 within the Queen Elizabeth University Hospital and Royal Alexandra Hospital. The multi-disciplinary team composed of community staff (Frailty Practitioners, Allied Health Professionals, Pharmacy and Frailty Support Workers) work alongside the acute team to identify, assess and turn around patients at the earliest opportunity, up to 72 hours post-admission. This work aligns with preventative measures such as the development of HSCP Frailty Pathways to support prevention/early intervention activity and future care planning to maintain individuals at home for longer, reducing risk of admission to hospital. The Home First Response Team at both sites assessed 1,979 patients in 2023/24 with 50% being discharged. A Clinical Lead for Advanced Frailty Practitioners has been recruited to support education leadership, teaching and learning across the Frailty network including collaboration with Universities, Operational Leads / AHP Director and Frailty Programme.

4.4 **Frailty at Front Door GRI**. This service was established within the last 18 months and has improved pathway for patients aged >75 with frailty. Resulting in reduced length beds stays from 13-7 days and reduced readmission rate from ~23%-7%. This has been achieved through early identification via frailty screening tool, a dedicated frailty receiving area, early Comprehensive Geriatric

Assessment (CGA) and a daily multi-disciplinary team huddle between acute and community services. HSCP input is integral to this daily huddle as 66% of patients reside within Glasgow City. A HSCP frailty practitioner attends the daily huddle and is able to provide feedback on patient history and community support thereby facilitating earlier discharge. Frailty practitioners will also follow patients into the community, completing the CGA and preventing readmission by direct intervention or referral onto the wider Community Rehabilitation team. There have been 200 Glasgow patients discussed at the GRI frailty huddle, with 25% referred to rehab on discharge from hospital regardless of length of stay and 4 referred directly to a frailty practitioner from ward 53 to support an early discharge.

4.5 **Falls Pathways.** Work is ongoing to reduce the number of conveyances to ED following a fall and to improve our prevention approaches to reduce the risk of falls.

- **Community Integrated Falls & Frailty Pathway.** In collaboration with the Scottish Ambulance Service (SAS), NHSGGC Administration Hub and Flow Navigation Centre, HSCP rehabilitation teams provide timely and appropriate support for individuals who have fallen, those at high risk of falling or those identified as frail and will offer clinically safe alternatives to conveyance to our Emergency Departments for urgent care. The pathway was refreshed in 2024 to include frail patients that would benefit from a referral to a community rehab team. The pathway has thus far demonstrated an increased rate of non-conveyance for fallers with 25% non-conveyance in 2023/24, though not yet reaching the 30% stretch target agreed. A total of 1,933 patients attended by SAS for a fall were non-conveyed in 2023/24 and 747 of these patients were referred for community assessment and support. In Glasgow City, 406 patients were referred for community assessment in 2023/24.

- **Care Home Falls Pathway**. An alternative pathway was required for Care Home residents who experienced a fall that may not require an urgent conveyance to ED. The aim is to reduce unnecessary attendances to ED by providing care homes a direct call to the Flow Navigation Centre for advice/support, this may be via a scheduled Near Me triage call to assess clinical status and signposting to the most appropriate place for intervention or advice to remain within the home. There have been 233 calls to the pathway in 2023/24, an average of 19 per month with 74% of these calls not resulting in an admission to ED. In Glasgow City there have been 104 calls to the pathway in 2023/24 with 86% not resulting in an ED admission.

4.6 **Future Care Planning**. This programme aims to increase Future Care Planning conversations with individuals and the Future Care Plans available via Clinical Portal and the Key Information System (KIS) to support people living with frailty to plan for their future care needs, and, when appropriate, death. In 2023/24, we have seen a 95% increase in Future Care Plans available on Clinical Portal since 2022/23. For Glasgow City, there were 416 Future Care Plans, a 38% increase from the previous financial year. Figure 6 shows the number of available plans by locality for the past 2 financial years. There is currently no tool within our IT systems to capture the Future Care Plans that have been

accessed or if it has influenced the decision not to convey to an acute setting for care or an admission and this is an area for improvement going forward.

Glasgow City Locality	2022/23	2023/24	% Increase/Decrease
GC Wide (Locality Unknown)	**139**	**53**	**-62%**
North East	49	62	+27%
North West	**46**	**144**	**+213%**
South	67	157	+134%
TOTAL	**301**	**416**	**+38%**

Figure 6. Future Care Plans on Clinical Portal 2022/23 and 2023/24

5. Recommendations

5.1 The Integration Joint Board is asked to:

a) Note the contents of this report.