Item No: 12

Meeting Date: Wednesday 27th November 2024

Glasgow City
Integration Joint Board

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Winter Planning 2024/25

Purpose of Report:	To update the Integration Joint Board on the winter planning arrangements for 2024/25.

Background/Engagement:	Guidance has been issued by the Scottish Government to all NHS, IJB Chairs and Local Authorities setting out the expectations for Winter 2024/25. 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 have been taken into account to ensure adequate access to a range of services to support people through Winter.
Fairer Scotland Compliance:	None.
Financial:	There is an expectation of £2.5M of additional winter funding from Scottish Government to the Health Board, however is no expectation of additional funding from the Health Board to HSCPs. The HSCP's financial position has meant that planning for winter has been constrained to what can be delivered within existing budgets. This has limited the scope for new actions, out with our existing improvement programmes.
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 2024/25.

2. Background

2.1 Health Board winter planning commenced in May 2024 and has culminated with the production of the NHS GGC Winter Plan. The plan, designed as a whole-system effort, details how the challenges of winter will be met by the Health and Social Care system in Greater Glasgow & Clyde in line with Scottish Government's Winter Planning Priorities:

- **Priority One**: Prioritise care for all people in our communities, enabling people to live well with the support they choose and utilise effective prevention to keep people well, avoiding them needing hospital care
- **Priority Two:** Ensure people receive the right care, in the right place at the right time, this includes prioritising care at home, or as close to home as possible, where clinically appropriate.
- **Priority Three**: Maximise capacity to meet demand and maintain integrated health and social care services, protecting planned and established care, to reduce long waits and unmet need.
- **Priority Four**: Focus on supporting the wellbeing of our health and social care workforce, their capacity and improving retention, as well as recognising and supporting Scotland's unpaid carers.

2.2 The winter plan action list details whole-system integrated activity to meet winter demand and for HSCPs is primarily focussed on contributions to reducing unscheduled care and promoting efficient discharge. For council only social care functions service level winter planning is conducted prior to winter. This is in addition to business continuity planning which is conducted in expectation of poor weather impacting on service delivery.

2.3 Planners were able to increase the engagement with staff beyond that which was achieved in previous years and efforts were made to ensure that the plan reflects lessons learned from winter 2023/24. Over 220 staff members from across Health, Social Care and partner agencies were involved across 6 workshops and numerous service specific engagement events, as detailed in Appendix 1.

2.4 The NHSGGC 2024/25 Whole System Winter Plan was approved by the NHS GGC Corporate Management Team on 3 October 2024 and by the NHS GGC Board on 29 October 2024. The full Winter Plan can be accessed in the Board meeting papers at the following link (paper 24/112): https://www.nhsggc.scot/downloads/nhsggc-board-meeting-documents-29-october-2024/

2.5 The verbatim narrative of the Winter Plan for the areas of responsibility which the HSCP delivers on behalf of the IJB, namely Primary Care and Community Services is attached at Appendix 2.

2.6 Assurance to Scottish Government as to readiness for winter is for the second year taking the form of a “Winter Checklist” for Health Boards. This has been drafted by NHSGGC Corporate Planning with assistance from all HSCP Planning leads. This was submitted to the Scottish Government on 16 October 2024.

2.7 Key risks identified heading into winter and detailed further in the plan are as follows.

- **Impact of Cost-of-Living Crisis –** Continuing impacts of the surge in inflation in recent years is expected to negatively impact on both staff and patients, particularly those who are already vulnerable and on lower incomes.

- **A surge in COVID or other pathogens –** The possibility of a more severe uptick in respiratory and other winter pathogens has the potential to stretch urgent care services.

- **Disruption of planned care –** The risk of not meeting trajectories for planned care remobilisation if urgent and unscheduled care demand forces reallocation of resources.

- **Workforce –** The risk of higher than expected sickness absence impacting on areas of the system that are already experiencing vacancies or staffing issues.

- **Finance –** Our planning this year is set within the context of an extremely challenging financial position – our actions are therefore focussed on areas of highest impact in the community, but ambition has been restricted by the financial realities faced by HSCPs.

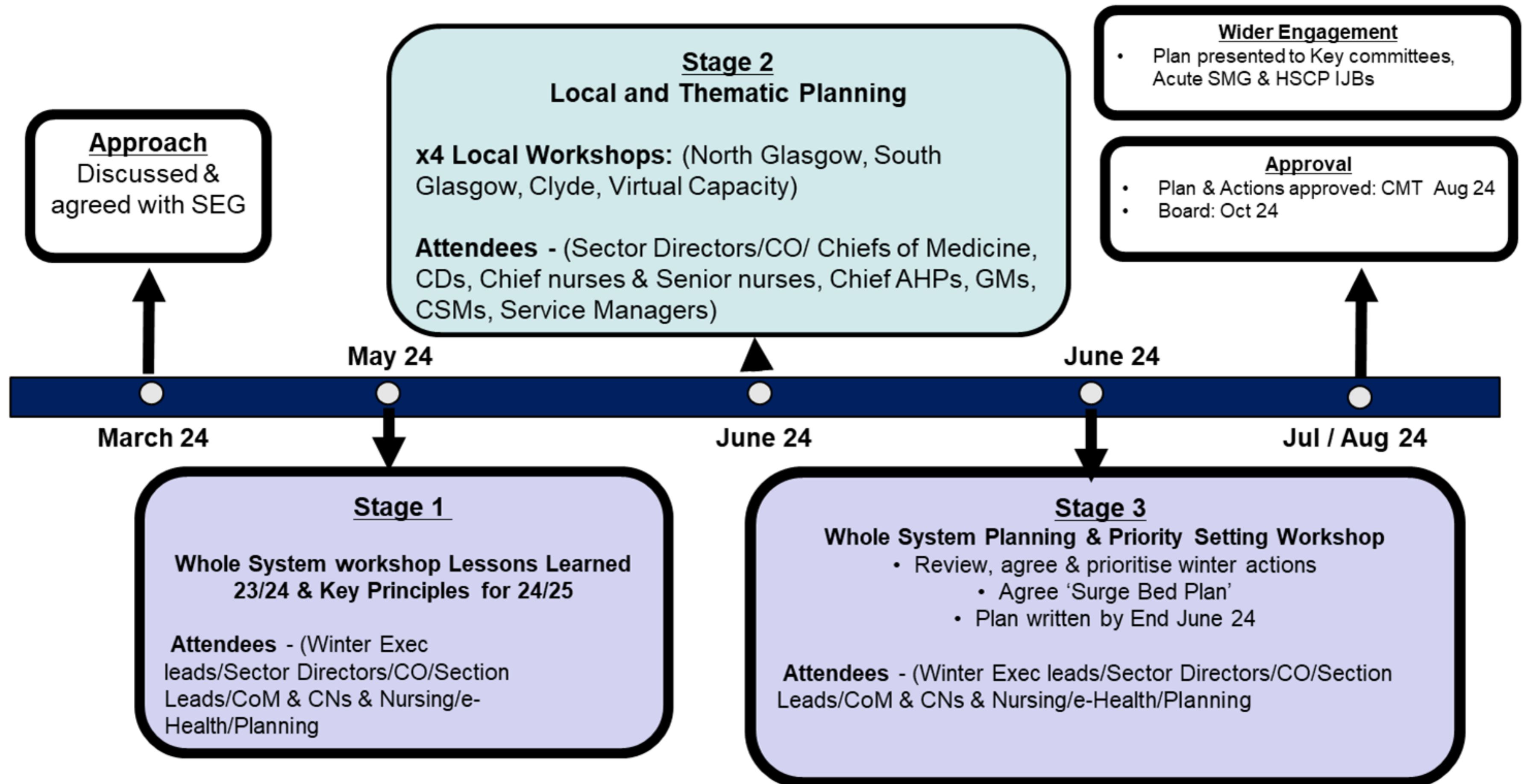
- **Whole system flow –** The risk that length of stay increases, and discharge performance is challenged.

3. Recommendations

3.1 The Integration Joint Board is asked to:

a) Note the contents of this report.

Appendix 1



Appendix 2

Primary Care

In preparation for winter work is underway to support the development of initiatives for General Practice (GP) both for our in and GP Out of Hours (GPOOH) services. The vast majority of urgent care is delivered in Primary Care who continue to work to ensure the most efficient use of all our whole system services and resources.

Our key actions for winter 2024/25:
• Ensuring future care plans (FCPs) are up to date and accessible through the electronic key information summary (eKIS) element of a patient's emergency care summary • Supporting our General Practice in the implementation of the Sustainability Framework to ensuring robust governance and prevent inappropriate diversion of activities within the system amid increased demand • Pilot and evaluate Asynchronous consulting within a small group of General Practices • Promoting the completion at discharge of a 'fit note' following an inpatient stay to reduce increase demand on General Practice • Through the General Practice Sustainability Framework 2023/24 enable General Practices to identify, manage, review Business Continuity Plans (BCPs) and escalate risks • Support patient flow through 'Call Before You Convey' (CBYC) for the those living in care homes • Supporting public messaging on full system access for the Right Care, Right Place, Right Time including alternative to General Practice and the importance of winter vaccinations • Promote the use of the NHSGGC General Practice toolkit to support practice flexibility this winter • Continued contribution of whole system actions with emphasis on developing pathways to identified specialities for general practice to support patient flow • Increase direct access for general practice via our Flow Navigation Centre (FNC) for Minor Injury pathways

Primary Care services are committed to the continued contribution of whole system actions with emphasis on developing pathways to identified specialities for general practice to support patient flow through 'CBYC' i.e. for the those living in care homes, requiring directed to most appropriate care e.g. GPOOHs to reduce admissions to hospital and possible impact on emergency departments. We will work with FNC to increase direct access to general practice for Minor Injuries Unit (MIU) pathways and we will continue to contribute to the developing of public messaging on full system access for the Right Care, Right Place, Right Time including alternative to General Practice and the importance of winter vaccinations.

General Practice

A pilot of asynchronised consultation is underway within 6 GP practices with plans to increase this to 12. This will support patients to seek advice for non-urgent medical conditions, upload health data, submit questions, access self-help information and locate appropriate local services.

Ensuring FCPs are up to date and ensuring the FCP information is more widely accessible through the eKIS to ensure patients are cared for in their preferred location and admissions to hospital are prevented.

To reduce some demand on General Practice, we will continue to promote that where a patient is seeking a fit note following an inpatient stay that this can be done as part of discharge process saving time for both GP and patient.

The General Practice Sustainability Framework 2023/24 is in place to support contractors, HSCPs and NHSGGC and to further enable General Practices to identify, manage, review BCPs and escalate risks. This will ensure robust governance and early warning of emerging risks to the board through frequent reporting to the Strategic Executive Group (SEG).

Urgent Dental Care

We are committed to continuing to provide daytime emergency dental care for unregistered and deregistered patients 5 days per week. To support access for these patients a test of change in 2023/24 increased available daytime emergency dental service appointments by 20 per week and remains in place.

We continue to provide Out of Hours (OOH) emergency dental care to patients registered with General Dental Practitioners and unregistered patients 7 days per week.

Community Services

Integrated community health and social care planning for winter is aligned to supporting and maintaining capacity in Primary Care and enabling patients to remain in community settings where clinically appropriate.

Our key actions for winter 2024/25:
• Maximise our 'Discharge to Assess' programme to ensure that medically fit patients can be discharged to their homes or other suitable settings, where assessments and care planning can be conducted • Ensure our care home capacity meets need and is flexible to support timely discharge • Maximise the use of telecare and digital options to ensure timely discharges and continued patient support • Proactive engagement in guardianship issues as part of Future Care Planning to ensure that patients' care needs are managed effectively

- Maximise our HSCP Frailty Pathways, focusing on prevention and early intervention to maintain individuals at home and reduce hospital admissions
- Preserving acute capacity through admission prevention / early discharge and optimising patient flow back into community settings through effective discharge management
- Optimising our Mental Health Assessment Unit (MHAU) capacity
- Promote and embed our 'Home First' ethos with our acute and community teams to minimise unnecessary acute care
- Expand our Care Home CBYC approach sustainably across all of GGC to avoid unnecessary conveyance and support our patients to remain at home

Partnership Context
HSCPs anticipate a repeat of last year's increased demand for community health and social care services due to the ongoing cost-of-living crisis. Despite falling inflation, many citizens may still face the "heat or eat" dilemma, prevalent over the past two years. HSCPs are proactively engaging with vulnerable citizens to maximise income, secure housing, and take preventative measures ahead of colder weather. Effective service delivery will depend on marshalling third-sector resources, yet financial pressures on local authorities may hinder the provision of services offered last winter.

Staffing challenges continue to impact service delivery, with higher vacancy and absence rates in NHS and local authority posts compared to pre-COVID levels. This is particularly concerning for critical roles like Social Worker (Mental Health Officer) and B5 community nurses, where there is a 13% vacancy rate. High vacancy levels in key roles are driving overspending on supplementary staffing, further straining HSCP budgets.

Primary Care & Community Services
HSCPs have now completed the enhancement of their Primary Care estate delivered through the Primary Care Improvement Programme (PCIP) funded infrastructure projects. The additional clinical space is now fully utilised for primary care services and Community Treatment and Care (CTAC), supporting the integrated delivery of health and social work services.

The addition of PCIP-funded staff, particularly Advanced Nurse Practitioners (ANPs), has strengthened clinical decision support for community teams.

HSCPs are also focused on strategic communications to guide patients into appropriate services. Inverclyde HSCP, for example, has effectively used billboards to promote vaccination and service redirection.

Community Mental Health
We will maintain access to first responders, GPs, etc. to MHAUs and distress response services to maintain contribution to reducing ED presentations and further develop the mental health pathways in NHSGGC for Adults and Older People that currently link SAS, EDs, Police, FNC, NHS24, distress response services and Mental Health Assessment Units (MHAUs).

Conveyance and Admission Prevention
To prepare for winter 2024/25, HSCPs have invested in early intervention and prevention initiatives and revised their Unscheduled Care Delivery Plan for 2024-2027, which will be reviewed and approved by the Integrated Joint Boards (IJBs) ahead of winter.

Several initiatives are showing strong evidence of reducing unnecessary ED attendance, admissions, and unscheduled care bed days, though the trends around unscheduled bed days remains challenging. Our Home First ethos continues to be embraced by acute and community teams to minimise unnecessary acute care.

The Community Integrated Falls Pathway, provides an alternative to ED conveyance for fallers, allowing SAS crews to refer patients through the admin hub to HSCPs for next-day assessment and support by community rehabilitation. This pathway has diverted over 1,700 patients with an average of 24% of fallers being non-conveyed each month.

Falls in care homes, which occur three times more frequently than in the community, are addressed through the Care Home Falls Pathway. This pathway provides a direct advice line for care homes, preventing 68% of potential ED conveyances. To increase awareness, a robust communication network has been developed ahead of winter, closely linking with the Care Home Collaborative.

During Winter 2023/24, all six HSCPs implemented a "CBYC" test-of-change for care homes, recognising that 53% of care home residents conveyed to ED are not admitted. This initiative, which utilised Care Home Liaison Nurses, District Nurses, and ANPs, resulted in only 4% of 1,345 calls from care homes leading to ED conveyance. For Winter 2024/25, HSCPs will expand this CBYC approach sustainably across all care homes. This will be supported by non-recurring care home collaborative funding in the first instance.

The Home First Response Service, launched in November 2022, continues to refine its hub-and-spoke model. This service delivers virtual multidisciplinary teams (MDTs) within two of our acute sites to identify and turn around patients with frailty diagnoses within 72 hours, resulting in more than 50% of these patients being managed at the ED front door and a threefold increase in community rehabilitation referrals. The spoke elements involve developing HSCP Frailty Pathways across all six HSCPs, focusing on prevention and early intervention to maintain individuals at home and reduce hospital admissions.

Efforts are also underway to optimise Community Rehabilitation pathways across HSCPs, where referral numbers have increased by 20-60% compared to pre-COVID-19 levels. Urgent referrals have risen by 20-35%, leading to longer waiting times for routine assessments, with most partnerships experiencing waits of over two months for non-urgent physiotherapy and occupational therapy.

Glasgow City HSCP is redesigning the Hospital @ Home service to integrate acute-level care within the community using existing community nursing staff. This redesigned model will be implemented in November 2024 and combine Hospital @ Home with the CBYC initiative within Glasgow City HSCP and provide capacity for 11 Hospital @ Home virtual beds.

Renfrewshire HSCP is developing a Hospital @ Home model initially with non-recurring funding from HIS. Ahead of winter Phase 1 will encompass transfer of existing inpatients on a Frailty pathway within RAH to Hospital @ Home. Between January and March 2025, Phase 2 and Phase 3 will incorporate further development of the Home First Response pathway and referrals from Emergency Department (ED) clinicians and the front door frailty team including direct referrals through TRAK/Consultant connect from GP practices.

Discharge Management

Optimising patient flow back into the community is crucial for preserving acute medical resources and ensuring that patients receive care as close to home as possible. To achieve this, HSCPs are fully committed to the Scottish Government's "Discharge without Delay" (DwD) programme. All HSCPs are engaged in daily MDT activities aimed at reducing discharge delays.

Hospital Social Work Teams are proactively working within wards to address discharge barriers and are developing a single, integrated community/acute DwD dashboard. The adoption of the Planned Date of Discharge (PDD) has expanded, enhancing the coordination between agencies involved in discharge planning. Efforts to increase the availability of seven-day discharge options and same-day care at home services are ongoing across the Board. Additionally, work streams focused on patient transport, pharmacy co-ordination, and discharge communication are being optimised to facilitate early discharges.

An increasing challenge is the delayed discharge of Adults with Incapacity (AWI) patients, driven by an aging and more complex patient population. HSCPs are utilising 13ZA legislation where appropriate to move patients to alternative care settings and are advocating for legislative changes with the Scottish Government to support safe discharges while upholding patients' rights. Proactive engagement in guardianship issues is also a key part of Future Care Planning to ensure that patients' care needs are managed effectively.

The principles of the Discharge to Assess Policy, implemented in 2021, continue to be embedded within HSCPs. This policy ensures that medically fit patients can be discharged to their homes or other suitable settings, where assessments and care planning can be conducted. Intermediate care beds, available in some HSCPs, offer time-limited interventions that can prevent hospital admissions, facilitate rehabilitation, and enable the assessment of future care needs outside of an acute ward. HSCPs with designated intermediate care beds closely manage performance, ensuring throughput and capacity are maximised, with regular reporting to IJBs and working groups addressing any issues.

The digital telecare infrastructure transition is a multi-million-pound investment, to provide a more reliable service to an increasing number of users. Digital Telecare is a critical tool for supporting discharges and helping citizens remain in their homes as long as possible and all local authorities are undergoing transformation of telecare services from analogue connectivity to a digital service. This will be achieved ahead of Jan 26 in order to meet the deadline of the OFCOM decommissioning of the analogue telephone network. Renfrewshire have delivered a fully digital service in 2024, whilst other HSCPs are in the process. Glasgow City, East Renfrewshire will have digital alarm receiving centres ahead of Winter 24/25 and all HSCPs are rolling out digital devices to their service users. Digital connectivity will provide a future proofed service that can support discharge, maintaining citizens in the community and has the potential to link to citizens own digital technology to enhance safety in the security.

Responder services, which have also received investment from HSCPs, offer essential support by providing additional personal care and assistance to uninjured fallers. During winter, HSCPs will maximise the use of telecare to ensure timely discharges and continued patient support.

Operational Care Services
GGC has 135 care homes. The care home sector, both public and private, faces significant pressures, with occupancy levels exceeding 95%. HSCPs are working closely with providers to ensure capacity is maintained through winter and will offer winter vaccinations to both residents and staff.

Care at Home services remain critical to effective discharge. Best practice continues to be shared through the pan-GGC Care at Home working group to ensure capacity meets need and is flexible to support timely discharge. Across GGC more than 5 million Care at Home visits are delivered per annum. To enhance capacity, a large-scale Home Carer recruitment drive has begun, aiming to ensure services are fully staffed by November 2024.

Pharmacy

Our pharmacy service is essential in ensuring that patients are supported within their communities to receive the Right Care, at the Right Place at the Right Time. Our pharmacy service is also instrumental in supporting optimal patient flow within our acute hospitals.

Our key actions for winter 2024/25:
• Increasing our prescribing capacity within community pharmacies • Stabilising our community pharmacy provision to minimise impact to services • Enhanced public awareness of Pharmacy First through integration into the overall Primary Care communications strategy including targeted messaging

To continue to increase our prescribing capacity within community pharmacies, we will develop and enhance our current Independent Prescriber (IP) population who will be able to deal with common clinical conditions that would normally have to be seen by a General Practitioner (GP). We plan to increase the number of IPs within community pharmacies from 139 to 160 by December 2024.

As outlined in Section 8, our Communications Team will support the enhanced public awareness of Pharmacy First through integration into the overall Primary Care communications strategy, including targeted messaging about consultation availability, benefits and spotlighting the role of pharmacists as independent prescribers.

We will ensure early awareness of any changes beyond core hours for our community pharmacy provision, alongside consideration of demand/needs that will enable early discussions to minimise impact to service. We will examine and review the current model hours of service and look to stabilise community pharmacy provision especially later into the evenings and on Saturday afternoons to support patient care in communities.