Item No: 15

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

Glasgow City Integration Joint Board

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

Contact: **Liam Herbert, Head of Planning, Older People's Services**

Phone: **0141 427 8372**

Winter Planning 2023/24

Purpose of Report:	To update the Integration Joint Board on the winter planning arrangements for 2023/24.

Background/Engagement:	Guidance has been issued by the Scottish Government to all Health Boards, IJB Chairs and Local Authorities setting out the expectations for Winter 2023/24. 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 to support and enable supporting people to remain living independently at home or within their community, preventing unnecessary engagement with formal service provision and keeping people safe from harm.

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:	None.
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 2023/24.

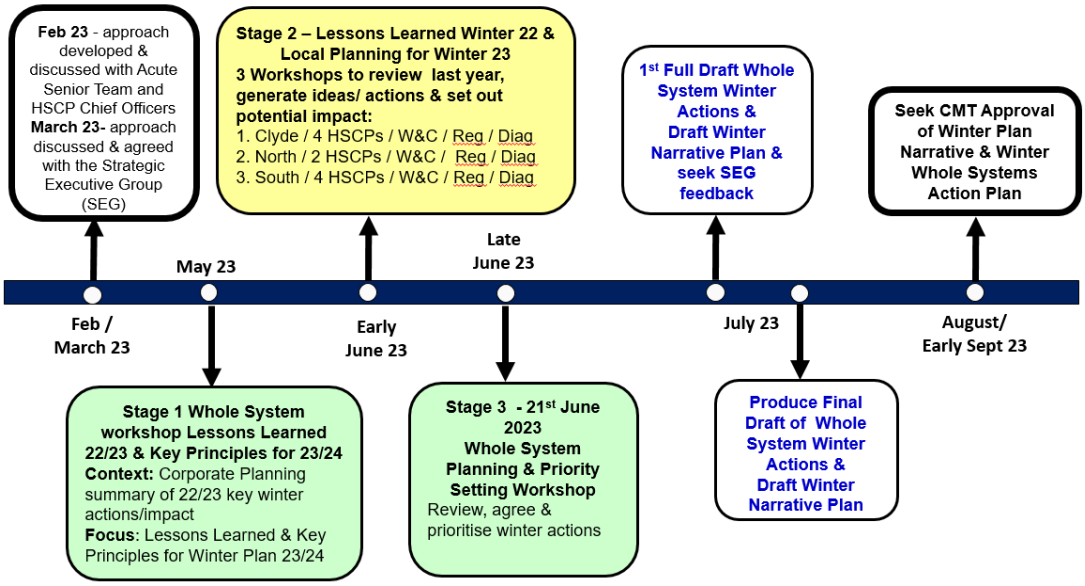
2. Background

2.1 Winter planning commenced in May 2023 as detailed in Figure 1 and has brought together numerous stakeholders from the Health Board, HSCPs, Public Health Scotland, Scottish Ambulance Service, NHS24 and third Sector colleagues to detail how the challenges of winter 23/24 will be met by the Health and Social Care system in Greater Glasgow & Clyde.

2.2 Significant engagement has taken place across our whole system to help review lessons learned from last winter and develop our priorities for this winter as follows:

- Over 50 whole systems leads have supported the development of the key winter principles, lessons learned and proposed whole system actions for winter 23/24.
- Over 150 staff from primary care, mental health, community services, HSCPs and acute sectors have participated in three local winter planning workshops.
- Further follow up conversations have taken place with staff unable to attend the workshops.
- Further discussions were also undertaken with primary care clinical advisory group and the primary care sustainability & support group, and community pharmacy colleagues to help inform our planning.

Figure 1: Approach to Developing the Winter Plan 23/24



2.3 There are numerous recurring contextual challenges that are out with the control of the IJB or Health Board, however, will be mitigated where possible through prudent preventative measures.

- It is recognised that sustained cost of living and poverty related pressures are having an increasing impact on the overall health and wellbeing of our population. Specifically, this can impact on people staying well and staying well at home as well as ability for an effective discharge to take place.
- Demand for support has never been higher and many third sector and statutory sector partners within social prescribing networks are experience funding shortfalls.
- Uncertainty around fluctuating levels of COVID-19 and its enduring impact on service delivery, including the requirement to further vaccinate staff and vulnerable citizens.
- Severity of peaks in other respiratory infections including Influenza.
- Enduring recruitment challenges combined with above average seasonal staff absence on the ability of services to maintain planned service levels.

2.4 The plan was approved by the NHSGGC Corporate Management Team in early September with assurances on content submitted to Scottish Government in late September. Work continues to develop and cost the accompanying Action Plan that details specific key performance metrics for the various winter initiatives.

2.5 Appendix 1 includes the verbatim narrative of the Winter Plan for the areas of responsibility which the HSCP delivers on behalf of the IJB, namely Community and Primary Care services. The full Winter Plan can be accessed here: https://www.nhsggc.scot/downloads/nhsggc-board-paper-23-74-winter-plan/

3. Recommendations

3.1 The Integration Joint Board is asked to:

a) note the contents of this report.

Appendix 1

Community Services

Delivered through GGC's 6 Health and Social Care Partnership's (HSCPs), 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. This by extension includes initiatives focussed on preserving acute capacity through admission prevention and seeks to optimise patient flow back into community settings, achieved through effective discharge management.

Partnership Context

HSCPs envisage a repeat of the increased demand for community health and social care services experienced last year, due to the ongoing cost-of-living crisis. With inflation remaining at over 8% at time of writing there is an expectation that many citizens will be forced into the 'heat or eat' dilemma that impacted many service users last year. All HSCPs are proactively engaging with our most vulnerable citizens to maximise income, secure appropriate housing and act preventatively ahead of colder weather. Marshalling third sector resources and repeating local authority initiatives such as "warm hubs" will be key to effective service delivery throughout winter however financial pressures in local authorities will make it increasingly difficult for HSCPs to deliver the full range of services that were delivered last winter.

Staffing challenges continue to impact on optimised service delivery across the HSCPs. Partnerships are experiencing higher levels of vacancy and staff absence in both NHS and local authority posts against a pre-COVID baseline. This is particularly challenging where vacancies impact on skillsets critical to whole system working such as District Nursing and Social Worker (Mental Health Officer) specialisms. Above expected vacancy levels across several pinch point roles continues to drive overspends in bank and agency staff usage that further pressurise depleted HSCP budgets. Confirmation of additional workforce funding from Scottish Government will be required at least three months ahead of the required date of impact to allow time for the recruitment process.

Primary Care Responsibility

HSCPs continue to enhance our Primary Care estate through the delivery of the Primary Care Improvement Programme (PCIP), supporting effective delivery of Primary Care and integrated Social Work services housed on the HSCP estate by increasing clinical capacity in our existing infrastructure. Additional PCIP funded staff, notably Advanced Nurse Practitioners (ANPs) have also enhanced the clinical decision support available to community teams. Given the sustainability challenges in General Practice, NHS GGC is implementing a new standardised approach of escalation to ensure robust governance and to better understand the impact on patient care. The General Practice Escalation Framework built upon the NHS GGC COVID-19 Escalation Plan sets out measures to enable General Practices (GP) to continue delivery of services and manage increased demand. It is important that this is considered in relation to the overall NHS GGC plan to ensure that activity is not inappropriately diverted around the system.

For Winter 23/24 HSCPs are committed to increasing the effectiveness of their Out of Hours (OOH) services by consolidating and communicating OOH Community services to all stakeholders and expanding some OOH services into a 7-day model through a test-of-change. Digitisation continues to be delivered across Primary Care with expansion of the *Near Me* virtual consultation capability and a desire to develop asynchronous consulting resources, affording increased flexibility to patients in the delivery of their healthcare. All HSCPs also continue to contribute to shaping strategic communications around Primary Care capacity to ensure the patients are appropriately signposted into services and that demand on the system does not routinely exceed capacity due to the increased patient acuity and demand for primary care services observed since the COVID-19 pandemic.

Detailed actions for preserving Primary Care capacity this winter are presented in the Primary Care section below.

Community Service Delivery

Community nursing and Allied Health Professional (AHP) roles remain critical to achieving the strategic aim of care being delivered as close to home as is possible, with the "Home First" ethos well embedded across integrated community teams. HSCPs continue to maximise and optimise available resource with recurring funding having been used to enhance staffing, particularly Frailty Practitioners, AHPs and Community Support Workers who are key to delivering the enhanced frailty pathways in development across the 6 HSCPs. East Dunbartonshire are planning to further increase their successful extension of core District Nursing (DN) hours to all weekends. Alongside the ANPs integrated into their DN service, the impact is anticipated to be; reduced calls to GP OOH and NHS24 resulting in avoidable conveyance to hospital where being cared for at home or in the care home if preferred by the patient, and where it is clinically appropriate. Glasgow City HSCP (GCHSCP) has invested significantly in increased treatment room space for Community Treatment and Care (CTAC) services, freeing up General Practice and District Nursing capacity.

For Palliative Care, a review of the Marie Curie Managed Care (MCMC) has been conducted with feedback from across the five HSCPs which currently use the service. Desire for a more flexible service has created consensus to move toward HSCP aligned palliative and end of life care arrangements. This locally provided arrangement will support more flexible and person-centred care provision; linking directly with the OOH DN service and which includes a similar ratio of Registered Nurses to Healthcare Assistants as is currently being provided by Managed Care. A notice period of six months will allow the HSCP to achieve a state of readiness to seamlessly transfer care (predominately overnight) from Managed Care to Out of Hours.

Community Mental provision is also a key priority for the 6 HSCPs with both the NHS GGC Mental Health Strategy and Older Peoples' Mental Health sub-strategy having been revised since last Winter. Bed remodelling across the inpatient estate will occur through winter, freeing up resources to be invested in enhancing Community Mental Health services.

Detailed MH actions are included in the mental health section below.

Admission Prevention

Avoidance of unscheduled care remains a key objective of HSCP service delivery. Despite budgetary pressures, HSCPs have continued to invest in early intervention and prevention initiatives throughout this financial year in anticipation of Winter 23/24 and have a specific locus of Unscheduled Care avoidance work, centred on the Scottish Government's High Impact Change area 8 (HIC 8).

The **Hospital at Home** (H@H) test of change ended in Mar 23 however the service has been maintained whilst evaluation is undertaken. SEG has approved that a hosted model (H@H) should be expanded across NHS GGC with a financial framework and phasing still to be agreed. In the interim, the service continues to be funded by GCHSCP. The service was expanded in Jul 23 from 10 to 15 beds, following the introduction of criteria led discharge and revised Multi-Disciplinary Team (MDT) review procedures. Delivered within the same staffing envelope the intent is for further expansion to 20 beds in Aug 23. Two additional Glasgow City GP clusters will also come on stream in Aug. Already delivered ahead of winter, GPs can now also access a live bed state which enables them to know if a bed is available before committing time to discuss referral with their patient.

A whole-system effort is the continued refinement of the **Home First Response Service**, launched with phased implementation from Nov 22. Delivering an augmented MDT approach composed of community staff (Frailty Practitioners, AHPs, Pharmacy and Frailty Support Workers) embedded within two acute sites and working alongside the acute team to identify, assess and turn around patients at the earliest opportunity, up to 72 hours. The service is routinely delivering more than 50% of frailty diagnoses; being turned around at the ED front door, with a threefold increase in community rehab referrals (against baseline) expected ahead of Winter. This work aligns with preventative measures such as the development of HSCP Frailty Pathways to support prevention/early intervention activity and ACPs to maintain individuals at home for longer, reducing risk of admission to hospital.

The **GGC Falls Pathway** is now well established across the Board and continues to be optimised ahead of winter due to the higher likelihood of falls at this time of year. The pathway remains the focus of a multi-organisational collaboration to review uninjured fallers, with senior support from GGC Administration Hub, HSCP rehabilitation services, Scottish Ambulance Service (SAS) and Digital Health colleagues. The pathway continues to strengthen and triangulate information for those presenting with falls at our front doors, minimising turnaround times and admission rates, to enable the best outcomes for individuals. The next phase of work will explore options for call-before-convey pathways for other clinical presentations within care homes, utilising local HSCP advance decision makers in addition to escalation routes within Funded Nursing Care (FNC). This work will build upon the evidence base including a tested model within East Dunbartonshire HSCP.

Discharge Management

Optimising patient flow back into the Community is critical to preserving acute medical resources for those who need it most but is also essential to the ambition that patients are best served when clinically appropriate care is delivered as close to home as possible. Work continues to fully rollout the Scottish Government's HIC 7: *Discharge without Delay* agenda with all HSCPs engaged in daily MDT activity to reduce delays.

Hospital Social Work Teams continue to proactively reach into wards to tackle barriers to discharge with work underway to deliver a single integrated community/acute Discharge without Delay (DwD) dashboard. Adoption and use of Predicted Date of Discharge (PDD) is established and is being expanded upon, providing the opportunity to strengthen interface multi-disciplinary discharge planning. Social Work and Care Home providers continue to expand the availability of 7-day discharge options across the Board, as well as maximising the availability of care at home services for same day discharge.

Adults with Incapacity (AWI) patients continue to make up a considerable number of delayed discharges. HSCPs continue to make use of 13ZA legislation where appropriate to enable movement of the patient to an alternate place of care. HSCP board wide reps continue to advocate for overhaul of the legislation in conversations with Scottish Government. Regrettably, fixed term additional funding for additional AWI legal resources have been reduced to 1 FTE, depriving Glasgow City (which has the bulk of AWI delays) of its additional lawyer. Options are being explored to fund the previous level of legal resource ahead of winter due to the impending additional demand for beds. Furthermore, HSCPs are proactively engaging to remedy guardianship issues ahead of time to ensure that patients' care and support needs can be effectively managed.

Intermediate Care remains an effective option for delivering rehab / reablement services in a care home setting as opposed to an acute ward. The majority of HSCPs maintain Intermediate Care (IC) beds. Due to budgetary pressures IC capacity has been reduced this year with Glasgow City reducing from 75 to 60 beds. This will increase pressure on this highly subscribed service. Work is underway to take forward improvement opportunities to maximise the use of capacity and increase throughput. This includes early identification of discharge from acute services, enabling rehabilitation opportunities, weekend admissions and supporting assessment and decision making for onward care, and removing delays / barriers for discharge from IC. Ongoing reviews of performance reporting to the Integrated Joint Board regarding length of stay, discharge home and occupancy; and there is daily reporting and increased scrutiny of patients to support throughput.

HSCPs continue to transition from analogue to **Digital Telecare** through winter ahead of the decommissioning of national analogue telephony in 2025. Transitioning to digital infrastructure and devices represents multi-million-pound investments by HSCPs in this key tool to support discharge and maintain citizens in their own homes for as long as is practicable. Additionally, responder services, invested in by HSCPs, provide an enduring ability to provide additional personal care support and lift uninjured fallers. Through Winter HSCPs will maximise the use of telecare to support timely discharge.

Operational Care Services

Across GGC there are 185 care homes, with over 9,000 staff and ~15,000 residents. The authority delivered and private sector Care Homes sectors remain under substantial pressure with occupancy levels of >95%; and there have been several closures of independent Care Homes observed this year. HSCPs continue to contribute to national conversations on solutions to the current fragility of the independent care home sector. However, the present situation leaves a reduction in flexibility for HSCPs to spot purchase beds in response to discharge demand, in addition to limiting options for additional beds for Intermediate Care.

HSCP commissioners and operational care leads continue to work with Care Home providers to manage flow and support homes to retain patients where possible whilst aiming to limit admissions to acute hospitals. Options are being explored to build on the success of the Care Home Falls Pathway to extend call-before-convey options to Care Homes, enabling prof-prof advice as an alternative to SAS callouts where appropriate.

Vaccinations for care home residents and staff remains a priority leading into winter, with a singular vaccination campaign planned to reduce the impact of circulating seasonal viruses and COVID-19. Recruitment campaigns remain underway to limit the impact of staff vacancies on Care Homes' ability to fully open their beds. However, this remains challenging in the current financial climate and HSCPs remain involved in national conversations around stabilising the Care Home sector ahead of winter.

The capacity of **Care at Home** services remains critical to supporting hospital discharge. All HSCPs are maximising the hours delivered within available budgets. Ahead of winter a Pan GGC Care at Home group has already been established to further explore how Partnerships can address challenges by sharing best practice, supporting process improvement and engaging as a collective about challenges or issues that are common across all 6 GGC HSCPs (e.g. referral pathways from secondary care, access models, response models, resource allocation models etc).

Large scale Home Carer recruitment has commenced to allow a smooth transition into services prior to Nov 23. Thereafter, targeted localised recruitment will be used to plug any gaps due to attrition. In Glasgow City, a paid Internship Programme with Glasgow Clyde College will provide student intern placements during their 18-week Care course starting in Aug 23. This mentored work experience allows students to fully participate in the role of Social Care Assistant and will lead to employment offers to successful interns.

Primary Care

In preparation for winter, work is underway to support the development of initiatives for General Practice both for our in and Out of Hours (OOH) services but crucially it is the contribution of Primary Care services in whole systems working that will ensure the most efficient use of all our services and resources.

Primary Care services are committed to the continued contribution of whole system actions with emphasis on patient flow through **call before convey** 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 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

Key actions for General Practice ahead of winter include:

- Developing a General Practice winter response plan to support practice flexibility this winter
- In addition the GPOOHs service will refine the services escalation plan in preparation for winter

To further support General Practice to better direct patient to access right care, right place, right time through efficient triage and workflow systems we will develop the case for procuring and implementing **asynchronised consultation** enabling primary care to focus of those who need our clinical intervention rather by providing remote advice and treatment. This is reliant on national funding and is part of our **digital development programme.**

Ensuring **anticipatory care plans (ACPs)** are in up to date is a key action ahead of winter 2023. Ensuring the ACP information is more widely accessible through the **electronic key information summary (eKIS)** element of a patients emergency care summary is being considered for specific patient groups to ensure patients are care for in their preferred location and admissions to hospital are prevented.

To reduce some demand on General Practice we will explore 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.

We are also refining the **General Practice Sustainability Framework 2022** 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 weekly reporting to SEG.

Urgent Dental Care

We are committed to continuing to provide day time emergency dental care for unregistered GDS patients, 5 days a week. We have recently commenced a test of change with a view to increasing available emergency appointments within the day time emergency dental service to support access for unregistered and deregistered patients. The test of change commenced at the end of June 2023 for a period of 3 months with evaluation thereafter.

Community Pharmacy

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 GP. We plan to

increase the number of IPs within community pharmacies from 73 to 100 by December 2023.

We will support a reduction in discharge time for patients through the completion of a discharge pilot where patients receive their discharge medicines from hospitals at their local community pharmacy alongside a medicines review. This pilot will also help to inform national discussions around a potential national service.

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.

To reduce pressure within GPOOH and ED and increase patient self-management, we plan to have a test of change for an unscheduled care service at weekends which will include collaborative working with FNC and GPOOH service directing patients to independent prescribers working within community pharmacies as a triage centre.