AGENDA ITEM NO: 7

Report To:	**Integration Joint Board**	**Date:**	**27 January 2025**
Report By:	**Kate Rocks, Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/57/2024/AB**
Contact Officer:	**Alan Best Head of Health & Community Care Inverclyde Health & Social Care Partnership**	**Contact No:**	**01475 715212**
Subject:	**NHS GGC Whole System Winter Plan**		

1.0 PURPOSE AND SUMMARY

1.1 ☐For Decision ☒For Information/Noting

1.2 To provide an update to Inverclyde HSCP IJB on the winter planning arrangements in place for winter 2024-2025.

2.0 RECOMMENDATIONS

2.1 The Integration Joint Board is asked to note the contents of the report.

Kate Rocks
Chief Officer
Inverclyde Health and Social Care Partnership

3.0 BACKGROUND AND CONTEXT

3.1 The NHS GGC whole system winter plan is made up of two parts:

- A narrative document describing our whole system winter plan and a summary of the key actions we will take to prepare for winter 2024/25.

- An action plan setting out the specific whole system actions we will undertake to support and manage winter pressures. The whole systems action plan sets out a description of the action, the intended impact of each action and how we propose to measure the successful delivery of each action.

3.2 The Scottish Government's Winter Planning Priorities are listed below:

- 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.

3.3 Greater Glasgow and Clyde Health Board began winter planning in May 2024. A Plan has been developed in line with Scottish Government's Winter Planning Priorities which takes a whole system approach to addressing the challenges of winter.

NHSGGC 2024/25 Whole System Winter Plan (The Plan) includes an action list which details whole-system integrated activity to meet the increased demand over the winter period. HSCP's have been tasked with actions which reduce unplanned admissions and supporting early discharge.

On the 3 October 2024 the Plan was approved by NHS GGC Corporate Management Team, and, on the 29 October 2024 The Plan was approved by NHS GGC's Board.

4.0 PROPOSALS

4.1 It is anticipated GGC Health Board will receive funding in the region of £2.5M of additional winter funding. There is no expectation of additional funding to HSCP's to deliver actions within The Plan therefore any activity needs to be delivered within existing budgets. Local delivery will be in line with existing programmes of work, particularly within Unscheduled Care.

5.0 IMPLICATIONS

5.1 The table below shows whether risks and implications apply if the recommendation(s) is(are) agreed:

SUBJECT	YES	NO
Financial		X
Legal/Risk		x
Human Resources		X
Strategic Plan Priorities		X
Equalities, Fairer Scotland Duty & Children and Young People		X
Clinical or Care Governance		X
National Wellbeing Outcomes		x
Environmental & Sustainability		X
Data Protection		X

5.2 **Finance**

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A					

5.3 **Legal/Risk**

There are no legal considerations.

5.4 **Human Resources**

None

5.5 **Strategic Plan Priorities**

In line with Inverclyde HSCP's Strategic Plan

5.6 **Equalities**

(a) Equalities

This report has been considered under the Corporate Equalities Impact Assessment (EqIA) process with the following outcome:

	YES – Assessed as relevant and an EqIA is required.
X	NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, assessed as not relevant and no EqIA is required. Provide any other relevant reasons why an EqIA is not necessary/screening statement.

(b) Equality Outcomes

How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
We have improved our knowledge of the local population who identify as belonging to protected groups and have a better understanding of the challenges they face.	Improves access to services
Children and Young People who are at risk due to local inequalities, are identified early and supported to achieve positive health outcomes.	Improves access to services
Inverclyde's most vulnerable and often excluded people are supported to be active and respected members of their community.	Improves access to services
People that are New to Scotland, through resettlement or asylum, who make Inverclyde their home, feel welcomed, are safe, and able to access the HSCP services they may need.	Improves access to services

(c) Fairer Scotland Duty

If this report affects or proposes any major strategic decision:-

Has there been active consideration of how this report's recommendations reduce inequalities of outcome?

	YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
X	NO – Assessed as not relevant under the Fairer Scotland Duty for the following reasons: Provide reasons why the report has been assessed as not relevant.

(d) **Children and Young People**

Has a Children's Rights and Wellbeing Impact Assessment been carried out?

	YES – Assessed as relevant and a CRWIA is required.
X	NO – Assessed as not relevant as this report does not involve a new policy, function or strategy or recommends a substantive change to an existing policy, function or strategy which will have an impact on children's rights.

5.7 **Clinical or Care Governance**

If there is a greater than anticipated seasonal virus impact it is likely to increase demand for service at the same time as Inverclyde HSCP experience higher than usual levels of sickness absence. This will be mitigated by staff vaccine access and service contingency plans.

5.8 **National Wellbeing Outcomes**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Improves health and wellbeing
People, including those with disabilities or long-term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Supports independent living
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Improves experience of services
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Improves quality of life
Health and social care services contribute to reducing health inequalities.	Reduces inequalities
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	Supports unpaid carers
People using health and social care services are safe from harm.	Keeps people safe
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Engages with our community
Resources are used effectively in the provision of health and social care services.	Effective use of resources

5.9 **Environmental/Sustainability**

Summarise any environmental / climate change impacts which relate to this report.

Has a Strategic Environmental Assessment been carried out?

	YES – assessed as relevant and a Strategic Environmental Assessment is required.
X	NO – This report does not propose or seek approval for a plan, policy, programme, strategy or document which is like to have significant environmental effects, if implemented.

5.10 **Data Protection**

Has a Data Protection Impact Assessment been carried out?

	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.
X	NO – Assessed as not relevant as this report does not involve data processing which may result in a high risk to the rights and freedoms of individuals.

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	x
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 Staff engagement has been a key focus while developing The Plan, staff were asked to reflect on successes and failures from previous winters which is evident within The Plan [page 5]. Over 220 staff members across Health, Social Care and partner agencies were involved in 6 workshops and service specific engagement events.

8.0 BACKGROUND PAPERS

8.1 Whole Systems Winter Plan 2024-2025
Winter 24-25 Whole Systems Action Plan

WHOLE SYSTEM - DRAFT Winter Actions

24th September 2024

Action Status
Delivering Intended Impact
On Schedule
At Risk
Delayed

Alignment to SG Winter Priorities	ID	Area of Impact	Winter Action	Impact Rating	Intended Impact	Current Baseline	How will the impact be measured?	STATUS (Impact being met)	Proposed Timeline for completion	Service Lead (Responsible)	Executive Lead (Accountable)
1	**1**	**Prevention through Vaccination**	**Vaccination** - Deliver our winter vaccination programme for Flu and the COVID booster to all those eligible before 15th December including Care Homes and Housebound (estimate 450,000 patients eligible for Covid and/or flu vaccinations in NHSGGC)	**3- High**	To help protect those most at risk from respiratory illnesses	Baseline from 203/24 NHSGGC Overall: Covid - 49.5% Flu (adults) - 46.8% Flu (children) - 62.6% Health Care Staff: Covid (front line workers only) - 32.6% Flu - 39.6%	Actions will also be monitored via NHSGGC vaccination governance structures including the Strategic Immunisation Group - Uptake parameters to be defined by Scottish Government.		End Dec-24	**Bryan Forbes**	**Emilia Crighton**
1	**2**	**Prevention through Vaccination**	**Vaccination -** Increase vaccination uptake for low uptake cohorts: 1. Review of Glasgow City venues to provide more local access to community clinics 2. Convene a corporate short life working group to develop action plan to improve uptake of winter vaccinations amongst health and social care staff 3. Peer vaccination	**3- High**	Increased vaccination uptake	23/24 baseline was: 6 venues (and only 1 in South Glasgow where uptake was lowest)	Monitored via NHSGGC vaccination governance structures including the Strategic Immunisation Group including implementation of action plans and impact on uptake.		End Dec-24	**Marion O'Neill**	**Emilia Crighton**
1	**3**	**Prevention through Vaccination**	**Vaccine Communications** Supporting operational team to promote clinics for staff and public as appropriate	**3- High**	Early and broad reaching uptake of the vaccine, while minimising unneeded contact with General Practices.	**Baseline from 203/24 NHSGGC Overall:** Covid - 49.5% Flu (adults) - 46.8% Flu (children) - 62.6% **Health Care Staff:** Covid (front line workers only) - 32.6% Flu - 39.6%	Measured via vaccine uptake statistics		End Dec 24	**Neil McSeveny**	**Sandra Bustillo**
2, 3	**4**	**Care Closer to Home - Virtual Bed Capacity**	**Community Hospital @ Home** -(new model from Nov 24) cement H@H as a community health led service, expand geographical coverage to whole of Glasgow City	**3- High**	Improve patient experience providing care at home for more patients and avoid hospital admissions. This will reduce bed pressure within acute hospitals - Based on an average length of stay of 4 days and scaling up to a provision of 11 virtual beds it is anticipated that the service could see up to 1,000 patients per year. Noting the average length of stay for an Acute geriatric assessment bed is 11 days	No baseline as new model will not go live until Nov 24	Occupancy levels of virtual beds. % out of 8 beds initially, scaling to 11 over time.		Dec-24	**Anne Mitchell**	**Jackie Kerr**
2, 3	**5**	**Care Closer to Home - ED Capacity and Bed Day Demand**	**Care Home Call Before You Convey** - We will build on the successes of last years Call Before You Convey test of change in care homes to develop a CBYC model for Care Homes in Winter 24/25.	**3- High**	Reduction in ED attendances / Admissions / Unscheduled Bed Day Use Ed Attendance: between ~153/ month and ~387 / month Admission Avoidance: between ~ 77 / month and ~ 198 / month Bed Pressures reduced by: between 1309 bed days / month and 3366 bed days / month	Current conveyances from Care Homes (~420/month) x average Care Home LOS (17d)	Reduction in baseline conveyances from Care Homes (~420/month) x average Care Home admission LOS (17d)		Dec-24	**Stephen Fitzpatrick / Fiona Smith/ Kim Campbell**	**Jackie Kerr**

Appendix 1

Alignment to SG Winter Priorities	ID	Area of Impact	Winter Action	Impact Rating	Intended Impact	Current Baseline	How will the impact be measured?	STATUS (Impact being met)	Proposed Timeline for completion	Service Lead (Responsible)	Executive Lead (Accountable)
2, 3	**6**	**Care Closer to Home - Virtual Bed Capacity**	Develop a Hospital at Home model in Renfrewshire HSCP, initially with non-recurring funding from HIS - Phase 1 (by Nov) will encompass transfer of existing inpatients on a Frailty pathway within RAH to Hospital at Home - Phase 2 (by end January) Home First Response pathway will be further developed to provide Hospital at Home as a pathway from ED to prevent hospital admission. This will incorporate referrals from Emergency Department (ED) clinicians and the front door frailty team - Phase 3 (by March 2025) direct referrals through TRAK/Consultant connect from GP practices		Improve patient experience providing care at home for more patients and avoid hospital admissions. This will reduce bed pressure within acute hospitals - Based on an average length of stay of 7 days and a provision of 15 virtual beds it is anticipated that the service could see up to 780 patients per year. Noting the average length of stay in RAH OAAU is 9.8 days	New service so no established baseline. Note that the H@H service in Glasgow City has typically operated at c. 50% occupancy	Occupancy levels of virtual beds, average LoS in H@H compared to in OAAU		Mar-24	**Carron O'Byrne, Victoria Cox**	**Christine Laverty**
3	**7**	**Care Closer to Home - ED Capacity and Reduce Bed Day Demand**	**Care Home Falls Pathway -** We will continue to work with SAS colleagues to maximise the number of conveyances from Care Homes that can be avoided by offering prof-prof calls through FNC.	**3- High**	Reduced conveyances from Care Homes ED Attendance: between ~5/month≅24/month Admission avoidance: between ~2/month ~ 12/month Bed Pressures: 34 bed days / month204 bed days / month	Current conveyances from Care Homes (~420/months)	Reduction in baseline conveyances from Care Homes (~420 per month) x Average LoS (17d for care home residents)		Dec-24	**Kim Campbell & Fiona Smith**	**Jackie Kerr**
3	**8**	**Care Closer to Home - Primary Care Capacity & ED Capacity**	**Community Integrated Falls and Frailty Pathway -** We will continue optimise our community pathway with SAS colleagues to enable referral into community rehab as an alternative to conveyance for fallers where it is deemed clinically appropriate	**3- High**	Reduced Conveyance to ED by between ~43 and ~82/month Admission Avoidance: between ~6 and 12 per month≅12/month Bed pressures reduced by: between 90 and 180 bed days / month	Average for 23/24 is 25% falls non-conveyed Average referrals 62	% non-conveyance for fallers by SAS crews (target 30%) Increase in number of SAS referrals to HSCPs (target 60) Average LoS (15d)		Dec-24	**Kim Campbell & Fiona Smith**	**Jackie Kerr**
2	**9**	**Community USC Pathway - Primary Care Capacity**	**Community Pharmacy -** we will develop and enhance our current Independent Prescriber (IP) population within community pharmacies who will be able to deal with common clinical conditions that would normally have to be seen by a GP.	**3- High**	Increased IP capacity within 40% of community pharmacies to support increase patient support	139 IPS	Measure the number of prescribers and application for prescription pads. IPs will increase to 160 by Dec 2024		Dec-24	**Alan Harrison**	**Gail Caldwell**
1, 2	**10**	**Primary Care and ED Capacity**	1. **ABC (Ask yourself, Be aware, Call 111)** To deliver reinforcement messaging supporting Right Care, Right Place to ensure staff and the public are aware of where to access treatment. This will centre on evolution of ABC campaign. 2. **Student Campaign**: Communications will be developed to target the student population of NHSGGC, with comms aimed at freshers week and return post Xmas ensuring students know how to access support and advice at the right place and right time. **3. Home for Lunch** Updating and relaunching 'Home For Lunch' discharge campaign	**3- High**	1. To increase awareness of pathways and reduce incorrect presentations. 2. Increased awareness of digital support and ED alternatives amongst students and university staff using a mix of direct and indirect marketing approaches 3. Ensure patients and families are aware of the pre midday discharge approach and encourage conversations to be had early to encourage smooth flow of patients out of the hospital	1. ABC - 60% had seen messaging in 2024 based on ED / ABC survey. 2. Total Consultations 18-25 year olds in October 2023 = 409 versus June = 238 equates to 58% increase. web traffic: tbc . Social Engagement: tbc 3. See discharge without delay measures . Home for lunch webpage visits: tbc	1. ABC Campaign 10% Increase in awareness of ABC messaging . Increase in FNC usage coupled with X% (what is board target?) decrease in F1 / F2 A&E presentations over winter. 2. Student Campaign Increase in click-throughs to student pages by 25%. Increased awareness of FNC by 10% from ED survey Increase in FNC usage by 16-25 year olds coinsiding with decrease in physical site presentations through Sept-December 3. Home for Lunch Increase in traffic to Home For Lunch dedicated Webpage increasing by 20% 5% increase in SM / Media coverage of Home For Lunch messaging compared to 2023-2024. Increase in pre-noon / same day discharges in line with board target.		1. Completion - March 2025 2. Sept - December 2024 3. Launch - October Completion - March 2025	**Neil McSeveny** **Fraser Ferguson / Sector Directors**	**Sandra Bustillo**

Alignment to SG Winter Priorities	ID	Area of Impact	Winter Action	Impact Rating	Intended Impact	Current Baseline	How will the impact be measured?	STATUS (Impact being met)	Proposed Timeline for completion	Service Lead (Responsible)	Executive Lead (Accountable)
1, 2	**11**	**Primary Care and ED Capacity**	**Public Messaging for 'Right Place' -** 1. Directing patients and Highlighting Redirection Policy 2. Ongoing operational support to service to highlight redirection policy through social media/ website/ physical / and print media 3. Supporting national messaging for Power of Attorney throughout winter to Increase public awareness of PoA to support early patient discharge from hospitals 4. On going service support and promotion around alternative pathways to ED, including care in community / Care Home Pathways /virtual pathways such as OPAT / Call Before Convey / Prof to Prof / Falls Pathway 5. Ongoing promotion of primary care services including GPs and Community Pharmacies as part of wider Primary Care strategy and 'fit Note on Discharge.	**3- High**	1. Inform patients of alternatives to ED, the potential to be redirected away from ED if they attend with a condition that could have been supported elsewhere and ensure patients are aware of self care resources, alongside care alternatives, reducing patient attendance rates at ED 2. Increasing staff and public awareness of new services to encourage usage of, resulting in a decrease in front door attendances / ED admissions 3. Reduce pressure on EDs and support appropriate patient pathways	1. ED question: Awareness of other services: Where would you attened for minor cuts and burns= 60% said at home. Where would you go for strain or sprain: 47% saiff at home . Broken bone or fracture: 43% said A&E. If you need medical health fast but it's not 999= NHS24: 65% 2. ED survey: Awareness of redirection: 2024 = yes: 437 versus no:142	Tracking links ED survey - feedback Potential for focus groups A mix of email open rates, tracking links , uptake of services over time Awareness levels of unscheduled care pathways and engagement through campaign materials Increase in understanding of how to use GP and pharmacy services ED survey to demonstrate 10% increase in patient understanding of risks they may be redirected. Overall decrease in non-ED presentations coupled with increase in usage of alternative services. utilise national KPIs based on national measures in place to track impact.		Ongoing Impact measured in March 2025	**Neil McSeveny**	**Sandra Bustillo**
2, 3	**12**	**Virtual Urgent Care - ED Capacity**	**FNC** - Maintain FNC high virtual discharge rate	**3- High**	Avoid attendances at ED - and increase virtual offering to patients.	40% FNC Discharge rate	Maintain or exceed 40% FNC Discharges (on present volumes this is circa 220 patients discharged from FNC per month) - monitored via USC Improvement Framework		Maintain	**Ed Pool & Arwel Williams**	**William Edwards**
2, 3	**13**	**Virtual Urgent Care - ED Capacity**	**FNC patient feedback -** seek continuous feedback from patients to ensure quality care being delivered through virtual consultations and inform improvements to service	**1- Low**	Patient Experience Measurement Framework/Increase confidence in virtual consultations/Increased patient engagement from baseline. Maintain existing performance of 350 patient responses per month Sept 24 - 77% of patients agreed that their needs were being met. Sept 24 - 97% of patients would use FNC again.	Current Baseline of Responses @ Sept 24 - 6555 Responses - 350 per month Qualitative Measurement of output/outcomes from survey will be provided	Patient experience response volume and outcomes. Qualitative Measurement of output/outcomes from survey will be provided to inform improvements in service		Measure regularly and improvements identified	**Daniel Connelly**	**Sandra Bustillo**
2, 3	**14**	**Virtual Urgent Care - ED Capacity**	**NHS24:** Reduce direct referrals to ED from NHS24 by the FNC vetting, removing and treating (via virtual consultation) Direct ED Referrals on receipt and engaging with NHS 24 to review outcomes	**3- High**	Visible increase in virtual consultations. Reduction in the number of NHS 24 ED Direct Referrals at ED between 102 referrals per week (flow 1) and 212 referrals per week (flow 1 and 2).	Monitoring NHS24 direct referrals to ED - average of 465 direct referrals to ED per week.	Monitoring NHS24 direct referrals to ED -		Dec-25	**Fraser Ferguson & Charlene McLaughlin**	**William Edwards**
3	**15**	**Virtual Urgent Care - ED Capacity**	**Redirection** - Expand Minor injuries Pathway to include Minor Illness Pathway 24/7 with focus on redirection off-site to appropriate pathways. Explore the use of self-assessment tools for patients - particularly for Flow 1 patients.	**3- High**	Support the increasing number of people who are self presenting at ED to be redirected to appropropriate services.	Baseline to be confirmed by mid October	Measure number of patients redirected and where the patient is redirected to. This will be monitored via the UUC Measurement Framework		Dec-24	**Fraser Ferguson**	**William Edwards**

Alignment to SG Winter Priorities	ID	Area of Impact	Winter Action	Impact Rating	Intended Impact	Current Baseline	How will the impact be measured?	STATUS (Impact being met)	Proposed Timeline for completion	Service Lead (Responsible)	Executive Lead (Accountable)
3	**16**	**Mental Health Urgent Care - Right Place & ED Capacity**	**Mental Health** 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).	**3- High**	Ensure MH patients have access to urgent care and are in the right environment within our MHAUs. This will also reduce pressure on our E.Ds.	circa 1,350 per month or circa 16,200 p.a (average based on historical data) attednances within our MHAUs	Measure MHAU monthly activity from baseline average		Maintain	**K Gaffney**	**Jackie Kerr**
1, 2	**17**	**ED Capacity**	**Redirection to GPOOHs** -Build on the redirection pathway from QEUH and IRH EDs to GPOOHs and develop pathways to roll this out to GRI and RAH	**2-Medium**	Ensure patients are seen in the right place and seen by the most appropriate professional	Average of 17 patients per month are redirected to GPOOH per month.	Increase current redirection rates from EDs to GPOOHs as appropriate		Dec-24	**Allen Stevenson**	**Christine Laverty**
3	**18**	**Virtual Urgent Care - ED Capacity**	**Urgent Care Pathways:** Review all attendance activity from Jan-June 2024 to determine highest attendance source, to then focus on top 10 diagnosis, where the outcome was discharge. Identify opportunities for direct pathways, avoiding ED and to identify gaps in existing Professional to Professional Pathways i.e., Frailty, Older People and Stroke Services (OPSS), etc. Promotion of pathways for GPs to acute specialities to support prof to prof (avoiding attendance at ED via GP Referral and support direct admission where appropriate) SAS CBYC & Prof to Prof: Embed CBYC principles to mandate prof to prof discussion by SAS prior to conveyance of non-life or limb threatening conditions. Agree access to Prof to Prof support outwith FNC operational hours (10am-10pm).	**3- High**	Reduce attendances at ED/AU by up to 7% (this represents up to 68 fewer ED and AU attendances per week Reduce attendances at ED via GP Referral. Increase SAS calls to FNC via CBYC from average 30 calls per week to 164 per week (flow 1) and 719 patients per week (flow 1 and 2)	On average there is 3,470 patients a week who could have potentially accessed a more appropriate Urgent care pathway instead of ED Average 19 patients per week (flow 1) and 52 patients per week (flow1&2) patients attend ED via GP referrals. On average there is 30 calls per week to FNC via CBYC.	Reduced number of attendances at ED/AU Implement monitor and evaluate new alternative pathways and usage of additional Prof 2 Prof pathways. Decreased Number of GP attendances at ED compared to baseline Increase Total call volume via call before convey and outcomes - Report on SAS referrals to FNC, MH, GPOOH, Community Falls (including Falls and Frailty) - Develop live time Unscheduled Care Dashboard		Dec-24	**Fraser Ferguson, Charlene McLaughlin - working with Sector Directors**	**William Edwards**
2, 3	**19**	**Care Closer to Home - Virtual Bed Capacity**	**Virtual Beds OPAT -** Sustain high levels of activity within the South Sector OPAT Service and explore robust and feasible case for OPAT to be expanded into Clyde. (Please note discussions are underway with North Sector team)	**3- High**	Admission avoidance, improved patient experience - number of virtual beds to be quantified on completion of service spec	South maintain admission avoidance levels equivalent of ~ 50 beds per week. Clyde tbc	Maintained Bed days avoided in South Sector - Circa 50 beds per week - Clyde tbc		Dec-24	**Arwel Williams Neil McCallum and Melanie McColgan**	**William Edwards**
3	**20**	**Care Closer to Home - Virtual Bed Capacity**	**COPD Digital pathway** - Maintain levels of remote management of patients with COPD and move from 800 to a minimum of 1,000 patients	**3- High**	Ability to manage patients remotely and avoid admission Ed Attendance: between ~400 and ~500 fewer attendances Admission Avoidance: between ~400 and ~500 fewer admissions Bed Pressures: between ~2250 and ~4500 bed days saved	23/24 800 patient live on the remote management platform.	Target is total of 1000 patient in 24/25. Reduce emergency admissions and length of stay for patients onboarded onto digital remote care platform.		Dependent on Business Case	**N Warbrick**	**Denise Brown**
2, 3	**21**	**Reducing Acute Bed day Demand (RAH & QEUH)**	**Home First Response Service -** We will further develop our integrated frailty pathway to support early turnaround at the front door via the Home First Response Service at QEUH and RAH sites	**3- High**	% of frail diagnoses at ED discharged to community services. Target is 50% discharge from ED against an original target of 20%.	Currently delivering average 50% discharge from ED against an original target of 20%	Reduction in Unscheduled Bed Day use - number of patients discharged by HFRS x average LOS for 65+ (15d) ED Attendance: between ~42/month≅123/month Admission Avoidance: between ~21/month≅62/month Bed Pressures: between 315 bed days / month 930 bed days / month		Dec-24	**Carron O'Byrne & Kim Campbell & Stephen Fitzpatrick**	**Jackie Kerr**
2, 3	**22**	**Reduce Acute Bed Day Demand (GRI, RAH, IRH, QEUH)**	**Acute LoS -** Utilise Acute bed Model analysis & Access / BI Team work to support improvements in BADS rates and reduce urgent patient LoS in Medical Specialties	**2-Medium**	LoS reduced through 1. increased proportion of day case activity 2.Improvements in Medical speciality pathways to reduce LoS in line with peer / Scottish average LoS	Current baselines detailed within Bed model analysis - move to increase current BADS rates and reduce urgent medical specilaity LoS	Bed model analysis & LoS & BADS opportunites shared with sector team - action plans being developed for each sector which will be monitored through PRGs		Dec 24 to March 25	**Sector Directors**	**William Edwards**

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3	**23**	**Reduce Acute Bed Day Demand (all Acute Sites)**	**Glasgow City Intermediate Care -** We will seek to maximise throughput through the Winter period in order to take pressure off of acute wards, where rehab/reablement could be conducted in an IC setting.	**3- High**	Reduction in acute bed days	90% Occupancy. ALOS of 45 days.	Maximise throughput. Target of 90% Occupancy. Target ALOS <42 days.		December 24 onwards	**Jacqui McGoldrick**	**Jackie Kerr**
3	**24**	**Improve Inpatient Flow & ED Capacity**	**Improve weekend discharge rates** -through introduction of standard approach to Criteria Led Discharge.	**3- High**	Improve current weekend discharge rates at acute sites	Average weekend discharge rates Nov 23-Aug 24 of: Saturday - 8.1% Sunday - 6.4%	Improved weekend discharge rate across GGC Target: Saturday - 12.25% Sunday - 10%		Dec-24	**Sector Directors**	**W Edwards/ C Laverty/ M McColgan**
2, 3	**25**	**Improve Inpatient Flow & ED Capacity**	**Red Bag Programme** - We will maximise use of the recently relaunched Red Bag Programme to improve patient outcomes and facilitate efficient discharge of care home residents who are admitted to hospital	**1- Low**	Improved dialogue between acute & care homes and reduced impact on care home time. Reduced loss of original documentation (POA / DNACPR)Better information to support decision making / understand patient's baseline within ED may led to either avoidance of admission or support reduced LoS .	0% to be relaunched	Monthly data at care home level of attend / admit / LOS. Review with care homes through qualitative survey / dialogue / webinars		Dec-24	**Alan Gilmour & Stephen Fitzpatrick**	**Jackie Kerr**
3	**26**	**Improve Inpatient Flow & ED Capacity**	**Red Cross Discharge Transport** - Glasgow City HSCP Service in GRI & QUEH serving GCHSCP, East and West Dun, East Ren and South Lan areas - will maximise the use of its commissioned Red Cross transport service through winter to facilitate the timely discharge of patients from acute sites back into Community.	**3- High**	Support flow within acute hospitals - avoids ED crowding and ward discharge	727 journeys in 23/24 – unused capacity	Increase the number of patients supported by red cross transport during winter months through effective co-ordination and use of available capacity		Dec-24	**Alan Gilmour**	**Chief Officers**
3	**27**	**Protecting Planned Care Activity**	Develop detailed plan to: 1. Protect surgical bed capacity at Stobhill SCH and Victoria ACH, IRH and GGH 2. Maximise day case and short stay surgery through our ACH capacity 3. Maximise Same Day Discharge pathways 4. Relocate day case activity through our ACHs e.g. plastics 5. Identify the elective bed requirement at each acute hospital site to support the protection of elective beds	**3- High**	Continue planned care programme during winter months through agreed protected elective capacity	Maintaining elective activity levels within the acute division	Maintaining elective activity levels within the acute division		Dec-24	**Sector Directors & Susan MacFadyen**	**William Edwards**

Appendix 2

NHS Greater Glasgow and Clyde

DRAFT

Whole Systems Winter Plan 2024-25

NHS Greater Glasgow and Clyde

FINAL - Approved at NHSGGC Board 29th October 2024

Contents

Winter Planning Principles

This year's winter plan builds on our 23/24 plan. During winter 23/24 we measured the impact of our winter actions, this enabled us to focus both our time and resource on the actions with highest impact across our system.

Key to the success of last year's plan was a number of new initiatives which helped support person centred care and optimal flow across our whole system during the peak pressures of winter. The initiatives that had most impact across our whole system last winter included:

- **Virtual Pathways** - including, 'Call Before You Convey' (CBYC) pathways with Scottish Ambulance Service (SAS) and our Care Home Partners, Redirection and our Home First Response Service assessing and supporting frail elderly patients within our Emergency Departments (EDs) to return home with appropriate community support and avoid unnecessary hospital admission
- **Virtual Bed Capacity** – winter funding enabled the expansion of virtual beds to support care closer to home. Our Outpatient Parenteral Antimicrobial Therapy (OPAT) virtual wards had a significant impact for patients and avoided a significant number of admissions to our acute hospitals
- **Public Messaging** – throughout winter our plan was supported by a targeted public messaging campaign to support and empower patients to access urgent care in the 'Right Place at the Right Time'

As a result of all our whole system winter actions, in winter 23/24 we managed to maintain our planned care programme minimising impact for our patients. Protecting planned care continues to be a key element of our winter plan for 2024/25.

This year's plan has been developed in line with the 4 Scottish Government (SG) Whole System Winter Planning Priorities which are set out in Figure 1 below. Our key whole system winter actions have also been mapped to the 4 SG winter priorities.

Figure 1: Scottish Government Winter Planning Priorities in 2024/25

- **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

It is important to note that this year's plan has been developed within a much more challenging financial context. Our planning has therefore focussed on delivery of actions that will deliver the highest impact within existing resources, through redesign/improvement, to maximise impact and minimise cost. There are a small number of actions that will require funding. All the winter actions have been reviewed by senior systems leaders with only priority actions being put forward within our plan.

1 Introduction & Approach to Developing 2024/25 Winter Plan

1.1 Approach to developing the 2024/25 Winter Plan

Our winter plan is made up of two parts:

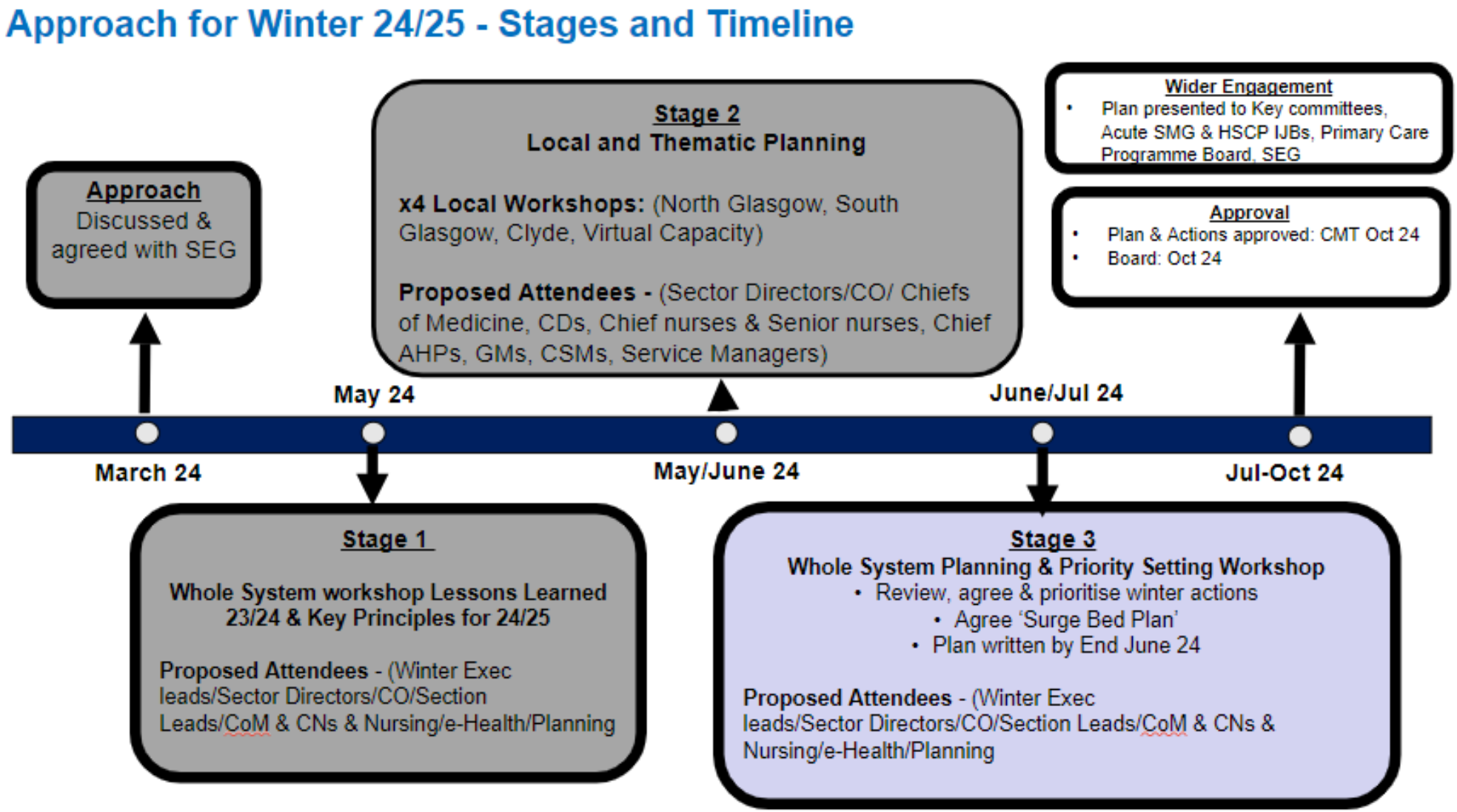
- A narrative document describing our whole system winter plan and a summary of the key actions we will take to prepare for winter 2024/25
- An action plan setting out the specific whole system actions we will undertake to support and manage winter pressures. The whole systems action plan sets out a description of the action, the intended impact of each action and how we propose to measure the successful delivery of each action

In addition to underpin this, local operational winter action plans have been developed. The local action plans set out site and service specific operational winter actions.

This winter plan document should be read in conjunction with the whole system winter action plan contained within Appendix 1.

A summary of the approach to developing our plan is set out in Figure 1.

Figure 1: Approach to Developing the 2024/25 Whole Systems Winter Plan



1.2 Whole System Engagement and Involvement

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

Over 80 whole systems leaders have supported the development of the key winter principles, setting our focus and direction for this year's plans and reviewing our lessons learned and proposed whole system actions for winter 24/25

Over 220 staff from Primary Care, Mental Health, Community Services, Health and Social Care Partnerships (HSCPs), Acute Sectors and our Corporate Services have participated in 4 local winter planning workshops with one specifically looking at whole system virtual capacity opportunities.

Our whole systems workshop events have enabled us to set out the key whole system priorities for this winter, and ensure we capture and learn from last year's winter by asking the following key questions:

- **What went well last year and what do we want to maintain or do again?**
- **What were the challenges?**
- **What virtual capacity pathways or capacity could, or should we develop?**
- **How can we best utilise our workforce during winter?**

We themed our local workshop discussions on the following key areas:

- **Primary Care, Community and Pharmacy Services**
- **Optimising Flow Across our Services**
- **Appropriate Admissions and Preventing Unnecessary Attendances**
- **Virtual Capacity Opportunities**

The aim of our process for winter 24/25 was to synchronise our planning and understand the impact of our actions last winter to enable us to build on our successes and more effectively manage the peak winter pressure in 2024/25.

Supporting peak pressures across our Whole System - in developing our whole system plan we have identified key actions that will support each element of our whole system during peak winter pressure.

Scottish Government (SG) Winter Planning – we will engage with the upcoming SG local engagement sessions following publication of their 2024/25 Winter Preparedness Plan in mid-September 2024.

SAS and NHS 24 – we continue to work with SAS and NHS 24 in support of many initiatives within our redesign of Urgent and Unscheduled Care Programme.

1.3 Key Elements of the 2024/25 Winter Plan

Figure 2 sets out a summary of the key elements of our winter plan in 2024/25.

Figure 2: Key Elements of the 2024/25 Winter Plan	
Winter Planning Context in 2024/25	This section of the plan sets the context for our winter plan in 2024/25, it includes the impact of recent changes to Scottish Government Infection Control guidance, the impact of future COVID or Influenza peaks, health inequalities and the cost-of-living crisis, set against the board commitment to meeting urgent and unscheduled care demand, cancer care needs and protecting planned care. This section also sets out the key risks this winter.
Vaccination Programme	This section of our plan sets out the Flu, COVID and other emerging pathogens vaccination programme.
Urgent Care	• **Primary Care:** this section of our plan sets out the key priority areas of work ahead of winter for primary care including GP practices and GP Out of Hours (GPOOH) services. • **Community Services**: this section of the plan sets out the winter plan for services delivered through the HSCPs and covers the context for HSCPs this winter, primary care responsibility, community service delivery, admission prevention, discharge management and operational care services. • **Community and Acute Pharmacy**: this section of the plan sets out the actions our pharmacy services will take to help manage our community and acute flow during winter. • **Hospital Care:** this section sets out the key planned improvements for winter 2024/25 and includes recent developments that we plan to scale up or accelerate ahead of winter. It also sets out the key whole systems actions we will take to support optimal patient flow across our whole system.
Protecting Cancer, Urgent and Planned Care	This element of our plan sets out how we plan to protect capacity to maintain and deliver cancer, urgent and planned care during the peak winter months.
Communication and Messaging	Central to our winter plan for 2024/25 is our communication and public messaging plan. This section provides an overview of our governance and command structure, our internal staff communications plan, our public messaging plan (Right Care, Right Place), our escalation planning and our patient engagement strategy.
Support Services	**Diagnostics, Estates and Facilities:** this section of the plan sets out the actions our key support services will take to help manage our acute flow during winter.
Workforce	Underpinning the winter plan is the Boards 3-year workforce plan, this section describes the specific preparations for winter in terms of staff well-being and mental health initiatives, additionality and recruitment progress, delivery of supplementary workforce.
Winter Financial Plan	A summary of the financial plan has been developed to support this year's winter plan.

2 Winter Planning Context

2.1 Cost of Living: Population Vulnerability and Whole Systems Pressures

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.

As part of our work to mitigate the impact of such pressures, we will continue to provide nonclinical support to help address both physical health as well as social, emotional and practical needs of our patients.

Alongside primary care services; community link workers and welfare advice in health partnerships (WAHP) continue to connect patients to a wide range of support social prescribing networks. Within acute hospitals Support and Information Service (SIS)/Family Information and Support Service (FISS) provide navigation support for clinical teams and connect patients into these networks.

Demand for support has never been higher and many third sector and statutory sector partners within social prescribing networks are experiencing funding shortfalls. As an 'Anchor' organisation it is necessary to explore a range of funding opportunities with our partners to help sustain the range of services required across GGC.

SIS discharge support provides help with crisis home energy intervention to prevent fuel disconnection and 'going home' food packages for our most vulnerable patients. The SIS will connect people into longer term money advice services, advocate to avoid benefit sanctions, connect with community food initiatives and engage befriending support and other community services to meet patient needs post discharge.

The beneficial impact of referral to benefit and debt management services (Financial Inclusion Services) by healthcare professionals has a strong evidence base and remains a priority action across all Local Authority Child Poverty Action Plans and Hospital Services through our Financial Inclusion partnerships.

Connections with Community Warm Spaces across libraries and community venues will support the provision of health information and promote digital access for patients. Training with partners to provide information, support and technical equipment enables greater use of reputable self-care web materials and apps as well as access to online functionality for NHS services such as Near Me.

Work to support our staff facing money worries continues to be a priority within our Staff Health Strategy.

Increasing reports of transport related financial barriers impacting on patient attendance for appointments suggests that alongside wider promotion of travel reimbursement, there is the need to explore opportunities to develop new and innovative solutions with partners.

2.2 Infectious Diseases

Infectious diseases modelling outputs from the Scottish Government or Public Health Scotland (PHS) teams for winter 2024/25 are not yet available. The following section summarises the observations for GGC from winter 2023/24 and builds on this to assess what we need to consider for winter 2024/25.

Winter 2023/24:

- Two COVID-19 waves, inpatients with recently diagnosed COVID-19 peaking mid-November (approximately 250 inpatients) and early January (approximately 300 inpatients) in GGC hospitals, lower compared to January and March peaks of the previous winter (2022/23) with approximately 500 inpatients each.

- Influenza activity was high, but lower than last season (2022/23) and similar to seasons 2017/18 and 2019/20. The peak of 239 inpatients with influenza in GGC hospitals in 2023/24 in early January coincided with the second COVID-19 peak, but increased activity was drawing out into February/March. The weekly number of new cases recorded in GGC inpatients from week 3 to week 10 during the season 2023/24, represented an increase compared to the figures recorded in the corresponding weeks of the previous six seasons (from 2017/18 to 2022/23).

- Other winter pathogens 'catching up': An increased number of pertussis detections was recorded from week 5 up to date, with a peak of 185 detections recorded in the spring in week 21. Pertussis incidence is cyclical, with significantly higher rates of infection ever few years. The last significant increase in pertussis was recorded in 2012/13. Whilst a measles outbreak occurred in England, sporadic cases were recorded in Scotland, including GGC, peaking in March and April. There was a significant increase in incidence rate for Mycoplasma pneumoniae recorded in early January, when it reached an extraordinary activity level, followed by a decrease in February.

What may be similar (uncertainties) for 2024/25:

- Timing of influenza peak: influenza peak in festive period coinciding with COVID-19 peak – highly probable, due to mixing patterns. Severity of influenza seasons and vaccine match remain difficult to predict, it is still too early to assess vaccine effectiveness in Australia or other parts of Southern Hemisphere

- Timing and number of COVID-19 waves: repeat of two COVID-19 waves likely, at least one of which likely around festive period (timing and severity of a second wave less certain)

- Levels of other winter pathogens: possibly still higher than pre-COVID, uncertainty over remaining susceptibility, uncertainties on whether levels of population immunity have now 'caught up'. Some other pathogens (e.g. mumps) are currently still at very low levels, and there is a potential for build-up of population susceptibility and future surge

- Unknown unknowns: as ever emerging/re-emerging infections may pose unexpected challenges – what may be the 'new MPOX'? (horizon: avian flu)

What is different/may be different:

- Introduction of a respiratory syncytial virus (RSV) vaccination programme in late summer and/or early autumn
- COVID-19 – cohorts for autumn vaccination programme to be confirmed, no details yet whether a spring programme will be implemented
- Integration of financial inclusion advice into initiatives for staff vaccination is being scoped

Vaccine impact:

The likely impact of the vaccination programme is difficult to estimate in advance, as vaccine effectiveness needs to be assessed in each season (dependent on match of vaccine strains with circulating strains, and protection to infection and severe presentation conveyed by vaccine). The following paragraphs provide context on the scale of vaccine impact, based on data from previous seasons.

It was estimated that in Scotland over 27,000 deaths were directly averted in people 60 years and older from December 2020 to November 2021 as a result of COVID-19 vaccination.[1] Data for England estimated that from December 2020 to the beginning of September 2021, over 230,000 hospital admissions in people over 45 years of age were averted directly due to COVID-19 vaccination.[2] Longer term data will be required to estimate the number of deaths or hospitalisations averted each season by COVID-19 vaccination. The relative impact of vaccination in any given season may decrease over time as an increasing proportion of the population have prior immunity from natural exposure and or previous vaccine doses.

Based on evidence from previous seasons (including those with a poor vaccine match), at the Scotland level, seasonal influenza vaccination of those aged 65 years and older on average prevented 732 (95% CI 66-1389) deaths from all causes, 248 (95% CI 10-486) cardiovascular-related deaths, 123 (95% CI 28-218) Chronic Obstructive Pulmonary Disease (COPD)-related deaths and 425 (95% CI 258-592) COPD-related hospitalizations.[3]

[1] Eurosurveillance | Estimated number of deaths directly averted in people 60 years and older as a result of COVID-19 vaccination in the WHO European Region, December 2020 to November 2021
[2] COVID-19 vaccine surveillance report published - GOV.UK (www.gov.uk)
[3] Corson, S., Robertson, C., Reynolds, A., McMenamin, J. (2019) Modelling the population effectiveness of the national seasonal influenza vaccination programme in Scotland: The impact of targeting all individuals aged 65 years and over. Influenza Other Respir Viruses 13(4):354-363. doi: 10.1111/irv.12583. Epub 2019 Jun 5.

2.3 Key Risks

Figure 3 sets out the key risks identified ahead of this winter.

Figure 3: Winter Planning – Key Risks

Risk	Impact Description
Impact of the ongoing Cost-of-Living Crisis: Population vulnerability and whole system pressures	This crisis will continue to be felt most acutely by those who are vulnerable, have health issues or are struggling economically. The risks to the service are many – increase in admissions beyond usual winter prevalence, increase in DNAs due to lack of funds to travel to appointments, delayed discharges due to disconnected home heating or energy or the cost of running medical equipment at home. There are also risks to staffing, prohibitive costs of travel to work, lack of nutritious food, and stress and anxiety about money worries may impact on attendance and performance. 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 at home as well as ability for an effective discharge to take place.
Surge in COVID and Non COVID related demand – Influenza & other winter pathogens 'catching up'	Resurgence of COVID, Influenza, other chronic respiratory or winter pathogens, and seasonal related conditions stretch existing capacity. Delays in treatment for routine conditions results in increasing acuity requirements. Urgent and Emergency care services across primary and secondary care continue to manage high numbers of activity and the consequences of delayed treatment.
Planned care services disrupted by demand for Unscheduled Care	Routine care in primary and secondary care is halted due to urgency of additional unscheduled care. Remobilisation trajectories for recovery of planned care disrupted leading to further extension of waiting times and unmet need.
Availability of workforce	Impact of potential higher sickness absence, current vacancies or potential industrial action on the ability of services to maintain planned service levels.
Financial Risk	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 (considering the actions that had most measurable impact last winter). Please note - The vast majority of our actions are being delivered within existing/available resources.
Whole Systems Flow and Resilience	Risk that length of stay increases, and discharge performance is challenged due to whole systems patient flow not being optimal.
Other 'emerging' potential risks	There are a number of emerging risks in relation to the ability of care home's ability to respond timeously to referrals for assessment.

3 Winter Vaccination Programme 24/25

In line with guidance delivered from Scottish Government and the Joint Committee on Vaccination and Immunisation (JCVI), the winter vaccination programme commenced on 23rd of September (Care homes, Housebound and Health care staff) with community clinics running from 1st of October).

Over 450,000 people will be eligible for this vaccination in NHSGGC, and we aim to offer all those eligible an appointment by the 15th of December 2024 (although the vaccine will

continue to be offered until the end of March 2025). National aspirations are that 85% of all eligible patients have been offered an appointment by the 8th of December but that appointments will continue to be available until January 31st for Covid and March 31st for Flu.

The flu programme will include:

- Residents in care homes for older adults
- All those aged 65 and over
- Frontline health and social care workers
- Non-frontline NHS staff
- Unpaid carers and young carers
- Household contacts of those with a weakened immune system
- All those aged 18 to 64 years in a clinical at-risk group. This includes:
    - those experiencing homelessness
    - those experiencing substance misuse
    - all prisoners within the Scottish prison estate

On Friday 2nd August, the Joint Committee on Vaccination and Immunisation (JCVI) announced the recommended eligible groups for Covid vaccination. Although Frontline Health and Social Care staff have not been named, reference is made to health authorities making decisions/using leeway to offer Covid-19 vaccination to Frontline HSCWs (including all staff in care homes for older adults) this winter.

Covid cohorts 2024-25:

- Residents in care homes for older adults
- All those aged 65 and over
- All those aged 6 months to 64 years in a clinical at-risk group
- Frontline Health and Social Care Workers

Work began in early 2024 to look at increasing attendance for Frontline and All Health care workers. Utilising Public Health Scotland's Health and Social Care Worker Report as well as local lessons learnt from the 2023 campaign have helped formulate the staff vaccination strategy for the 2024 programme.

- Utilisation of the Scottish Ambulance provided mobile bus to offer on-site vaccination for both Covid and Flu
- Return of Peer vaccination for Flu
- Vaccination Champions to help coordinate acute site drop ins and Peer Immunisation champions to help promote vaccination
- Public Health Vaccination teams to offer drop-in clinics at acute sites and ward roaming teams
- Increased communications and IT banners to promote vaccine effectiveness and clinic/drop in locations

The adult flu and all COVID vaccinations will mainly be delivered through a network of 20 community vaccination centres (with other arrangements made via HSCP Community Teams for those unable to travel to a clinic or those within settings such as care homes and prisons). The network of clinics will be supported using the Scottish Ambulance Service Mobile Unit which will be deployed in areas identified by community stakeholders as benefiting from a more local response.

In addition, the following support will be provided:

- Our peer support workers will continue to work with communities where vaccine uptake is low to gain insight into any barriers to vaccination and to develop strategies to overcome them
- Community pharmacies will also offer the flu vaccine to older people and those at higher risk from flu including those with well controlled asthma
- Maternity services will offer pregnant women the flu and COVID vaccines
- School age children will be offered the flu vaccine at school and younger children at children's community clinics

For the winter 2024 COVID-19 programme NHSGGC will be offering the following COVID-19 vaccines.

For all individuals aged 18 years and over, young people aged 12 to 17 years, children aged 5 to 11 years and children aged 6 months to 4 years the Pfizer-BioNTech mRNA (Comirnaty) vaccine will be offered.

Novavax Matrix-M adjuvanted COVID-19 vaccine (Nuvaxovid) may be used as a booster dose for persons aged 12 years and above when alternative products are considered not clinically suitable.

Introduction of the respiratory syncytial virus (RSV) vaccination programme will start in August 2024. Those turning 75-years-old, on and between 1 August 2024 and 31 July 2025, will be the first to receive invitations. The vaccine will also be offered to anyone who is aged 75 to 79 years old on 1 August 2024 as part of 'catch up' programme, as the RSV vaccine is new to Scotland and this group could not be given the vaccine before now.

Also starting from August, pregnant women will also be offered the vaccine to help protect their new-born babies from serious illness caused by an RSV infection. Pregnant women will be offered this during discussions at their 28-week antenatal appointment.
As this is the first year of the programme, there is still a level of uncertainty around the first season impact of a novel programme. For infants, only those born after the start of the programme will have any benefit from the vaccine and therefore any reduction in older aged children will be minimal this year.

4 Urgent Care

We continue to progress our programme of improvement to transform the way in which people access urgent care, providing person centred care, at the right time, in the right place.

The continued implementation of virtual and alternative pathways has shown a positive impact across our community, primary care and acute services. Ahead of winter 24/25 we will focus on prioritising our virtual capacity and interface care services to reduce the demand for in patient care where this care could be provided 'at home' or 'close to home'.

We remain committed to further developing our Urgent Care pathways in those areas that will have the greatest impact for our patients and staff, by providing immediate access to urgent advice or urgent care through a "digital front door" when clinically appropriate and ensuring only those who require to do so attend our EDs, eliminating delays and optimising emergency care for our most urgent patients.

4.1 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.

4.2 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.

4.3 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.

4.4 Hospital Care - Alternative & Virtual Pathways

We continue to see significant unscheduled care pressures, the implementation of alternative pathways in partnership with NHS 24 and SAS has shown a positive impact across our community, primary care and acute services.

Our key priorities that will make the greatest impact in 2024/25 will focus on embedding our virtual and community pathways to further reduce and or avoid attendances and admissions.

Our key actions for winter 2024/25:
• Build on our robust ‘CBYC’ model and develop our Interface with NHS 24, SAS and GPOOH • Ensure that patients are seen and treated in an appropriate setting, and direct patients to more appropriate care outwith our ED’s • Continues to increase activity and sustain a high closure rate in our FNC • Focus on maximising our digital first approach • Discussions are underway to explore options for expanding our OPAT virtual bed capacity to North and Clyde within existing resources

Ahead of winter 24/25, we have reviewed our attendance activity from Jan-June 2024 to determine the highest attendance source and to ensure we focus on the top 10 diagnosis, where the outcome was discharge. We will use this data to identify opportunities for direct pathways, avoiding ED and to identify gaps in existing Professional to Professional (Prof to Prof) Pathways i.e. Frailty, Older People and Stroke Services (OPSS), etc.

We have also reviewed our January - June 2024 data for NHS 24 Direct Referrals to ED to support FNC vetting, removing and treating (via virtual consultation) Direct ED Referrals on receipt and engaging with NHS 24 to review outcomes.

SAS, Call Before You Convey and Professional to Professional Advice

We will continue to build our robust 'CBYC' model and develop our Interface with NHS 24, SAS and GPOOH. This will include working with SAS to develop an action plan to reduce conveyancing rates to hospital. We will promote use of our Prof-to-Prof pathways for GPs to acute specialties and embed the CBYC principles to mandate Prof-to-Prof discussion prior to conveyance of non-life or limb threatening conditions. We will work to agree access to Prof-to-Prof support out with FNC operational hours (10am-10pm).

Signposting, Direction and Redirection

To ensure that patients are seen and treated in an appropriate setting, our EDs now have the ability to signpost and re-direct patients to more appropriate care outwith our ED's. This includes MIUs, Primary Care, Community Pharmacy, Musculoskeletal Physiotherapy (MSK Physio), dental and other appropriate pathways.

Over winter 23/24 we successfully implemented our refreshed Minor Injury redirection pathway within our ED departments. Ahead of winter 24/25 we will expand this pathway to include minor illness 24/7 with a focus on redirection off-site to the most appropriate pathways. We will also explore the use of self-assessment tools for patients – particularly for those patients within our Flow 1 cohort. This will be supported through a robust and tailored communications strategy to help promote the redirection policy across acute sites, while also continuing to signpost the public through the media, social media and online to the most appropriate services for their needs, and to ensure our wider public messaging campaign remains credible and effective.

Flow Navigation Centre (FNC)

The FNC continues to increase activity and sustain a high closure rate whilst also supporting an increase in the number of assessments. The service currently sees around 1,700 patients per month virtually and continues to achieve a discharge rate of above 40%. 'Near Me' video appointments are now the default for patients and is seeing in excess of 90% of patients via video consultation.

Ahead of winter 24/25 we plan to build on our success in the use of 'Near Me' and video consultations, (maintaining use of over 90%) and further using this to support remote consultations particularly through our CBYC Pathways. A key focus for winter 24/25 will be to increase direct access for GPs to access Flow Navigation minor injury pathway and explore opportunities to schedule GP referrals to MIUs.

Virtual Beds - Outpatient Parenteral Antimicrobial Therapy (OPAT)

Our OPAT service allows early discharge of medically stable patients who remain in hospital *only* because of the need for continued intravenous antibiotics. The OPAT service ensures patients can be treated as outpatients and avoid unnecessary hospital admission. The service currently supports 50-60 patients per week with corresponding saving of ~50 beds a week. We are exploring the potential expansion of virtual OPAT beds in Clyde and North Acute Sectors within existing resources.

4.4 Hospital Care - Optimum Patient Flow and Bed Capacity

The importance of optimum patient flow across our entire NHS and Social Care system is further heightened during the peak winter months. In developing this year's plan, we have considered the actions that will have most impact in supporting patient flow.

Our key actions for winter 2024/25:
• Support earlier discharge from hospital through improved Discharge Planning and Home for Lunch campaign • Reducing Delayed Days with a refreshed whole system plan for Delayed Discharges • Reduce Length of Stay (LOS) in targeted specialities to maximise bed usage • Identified Bed Surge Capacity that can be instated to support peak winter activity

Discharge without Delay (DwD) Programme

Ahead of winter we will fully implement Criteria Led Discharge (CLD). Criteria Led Discharge enables a clear clinical care plan to be agreed for all patients within 24 hours of admission, with a planned discharge date (including Saturday and Sunday) linked to functional and physiological criteria for discharge. A formal test of change has taken place in Inverclyde Royal Hospital (IRH) over the summer, with learning from that work informing CLD Standard Operating Procedures. This will help us to discharge more patients at the weekends and reduce bed pressures.

Home for Lunch Campaign and Management of Patient Boarding within Acute Hospitals

In order to support earlier discharged pre midday, we will continue to promote our Home for Lunch campaign to support setting patient expectations of home for lunch and discharge from the ward taking place earlier in the day. In addition, we will also set out the reasons why patients may require to be moved following their admission to support staff and patient communication. Our communications team will also support this campaign to ensure patients and families are aware of the pre midday discharge approach and encourage conversations to be had early to encourage smooth flow of patients out of the hospital.

Support for Boarding patients

To support winter capacity, improve patient flow and reduce LOS we will ensure that we have a multi-disciplinary approach to supporting our 'boarding patients'.

Winter Bed 'Surge' Plan

The bed 'surge' plan proposes that three wards are opened as 'surge' wards providing 48 additional beds for the three month period of January 2025 to March 2025. In extremis, additional beds (that are currently closed) have also been identified within the plan (note these are not costed within the winter financial plan).

Reducing Delayed Discharges
The number of people delayed in their discharge across NHSGGC has remained challenging for some time, with circa 300 people delayed on any given day over the last 20 months. In addition to the potential harm to the person delayed in terms of their health and wellbeing, there is also a significant impact on the board due to the number of bed days lost as a result of delays in discharge.

In July 24, the Scottish Government issued new targets for each HSCP to reduce the number of people delayed. Staff from across NHSGGC's HSCP, Acute and Corporate Services held a delayed discharge 'reset' session in August 24 to review current work streams, processes, and practices in relation to supporting people delayed in their discharge. A series of seminars are being held in Sept/Oct 24, after which work will be commissioned to reshape discharge-related work streams to improve performance across the board.

Following the completion of the seminars, an action plan will be developed to agree and progress the key actions, initiatives, and tests of change required to reduce the number of people delayed.

Some of the actions that have already been endorsed by the group progressing this work are outlined below.

Key Actions

- Embed the principles of the Final 1,000 Days Campaign within NHSGGC's culture across the board
- Raise awareness across all staffing groups of key work streams and processes relating to discharge (e.g., Discharge Without Delay) to ensure a whole system approach
- Continue to roll out and train staff on key Discharge Without Delay initiatives, e.g. Criteria-Led Discharge, Planned Day of Discharge, and increasing Pre-noon/weekend discharges
- Work is underway to share processes in place in each partnership to identify if there are any barriers to timely discharge with a view to adopting best practice.

Reducing Length of Stay (LOS)
As part of our acute bed modelling work we have identified site specific specialties and pathways where there are further opportunities to improve our current LOS. This improvement work is focussed on acute medical specialties where there are opportunities to review pathways and implement best practice to support reducing our LOS and support patient flow.

4.5 Paediatrics

Increased incidence of respiratory infections including Flu and Respiratory Syncytial Virus (RSV), alongside an increased acuity of illness and demands on primary care, have led to

significant pressures on the Royal Hospital for Children (RHC) ED and inpatient wards. This has resulted in higher and sustained demand for urgent care and unscheduled admissions, with the importance of optimum patient flow through RHC further heightened during the peak winter months.

In developing this year's plan we have reviewed and updated our annual contingency plans for RSV and have considered the actions that will have most impact in supporting our front door and patient flow, to ensure all children have timely access to high quality unscheduled and inpatient care services, and service readiness to address and respond to early winter pressures. Please note as outlined in Section 3 the RSV vaccination programme introduced in August 2024 will be offered to pregnant women during discussions at their 28-week antenatal appointment. As this is the first year of the programme, only those born after the start of the programme will have any benefit from the vaccine and therefore any reduction in older aged children will be minimal this year.

The RHC winter escalation process builds contingency and is managed through the daily Safety Huddles, Flow Co-ordinator, Hospital Co-ordinator and Lead Nurses through to Senior Management and Director as appropriate. It allows us to respond to service pressures, manage patient capacity and throughput, and support colleagues in managing demand. Existing communication processes are in place to escalate with partners across the system with a specific regional escalation policy in place for the Neonatal ITU.

Ahead of winter 2024/25 we will:

- Continue to foster our strong interphase with primary care and community services including our GP hotline and through offering winter specific training webinars and supporting information to all GPs
- Work with NSD to ensure capacity for those regional and national services delivered in RHC which would see impact beyond NHSGGC
- Further promote the RHC website and app https://www.rhcg.org.uk/ which has dedicated sections for GPs and parents on the management of bronchiolitis. This includes online bar codes to current pathways and guidelines etc.
- Continue redirection for paediatrics when adequate and possible
- Increase the dedicated RSV Nursing capacity to support this pathway during winter period
- Improve our continuous flow model through ED to inpatient wards

5 Protecting our Cancer, Urgent and Planned Care

In winter 23/24 we were able to continue our planned care programme for the first time by taking a number of steps to protect capacity and ensure we were in a stronger position ahead of winter with a focus on increasing the separation of elective and unscheduled care. For winter 2024/25 SG have asked the Board to prioritise the protection of planned and established care, to reduce long waits and unmet need.

This year we will build on last year's success and have agreed some specific actions to ensure we protect our cancer, urgent and planned care services.

Our key actions for winter 2024/25:

This winter each of our acute sites are developing a site specific plan to support the protection of planned care. This includes:

- Protection of surgical bed capacity at Stobhill SCH and Victoria ACH, IRH and GGH
- Maximisation of day case and short stay surgery through our ACH capacity
- Maximising same day discharge pathways
- Relocation of same day case activity to our ACHs
- Identification of the elective bed requirement at each acute hospital site to support the protection of elective beds

Underpinning the key actions above is a more detailed plan developed by the acute sectors which sets out how they will protect planned care activity across our acute sites, during the peak winter months. A summary of each sectors plan is included below.

South
VACH and GGH elective ward capacity will be protected to support elective activity over the winter period which will benefit General Surgery and Orthopaedics day case and theatre capacity and ensure waiting lists are maintained. The elective programme in QEUH will be protected to allow urgent, complex and cancer patients to be treated and ensure planned care beds are not utilised for boarders.

North
Elective capacity in GRI will be protected to maintain orthopaedic capacity. Where possible, ACH capacity will be utilised by transferring wrist and ankle patients from GRI to existing lists at Stobhill, and through review and maximisation of Friday lists in particular. We will also explore options to run General Surgery, Urology and semi-urgent lap chole lists in ACHs.

Clyde
Capacity will be added at the Same Day Assessment Unit at RAH, with opening hours expanded over the winter period to 24/7, 7 days per week, providing capacity for 8 inpatients and ability to maintain elective capacity. In addition, we continue to clear longest waiting lists in orthopaedics through waiting list smoothing, and with additional APP clinics in place. Existing capacity will be further maximised through robust management of leave to ensure consistent staffing and activity levels, through cross site booking, and by converting cancelled theatre slots to clinics.

Regional
Regional Services will focus on protecting both the ongoing elective programmes and the longest waiting patients in Plastic Surgery and Neurosurgery. Plastic surgery will protect elective beds to allow urgent, complex and cancer patients to be treated in GRI, as over 75% of the Plastic Surgery elective programme is for breast and skin cancers. Beds will also be protected within INS for elective Neurosurgery. This will allow the implementation of endoscopic spinal surgery, to bring down waiting times for patients with lower back pain, and will support the agreed capacity plans approved through the Board's access committees for ongoing reductions in the numbers of people waiting over 1 year.

Gynaecology
We will protect elective capacity across GRI, QEUH and RAH Monday to Friday. We will increase the utilisation of sessions in Day Surgery Unit in ACH to support Treatment Tie Guarantee (TTG) and allow urgent, complex and cancer patients to be treated and ensure planned care beds are not utilised for boarders.

6 Key Support Services

Our Diagnostic, Estates and eHealth services are key services that support the increase in demand and patient activity during the peak winter period. The services will support winter 24/25 as follows:

Mortuary Capacity
Previous winters' have identified the need to create additional mortuary capacity and have had a larger impact on mortuary services than at the height of the COVID-19 pandemic with indications that this will be the new norm. We will ensure the provision of some additional mortuary capacity to deliver the increased requirements during winter 24/25.

Diagnostics
Diagnostic services will support required increases in Imaging or Laboratory capacity to support flow and minimise impact on in-patients waiting times and delivering targets for key diagnostic tests.

Estates
We will ensure that the provision of additional equipment, domestic, catering and portering provision is sufficient to support increase in bed surge capacity and movement of patients during winter.

e-Health – Supporting the 'Digital First' Approach to Service Delivery
Our e-Health team supports our digital first programme to increase virtual and remote pathways across our whole system. This supports delivery of care closer to home and avoids the requirement to attend ED and/or be admitted to hospital.

The team continue to support the expansion of virtual appointments with a focus on maximising FNC referrals to specialties and virtual initial assessment with patients. In addition they continue to support the development of the Call Before You Convey pathways ensuring that our Care Homes are adequately equipped to embed these virtual pathways.

We will continue to build our digital pathway of remote management of patients with COPD through the use of wearable devices to prevent admission. During winter 24/25, we plan to increase the number of COPD patients monitored remotely from 800 to 1,000.

7 Workforce & Recruitment

Our winter workforce plan considers the impact of winter pressures across all job families in all sectors, directorates and partnerships. The challenges of winter are carefully thought through and the planned mitigations have been developed in collaboration with a wide range of stakeholders.

Our key actions for winter 2024/25:
• Protecting staff learning, development and wellbeing time • Promoting messages of looking after own health and wellbeing • Maintaining staff wellbeing and minimising absence where possible • Maximising staff availability

Sickness Absence is an ongoing known challenge peaking throughout the winter period impacting staff availability. We are preparing for this once again in 2024/25. Sickness absence from November 2023-March 2024 averaged 7.8% with 25.6% total absence and peaked in January 2024 at 8.2% and 26.5% total absence. This is noticeably higher than the 6.9% average sickness absence and 24.0% total absence from outwit this period in 2023/24.

All areas of the organisation are supported with detailed reporting providing visibility of those with any periods of absence, absence reasons and volume of absences over agreed periods. This reporting is published on a daily, weekly, and monthly basis, enhancing monitoring, and supporting a reduction in absence. All directorates have agreed action plans and target trajectories. All long-term sickness cases have been reviewed. Additional Human Resources (HR) support is offered to those managing sick absence performance, in line with the Attendance Management policy.

Psychological Absence accounted for 27.7% of all absence in 2023. To help address these absences, a Staff Health Strategy covering the period until March 2025 was developed and was approved at the NHSGGC Board meeting in December 2023. The Strategy has an important role to play in supporting staff mental (and physical) health and wellbeing and this is reflected within the four strategic objectives identified within the Strategy:

1. Strengthening support for mental health and wellbeing including stress
2. Promote NHSGGC as a fair and healthy workplace in line with Fair Work Nation principles
3. Address in-work poverty and promote holistic wellbeing to mitigate inequalities in health
4. Support for managing attendance

There is a wide range of work underway to deliver on these priorities, including support around stress, mental health, bereavement, menopause and physical activity. This includes delivery of an evidence based, high quality Occupational Health Psychology and Mental Health team and a single point of entry into the service to make it easier for staff to access the support that they require.

Overall, the aim of the Staff Health Strategy is to improve staff wellbeing, promote a caring workplace, reduce and prevent ill-health and reduce sickness absence. An action plan will monitor progress, and these key outcomes will allow us to measure improvements:

1. Achieve 80% or more iMatter score in relation to the organisation cares about my health and wellbeing
2. Increase awareness of resources available to support staff health and wellbeing to at least 80% of respondents in the 2024 Staff Health Survey
3. Reduction in all sickness absence by 2025 from current level towards target of 5%.
4. Increase awareness of the Staff Health Strategy from the 2022 Staff Health Survey by a minimum of 5% in the 2024 Staff Health Survey

Nursing Recruitment

Band 5 registered nursing roles have continued to be a challenge with establishment at 88% in Acute as of September 2024 and 86% in HSCPs. Registered nursing as a whole is 92% established in both Acute and HSCPs.

Our annual Newly Qualified Practitioners (NQP) recruitment campaign commenced in March 2024. As of September 2024, 155 candidates have accepted their offer with a further 512 going through pre-employment checks – a total of 667 NQPs who we look forward to welcoming to start their career this year ahead of winter. Upon commencing with NHSGGC, these NQPs will increase the Establishment to over 94% for Band 5 nurses.

A further campaign to recruit 101 internationally educated nurses (IEN) is concluding. All 101 offers have been accepted, with a further 19 on a reserve list. 43 IENs have had their pre-employment checks completed and will join NHSGGC in October with the further 58 being introduced in cohorts over the following months once their pre-employment checks are complete.

Staff Bank

Our Staff Bank has an always open recruitment approach to registered nursing, with targeted recruitment of Registered Mental Health Nurses. All Newly Qualified Nurses (NQNs) will be auto enrolled on to the staff bank.

Learning from 2023/24 initiatives will be used to develop best practice with bank staff engagement, a staff survey, and outbound calls to promote shifts to staff and capture commitments in advance.

The Staff Bank have again added administrative staff throughout the year, providing the option to deploy additional administrative support into wards to allow clinical staff to focus on patient care.

Another key focus is to continue to recruit doctors to the NHSGGC Medical Bank. Further to this, a focus on team service planning will ensure that all job planning is complete and that job plans satisfy the agreed policy and reduce the reliance on supplementary shifts.

8 Communication & Public and Staff Messaging

Communication and public messaging is central to our 2024/2025 winter plan.

Our key actions for winter 2024/25:
• Targeted Winter and Urgent and Unscheduled Care campaign in line with national SG campaigns • Support for the winter public and staff vaccination campaign • Focussed staff messaging to support delivery of our alternative and virtual pathways, and to support Right Care Right Place messaging • Ensure our ongoing patients' feedback is utilised to help shape key messaging and campaign focus across the winter programme

There are several key elements to our communication and engagement plan as follows:

Governance and Command Structure – we will report on activity and effectively adapt messaging based on developing service needs and ensure our messages are responsive. The Communications and Public Engagement Directorate is also embedded across services and can ensure integrated communications planning and delivery through services impacted by winter.

Public Messaging – key to our winter planning and our Urgent and Unscheduled Care programme is how we communicate with the public. In line with national SG campaigns, we will continue to run local messaging to support national campaigns. This will have three strands:

- **Direction:** Our ABC campaign for urgent and unscheduled care will direct the public to consider alternatives including self-care and community services ahead of calling 111 for advice. We will deliver a number of discrete targeted ABC public campaigns into winter, targeting different groups including students and men as well as working with key local influencer groups to help inform the public on how to appropriately use services

- **Promoting specific services:** We are actively promoting our FNC (Virtual A&E) alongside promotion of alternatives to urgent unscheduled care as well and this activity will ramp up in autumn when the student population increases. We will also deliver strong public messaging around the importance of the vaccination programme for both Flu and the COVID vaccination booster as well as providing support around the value of missed appointments to the NHS

- **Pharmacy First (PF)**: We will continue to enhance the public awareness of Pharmacy First through integration into the overall Primary Care communications strategy. This will include targeted messaging about PF – consultation availability, benefits, spotlighting the role of pharmacists as independent prescribers. The approach will utilise a suite of channels including social media, press and some community outreach

- **Redirection:** We will continue to advise the public of our redirection policy if an alternative service would be more appropriate for their needs

Patient and Public Feedback - The Patient Experience and Public Involvement (PEPI) team will continue to provide support and insight regarding patient and public behaviour and choice and this will be utilised to help shape key messaging and campaign focus across the winter programme. Engagement with key communities will continue, with ongoing insight capture through ED service evaluation.

This work will be led by our Communications and Public Engagement Directorate. As with previous years, the programme will use digital, traditional media and community outreach means.

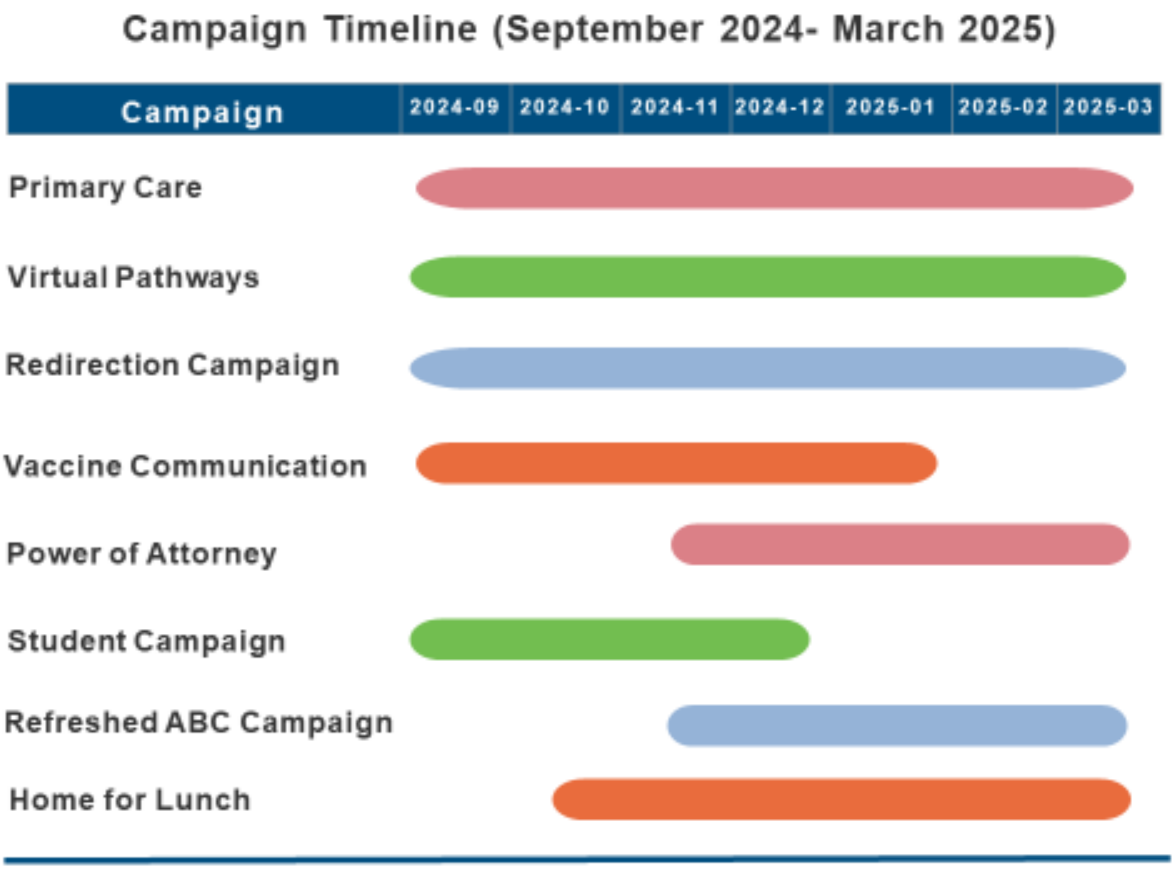
Staff Communication - based on our ED surveys we have identified that those referring Flow 1 patients to ED would benefit from further support and information on ED alternatives and care pathways. We will communicate with staff groups including primary care, Third Sector partners and Local Authorities teams to raise awareness of suitable alternatives.

We will also focus staff messaging on supporting early discharge of patients wherever possible. We will continue to promote our FNC, vaccine programmes, and Right Care Right Place messaging to our workforce and we will advertise alternative pathways to ED to staff as appropriate such as Consultant Connect / Call Before You Convey.

Vaccination

We will deliver staff and public messaging to support the autumn/winter vaccination programme, learning from what worked well in 23/24 and in review of other vaccination campaigns such as the pertussis campaign.

Our timetable for our winter campaign is detailed below:



9 Winter Financial Plan

The Boards winter plan has identified a range of both whole systems actions and local/service or site-specific action plans. These have been reviewed and assessed to identify those with the most impact. Actions that require additional funding have been costed and form part of the winter financial plan.

SG winter funding has now been confirmed with an allocation of £2.5m which is part of the Unscheduled Care funding package and linked to the delivery of the ED 4 Hour Target.

The total costs of this year's winter plan is £2.58m with a significant proportion of these costs associated with the opening of additional surge beds.

10 Monitoring the Delivery of Our Plan

Our whole systems winter action plan is contained within **Appendix 1**, for each element of our plan we have defined the key whole system actions we will undertake to support and address our winter pressures.

For each action we have identified the intended impact and how we will measure the actions impact. Each action has a responsible service lead and an accountable executive lead for delivery.

The whole systems winter actions will be tracked monthly throughout winter and progress reported through SEG with a focus on the actions that we have assessed as having the highest impact. This process will be led by the corporate planning team linking with the key service leads.

In support of our whole system actions we have also developed more detailed operational/service specific location action plans.

Appendices

Appendix 1: Whole Systems Winter Action Plan

Glossary

ANP	Advanced Nurse Practitioner
AWI	Adults with Incapacity
BCP	Business Continuity Plan
CBYC	Call Before You Convey
CLD	Criteria Led Discharge
COPD	Chronic Obstructive Pulmonary Disease
CTAC	Community Treatment and Care
DNA	Deoxyribonucleic acid
DwD	Discharge without Delay
ED	Emergency Department
eKIS	Electronic Key Information Summary
FISS	Family Information and Support Service
FCP	Future Care Plan
FNC	Flow Navigation Centre
GP	General Practice
GPOOH	General Practice Out of Hours
GPs	General Practitioners
GRI	Glasgow Royal Infirmary
HSCP	Health and Social Care Partnership
HR	Human Resources
IJB	Integrated Joint Board
IP	Independent Prescriber
IRH	Inverclyde Royal Hospital
JCVI	Joint Committee on Vaccination and Immunisation
LOS	Length of Stay
MDTs	Multidisciplinary Teams
MHAU	Mental Health Assessment Unit
MIU	Minor Injury Units
MPOX	Monkey Pox
MSK Physio	Musculoskeletal Physiotherapy
NHSGGC	National Health Service Greater Glasgow & Clyde
NQN	Newly Qualified Nurses
NQP	Newly Qualified Practitioners
OOH	Out of Hours
OPAT	Outpatient Parenteral Antimicrobial Therapy
OPSS	Older People and Stroke Services
PCIP	Primary Care Improvement Plan
PDD	Planned Date of Discharge
PEPI	Patient Experience and Public Involvement
PHS	Public Health Scotland

QEUH	Queen Elizabeth University Hospital
RAH	Royal Alexandra Hospital
RMN	Registered Mental Health Nurse
RSV	Respiratory Syncytial Virus
SAS	Scottish Ambulance Service
SEG	Strategic Executive Group
SG	Scottish Government
SIS	Support and Information Service
SVIP	Scottish Vaccination and Immunisation Programme
TTG	Treatment Time Guarantee
WAHP	Welfare Advice in Health Partnership