AGENDA ITEM No.7

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board (IJB) 25 November 2015
Agenda Item	7
Title	Winter Plan

Summary

Scottish Government has issued guidance to ensure that Boards are fully prepared for this winter in order to minimise any potential disruption to patients and carers. Each Health and Social Care Partnership within the NHS Greater Glasgow & Clyde area has a critical role in the wider health care service system. This plan sets out local preparations for winter 2015/16. The report also informs the IJB about unscheduled care planning being undertaken by four task and finish 'Safe and Supported' work groups using improvement methodology, these include:

a) Prevention and Anticipatory Care
b) Point of Possible Admission
c) During Admission
d) Discharge from Hospital

Presented by	Frank White, Head of Health and Community Care Candy Millard, Head of Strategic Services

Action Required

The IJB is asked to note the unscheduled care planning arrangements in place to support the wider health system over the winter period.

Implications checklist – check box if applicable and include detail in report

☒ Financial	☒ Policy	☐ Legal	☐ Equalities
☐ Efficient Government	☒ Staffing	☐ Property	☐ IT

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

INTEGRATION JOINT BOARD

25 NOVEMBER 2015

Report by Chief Officer

WINTER PLAN

PURPOSE OF REPORT

1. To inform the Integration Joint Board (IJB) about unscheduled care planning and preparations for winter.

RECOMMENDATION

2. The IJB is asked to note the unscheduled care planning arrangements in place to support the wider health system over the winter period.

BACKGROUND

3. Scottish Government has issued guidance to ensure that Boards are fully prepared for this winter in order to minimise any potential disruption to patients and carers. Each Health and Social Care Partnership within the NHSGGC area has a critical role in the wider health care service system. It has been agreed through the NHSGGC whole system planning group that each Partnership will produce a local unscheduled care plan with a particular focus on the winter period. These plans should cover:
   - The community service aspects of the 6 essential actions (Appendix 1)
   - Delayed discharge
   - Measures to reduce admissions and attendances
   - Delivery of key service features including single point of access, Care Home support and Anticipatory Care
   - Continuity and resilience
   - Developing an agreed set of indicators to monitor performance
   - Planning with GPs for the two long bank holidays
   - Local Improvement
   - Local Communications

4. The following report sets out local planning arrangements and planned actions under the twelve key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20. The relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance* (Appendix1) are covered within the twelve themes.

REPORT

Planning Activity

5. The HSCP management team reviewed national and NHSGGC guidance, reflected on performance and issues from last winter and have put in place a number of actions to strengthen the HSCP unscheduled care performance.

6. In addition, planning for delayed discharge and unscheduled care had already been identified as a priority area by the Strategic Planning Group. It approved the establishment of four distinct task and finish 'Safe and Supported' work groups using improvement methodology. These include:
   a) Prevention and Anticipatory Care
   b) Point of Possible Admission
   c) During Admission
   d) Discharge from Hospital

7. Partners in the task and finish groups, in line with integration legislation, include third sector, independent sector, carers, health and social care staff and managers, GPs and acute clinicians. The task and finish groups will report back at the beginning of December on a range of additional improvement opportunities they have identified. Prioritised actions will be tested over the winter period and learning captured and incorporated in the Implementation Plan for 2015-18.

Planned Actions

*i. **Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January***

Admission Avoidance

8. A series of measures are in place to avoid admissions:
   - Home care managers are authorised to increase care packages in and out of hours to avoid admission.
   - Third sector partners have been directed to triage and fast track urgent referrals to single point of access or direct to RES team.
   - Information of services and supports have been developed and shared with in house and partner services.
   - Single point of access team receive urgent referrals and rapidly refer to multidisciplinary Rehabilitation and Enablement clusters, who identify the most appropriate professionals to undertake rapid assessment and provide immediate access to preventative supports and care packages. This includes access to step up care home respite with rehabilitation support.

Anticipatory Care Planning

9. There are a number of anticipatory actions established across all health and social care teams. In particular:
   - Rehabilitation and Enablement Cluster Teams have systems in place to predict or identify vulnerable patients at risk of admission so that the necessary support can be given to avoid unnecessary admissions and help people remain in their own homes.

- Advanced Nurse Practitioners lead anticipatory care planning for patients with long term conditions this work has been successful in avoiding unnecessary admissions. ANPS and District Nurses will update ACPs and optimise 'just in case' prescribing.
- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with acute and the Scottish Ambulance Service.
- Community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period.
- A predictive stock order of essential equipment from EQUIPU, wound dressings, pharmacy, and syringe drivers will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.
- Homecare services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users. Council staff from less priority areas can be redirected to support this service and ensuring essential staff can get to and from work.
- Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP, East Renfrewshire Council, and relevant Third Sector websites. This will include "Know who to turn to" and NHSGG&C winter website link.

Expediting Discharge from Hospital

10. Tested measures and additional capacity have been put in place to expedite safe discharge from hospital and avoid re-admission.
    - Inreach social work capacity has been increased from 1 to 2 workers reaching into the new Queen Elizabeth hospital. The role of the workers is to identify people as early as possible (prior to fit for discharge) and commence planning for discharge.
    - A re-ablement home care worker is in place to identify people who would benefit from our re-ablement services and arranging home care cover.
    - A similar model of inreach into the RAH which has been very successful at bringing down delays and supporting people home will continue.
    - For the few people who might benefit from an extended period of assessment or rehabilitation care home beds with inreach from Rehabilitation and Enablement teams are available. This is a real step down model that enables us to do home visits and phased returns home – minimising the risk of readmission and maximising the success of returning home.

ii. Workforce capacity plans & rotas for winter / festive period agreed by October

11. Health and Community Care Service Managers will ensure that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods. This will be monitored via the Health and Community Care Managers meeting and reported to the HSCP Management Team.

iii. Whole system activity plans for winter: post-festive surge

12. The HSCP will continue to contribute to the whole system activity planning and ensure representation at winter planning groups. The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.

13. Situation reports (SITREPs) will be shared between the Community and Acute services to inform escalation pressures.

iv. Strategies for additional winter beds and surge capacity

14. The HSCP will respond where possible to support Acute services in managing surge capacity. There is additional capacity in the local care home market due to speculative development that could be utilised if required.

v. The risk of patients being delayed on their pathway is minimised

15. HSCP in reach services will continue to pro-actively plan discharge, indentifying and tackling any potential issues and barriers in advance of discharge.

vi. Discharges at weekend & bank holiday

16. The Community Nursing service, Telecare responder and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

vii. Escalation plans tested with partners

17. The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments as a result of a particular illness or virus, putting a strain GP services.

18. Regular meetings and phone calls to Care Homes from the commissioning team will be used to share information and identify any issues that require to be escalated.

viii. Business continuity plans tested with partner

19. HSCP staff have participated in a Council wide winter planning exercise to test plans locally. Lessons learned have been incorporated into the HSCP Business Continuity Plan and East Renfrewshire Council Severe Weather/Winter Plan.

20. GP Practices and Pharmacies have Business Continuity Plans in place that include a ‘buddy system’ should there be any failure in their ability to deliver essential services.

ix. Preparing effectively for norovirus

21. Information for Care Homes will be shared by the Independent Sector Integration Lead and the established Care Home Providers Forum.

x. *Delivering Seasonal Flu Vaccination to Public and Staff*

22. All health and Homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions.

23. The HSCP is undertaking peer immunisation for nursing staff and offering immunisation to home care staff.

xi. *Communication to Staff & Primary Care colleagues*

24. To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;

    - Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
    - Circulate updates on services available over festive period, including pharmacy open times, to GP practices
    - Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xii. *Effective analysis to plan for and monitor winter capacity, activity, pressures and performance*

25. The actions set out in this Winter Plan will be monitored and analysed on a fortnightly basis by the HSPC management team. If pressures increase this will increase to weekly or daily meetings as required.

    Particular measures that will be monitored include;
    - Bed days lost to delayed discharge
    - Bed days lost to delayed discharge for AWIs
    - Emergency admissions age 75yrs+
    - Percentage uptake of flu vaccinations by staff
    - Percentage uptake of flu vaccinations by GP population
    - Referrals to Re-ablement Services
    - Referrals to Hospital Inreach Team
    - Referrals to Single Point of Access
    - Demand and capacity (including GP practices)

26. A report analysing the activity, performance and pressures will be produced and reviewed at the end of the winter planning period.

FINANCE AND EFFICIENCY

27. The HSCP has received £537,000 to support winter and delayed discharge planning. Expenditure to date has been on additional inreach and stepdown capacity. The Safe and Supported programme of work will prioritise additional areas for investment.

CONSULTATION

28. The work has built on considerable consultation and engagement through the 'Better by Design' with people who have recent experience of discharge. 'Safe and Supported' workstreams will report back to a stakeholder event on 10 December, where improvement and investment proposals will be prioritised.

PARTNERSHIP WORKING

29. The 'Safe and Supported' workstreams include partnership representation from planning partners, working together to improve unscheduled care.
    - People who use services and unpaid carers;
    - Third and independent sector providers,
    - Acute hospital clinicians and discharge professionals
    - Social work and home care;
    - Nurses, AHPs and other professional groups;
    - GP locality links and CHCP RES locality managers

IMPLICATIONS OF THE PROPOSALS

Policy

30. This report sets out the local response to Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20. The relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance* (Appendix1).

Staffing

31. The requirement to ensure adequate home care cover for the festive period and sufficient post festival assessment capacity will impact on the capacity of certain service areas to grant leave. Managers will work with staff to ensure duty rotas are effectively and fairly managed.

CONCLUSIONS

32. East Renfrewshire Health and Social Care Partnership has prepared this plan in response to Scottish Government guidance to ensure that Boards are fully prepared for this winter in order to minimise any potential disruption to patients and carers. The plan sets out local preparations for winter 2015/16, building on CHCP experience of previous winters. Additional unscheduled care planning is underway with four partnership task and finish 'Safe and Supported' groups using improvement methodology:
    a) Prevention and Anticipatory Care
    b) Point of Possible Admission
    c) During Admission
    d) Discharge from Hospital

RECOMMENDATIONS

33. The IJB is asked to note the unscheduled care planning arrangements in place to support the wider health system over the winter period.

REPORT AUTHOR AND PERSON TO CONTACT

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October 2015

BACKGROUND PAPERS

National Unscheduled Care Programme: Preparing for Winter 2015/16 (DL (2015) 20.

Scottish Government 6 Essential Actions to Improving Unscheduled Care Performance

KEY WORDS

Winter plan; delayed discharge; unscheduled care; hospital discharge; improvement

A report to inform the Integration Joint Board about unscheduled care planning and preparations for winter 2015/16.

APPENDIX 1

6 Essential Actions to Improving Unscheduled Care Performance

To achieve:	Improve:	By managing:	Do these well:
Safe, person centred, effective care delivered to every patient, every time without unnecessary waits, delays and duplication	Patient and Staff Experience	Clinically Focused and Empowered Hospital Management	Triumvirate Management Clinical Leadership Escalation Safety, Flow Huddles
		Capacity and Patient Flow Realignment	Basic Building Blocks Bed Planning Toolkit Workforce Capacity Toolkit Guided Patient Flow Analysis
		Patient rather than Bed Management - Operational Performance	Patient tracking through System Admission/ discharge prediction Balance capacity & demand Proactive Discharge Management
		Medical and Surgical Processes arranged to Pull Patients from ED	Triage to appropriate assessment Flow through ED: minors/majors Access to Senior Decision Maker Access to Assessment/Diagnostics
		7 day services	Smooth admission/ discharge profile Surgical Emergency & Elective Services Integrated SAS Services/ decision support GP/OOH services
		Ensuring Patients are cared for in their own homes	Living & dying well at home Shift Emergency to Urgent Redirection / Know Who To Turn To Short stay assessment / Avoid admission