PERTH AND KINROSS INTEGRATION JOINT BOARD

27 October 2023

PERTH AND KINROSS HEALTH AND SOCIAL CARE PARTNERSHIP WINTER PLAN FOR 2023/24

Report by Chief Officer
(Report No. G/23/144)

PURPOSE OF REPORT

The purpose of this report is to provide the IJB with details of the approach to winter planning for integrated health and social care services delegated to the IJB. It provides details of the significant ongoing pressures and the plan to mitigate these in the context of the additional challenges presented over the winter months. It also seeks approval for funding proposals acknowledging the absence of Scottish Government funding in the current financial year for winter pressures.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:

- Notes the ongoing capacity and flow pressures in health and social care in Perth and Kinross which are likely to increase in the lead up to, and during, winter;
- Approves the Perth and Kinross Health and Social Care Partnership Winter Plan;
- Notes that a Tayside winter plan is being developed in collaboration across the three health and social care partnerships and NHS Tayside acute services which will be presented to the November IJB for noting; and
- Approves the additional spend to support whole system resilience over the winter period, through surge beds in Tay ward and the expansion and extension of the Early Discharge Project to March 2024.
- Issue the direction as set out in Section 6 in the report annex and Appendix 1 to this report.

2. BACKGROUND

2.1 NHS Tayside, the Health & Social Care Partnerships of Angus, Dundee and Perth & Kinross, Scottish Ambulance Service and other key stakeholders are engaging in a collaborative approach towards preparedness and planning for

winter 2023/24. This is coordinated and led by the Tayside Unscheduled Care Board with each partner responsible for their own operational response. This paper defines the approach which will be taken by the Perth & Kinross Health and Social Care Partnership (PKHSCP) and highlights the challenges inherent in our approach including financial constraints and workforce pressures.

2.2 The Tayside Winter Plan is supported by the work of the Scottish Government Unscheduled Care Collaborative. The Collaborative has defined five portfolios of work which set out high impact changes to support sustainable service delivery across the urgent and unscheduled care pathway. These are:

1. Community Urgent Care;
2. Flow Navigation;
3. Virtual capacity / Hospital at Home;
4. Front door flow; and
5. Optimising flow.

The PKHSCP winter plan focuses on maintaining people at home wherever possible throughout the winter and optimising flow through the hospitals to ensure there is enough capacity to provide inpatient care for acutely unwell people as required. Actions are in relation to Portfolio 1 (community urgent care), Portfolio 3 (virtual capacity / Hospital at Home) and Portfolio 5 (optimising flow). Flow navigation and front door flow are led by NHS Tayside and the PKHSCP winter plan is designed to support these portfolios.

With limited PKHSCP non-recurring investment to support our winter plan, our preference is to invest in Tay ward and the Early Discharge Project which have been proven to support people to go directly home rather than to an interim placement in a care home, which was strongly promoted in winter 2022/23 funded by Scottish Government. This allows us to maintain our strategic direction in relation to providing care at, or close to, home.

The PKHSCP winter plan also takes full account of the priorities for winter set out within the Scottish Government's winter checklist. The Tayside Unscheduled Care Board has oversight in Tayside for coordinating the winter response as part of the strategic approach to delivery. All three Health & Social Care Partnerships develop local plans which are contained within the overarching Tayside Plan demonstrating the ongoing commitment to partnership and integrated working and the appreciation that a whole system response is essential.

2.3 Due to the longer term impact of Covid-19 on vulnerable people and whole system capacity and flow, considerable pressure has been felt across inpatient services, care homes, care at home, community hospitals and more generally across all health and social care community teams and services. Locally, this is compounded by the existing pressures of an increasingly older population; the geographic spread of vulnerable people who rely upon community health and social care to support their daily living; and increased demand and complexity of people requiring support which impacts on service wide system capacity and flow.

2.4 The increase in the proportion of the population aged 65 or older can be seen quite starkly in the old age dependency ratio, which is defined as the number of people aged 65 or older per 100 people of working age. Figure 1 (below) illustrates the projected increase in the OADR for Perth & Kinross between 2019 and 2030. In 2019 there were 36 adults over the age of 65 for every 100 people of working age; this year (2023) there are just under 40 older adults per 100 people of working age, and by 2030 there are predicted to be just under 50 older adults per 100 people of working age.

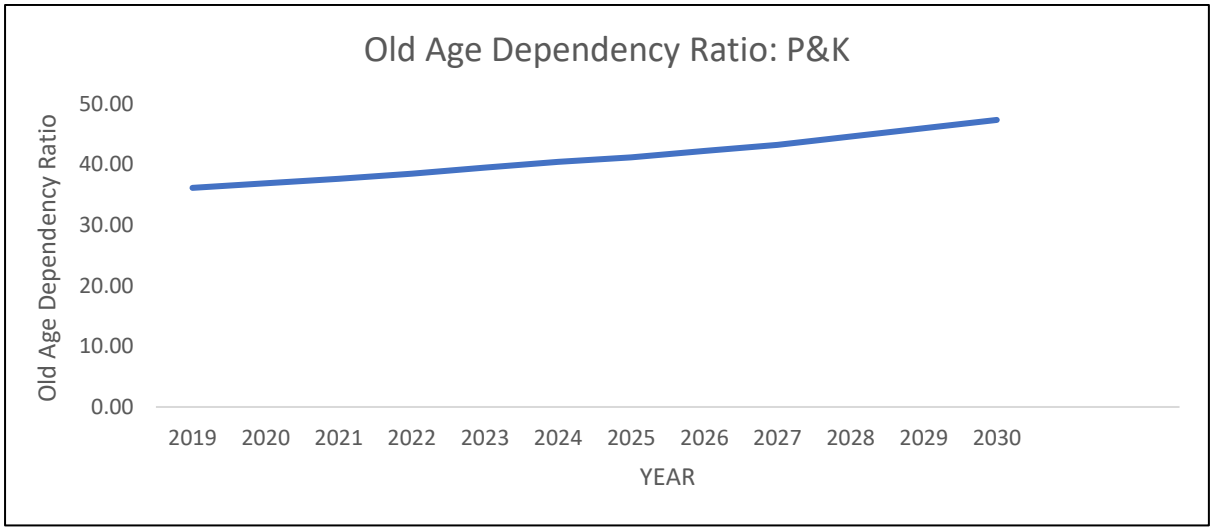

Figure 1: increasing old age dependency ratio in Perth & Kinross

3. PROPOSALS

3.1 The Scottish Government has confirmed there will be no additional funding provided to Health and Social Care Partnerships to support winter pressures. Our key aim for this period, therefore, is to support system and staff resilience. It is anticipated that the winter period will be more challenging this year, given the cessation of Covid precautions, and due to the general increase in demand across all health and social care services.

The focus of the winter plan for PKHSCP is to increase capacity until end of March 2024 to ensure that people get the right care, at the right time, in the right place, avoiding unnecessary admissions to hospital. Once admitted, to ensure that people are discharged as soon as they are ready, contributing to better health outcomes and making best use of resources.

3.2 Business continuity and resilience

A focus on business continuity and resilience will mean that we are better prepared to continue to provide health and social care services throughout the winter period and its particular challenges.

This will include plans to manage through adverse weather which affects staff travel to work, power cuts, a sharp increase in the number of people accessing health and social care support due to falls or infections, outbreaks of respiratory disease or other unexpected events. Actions we are taking to ensure business continuity include:

- Having maintained a consistent, low amber status over the summer months, PKHSCP remains committed to achieving and sustaining green RAG status over the winter period with the intention that no more than five Acute patients will experience delays in their discharge process, and no more than 25 patients will experience delays across the whole system. This will be a significant challenge in the context of our local demographics and without additional winter pressure funding this year. We will continue to assist in maintaining a length of hospital stay in community hospitals within the 28-day NHS Tayside target;
- HSCP is a core participant and stakeholder in Perth & Kinross Council Winter Planning preparatory events;
- Reviewing, updating and testing Business Continuity Plans (BCPs), including those for adverse weather conditions, to ensure sufficient capacity and flow to meet demand pressures, prioritising business critical services such as Community Alarm, HART and Urgent Care;
- Localities will secure 4x4 transport for the winter period to ensure key health and care staff can travel in all weathers to people regardless of their home location;
- Reviewing, updating and testing Festive Directory of services so that staff can always contact a manager and / or member of the senior team if they need advice and support;
- Reviewing and updating lists of particularly vulnerable people in the three localities to enable community teams to prioritise getting support to these people should an unexpected event occur;
- Taking a locality wide approach to planned leave especially during peak holiday periods;
- Encourage update of winter vaccines within our staff and patient cohorts to promote wellness as a preventative approach; and
- Working with home safety partners, community wardens and community organisations to maximise connections in localities, to provide simple home safety and winter resilience advice.

Intended Impact:

- To ensure that teams and services are winter ready to deal with surges in demand along with adverse weather challenges;
- To build flex and resilience into the system to enable delivery of the right care, in the right place, at the right time by the most appropriate services; and
- To ensure patient and staff safety.

3.3 **Community focused integrated care (supporting Portfolios 1 and 2)**

Over the past 12 months, we have continued to take forward programmes of work to enable older people receive the care and support they need at home, or as close to home as possible, with the intention of avoiding hospital admissions unless absolutely clinically necessary. Notable successes in integrated ways of working in the three localities (North Perthshire, South Perthshire and Perth City) have been achieved. These include the streamlining of referral processes, assessment sharing and the reduction of duplication to ensure the person with the right skills is supporting the person in need of help. We have also recently introduced the generic Assistant

Practitioner role to our community teams to prevent the need for cross referrals and multiple visits by different disciplines. This work will be further enhanced over time as we continue to work on developing integrated bases in the localities, where there will be multi-professional co-location to facilitate better communication; simplified access to services and person-centred services.

Actions underway to ensure our services are embedded in, and easily accessible to communities include:

- Community Flow Navigation: implementing a process to efficiently manage referrals from GPs, care homes, hospital front door, and hospital discharge to ensure people are directed to the right care from the right person at the right time;
- Integrated bases: forming integrated staff bases across Perth & Kinross to further support collaboration and more efficient working practices;
- End of Life Care: implementation of a structured and integrated approach for end of life care, to make sure people who are receiving this type of care can access it easily and receive the support they need quickly;
- Realistic medicine: increased use of a realistic medicine approach to support reductions in variation in treatment and access to treatment, reduce harm and waste and better manage risk across our services;
- Frailty: focus on prevention and early intervention. Work is underway to review our frailty pathways and develop education and training for staff, commencing with training for community teams on the Rockwood Scale which is a tool used to predict how frail a person is. Patients who score 5 or higher on the scale are considered to be very frail. If we are able to identify these patients at an early stage, we can put additional supports in place to prevent these people being admitted to hospital unless it's absolutely clinically necessary; and
- Advance Care Planning / ReSPECT: encouraging staff to initiate conversations with patients and families to create an understanding of what is important to that person for their future care. Patient preferences and clinical recommendations are discussed and recorded; they can be reviewed and adapted if a person's circumstances change. The record is not legally binding and anyone completing an advanced care plan and / or a ReSPECT form can change their mind at any time. Having these things recorded is important as it helps us to make sure that the care we provide for people is in line with their wishes and respects their right to make decisions about their own care.

Intended Impact:

- Easy and targeted access to services at the time of need, without the requirement of multiple or inappropriate referrals;
- Enables a multidisciplinary/ multi-agency wrap around or single service approach;
- Prevents duplication and enhances communication and awareness across teams;
- Enhances understanding of the needs of our service users and our local populations enabling us to better target resources;

- Supports the wishes of patients and their carers taking a holistic ‘What Matters to You’ approach; and
- Intervene early to prevent admission to hospital by maintaining care in the community.

3.4 **Optimising flow (supporting Portfolios 4 and 5)**

Over the past 12 months, we have continued to optimise capacity and flow through Perth Royal Infirmary (PRI) by working to reduce delays in discharges, make stronger connections between our frailty pathway and community services; and the Integrated Discharge Hub. Significant success has been achieved in reducing delays through a whole system approach to discharge planning. This has involved the development of a frailty discharge team to support the Frailty Unit in PRI; discharge pathways from hospital to home or locality based community teams; planned date of discharge; monitoring length of stay in our community hospitals and using the Early Discharge Project to increase care at home at the point of discharge.

Improving our care at home services is fundamental to ensuring that people who are clinically well do not end up in hospital (or have to stay in hospital once they are clinically well) because they are unable to access the support they need to continue to live independently. Over the winter period it will be necessary to increase care at home capacity.

The implications of there being no Scottish Government funding for winter pressures are significant for the HSCP. It will mean that our delayed discharge RAG status will be targeted at amber, which is sub-optimal for our NHS Tayside Acute colleagues.

Actions underway to optimise flow over the winter period (and beyond) include additional and increased service in certain areas until end March 2024, refining and enhancing improved process as well as:

- Ambulatory Care: working in partnership with Acute colleagues to support the opening of the Ambulatory Care area at PRI. Ambulatory Care allows patients to have diagnostic tests (including imaging) and a full clinical assessment prior to being admitted. If admission to hospital is not clinically necessary, patients can then go home with advice and supports in place;
- Care at Home Transformation: streamlining of referral processes for HART and Care at Home. Increasing efficiency in HART through automated scheduling that will reduce travel time and increase direct contact time;
- Planned implementation of PinPoint which will plot care geographically in a live system, targeting resources efficiently and increasing capacity;
- Transfer the Living Well team resource to deliver core Care at Home services to support people returning home from Crieff and Blairgowrie Community Hospitals;
- Continued provision of a weekend physiotherapy service to support flow at the front door and orthopaedics;
- Optimising Flow: building on the success of Discharge without Delay (DwD) actions, an Optimising Flow workstream has been rolled out

within acute medical wards in PRI. We are working to enhance and strengthen relationships with inpatient teams (including the hospital discharge team) and community teams;

- Interim placements: release of capacity for short-term placements from hospital to in-house care home provision;
- Early Discharge Project: we will continue and expand (further 250 hours) the early discharge project to get people home from PRI emergency department and from all acute medical wards if they do not need to be in hospital to receive care. This extension will continue until March 2024;
- Surge beds: we will maintain Tay ward at increased bed level (+50%) until March 2024. Maintaining surge beds in Tay ward and continuing the early discharge project will allow our improvement and transformation programmes (especially the care at home transformation programme) time to become embedded as a business as usual approach;
- Seven day discharge service: we are implementing a test of change for the Integrated Discharge Hub (IDH) to provide a seven day service, with a four week trial commencing 28th October 2023 with the potential to extend this;
- Interim placements: release of capacity for short-term placements from hospital to in-house care home provision and continual review of criteria to maintain an amber status. Consideration for independent sector use is escalated through Silver Command to EMT;
- Housing needs: work in collaboration with Housing colleagues to address specific housing needs;
- Expansion of an existing established Care at Home provider within the South locality to transition patients/clients from HART to Care at Home, releasing HART capacity; and
- Domestic and international recruitment drives for HART to increase capacity.

Intended Impact:

- Whole system approach will manage the patient journey timeously to prevent unnecessary delays;
- Maintain people at home in their communities wherever possible and facilitate timely discharge without delays should admission be required;
- Maintenance of strong relationships, highly effective communication, and understanding of skills and roles along with the ‘art of the possible’ between acute and community based teams;
- Continuity of discharge planning over the weekend should prevent high/peak workload at the beginning of each week;
- Building of capacity within teams that support discharges back into our communities; and
- Effective time management focused on travel and training will release capacity for active care.

3.5 **Urgent care (supporting Portfolios 1, 3 and 5)**

As part of a programme to transform our urgent care services to reduce hospital admissions we will be supporting people at or close to home, through

continuous improvement actions. Actions we are taking to improve urgent care access over the winter period include:

- Hospital at Home is currently operating Monday to Friday 0800-1800 at a start-up level from August 2023 in Perth City. Further recruitment is planned with a view to being fully operational by January 2024, supporting unwell older people in their own homes and avoiding hospital admission;
- Implementing Advanced Nurse Practitioner (ANP) single point of triage for urgent care. Advanced nurse practitioners are highly qualified, senior nurses who have completed extra training and academic qualifications to be able to clinically assess, diagnose, refer and treat patients. They are also able to manage more complicated problems, such as long term health conditions, and have an important role to play in supporting our delivery of urgent care services; and
- Exploring ways to build Advanced Practice capability within our existing community teams for example non-medical prescribing and Advanced Clinical Assessment.

Intended Impact:

- Easy access and a single point of contact for assessment and intervention within our locality settings; and
- Ensuring strong clinical and collaborative relationships between hospitals and community teams.

3.6 **Engagement with stakeholders (supporting Portfolios 1-5)**

The success of our winter plan relies on a consistent message being relayed to the public about how best to access the right care at the right time and in the right place. A key part of that is ensuring that staff, our third and independent sector partners and the general public know where and when to seek help. Actions we are taking to ensure our winter messaging is consistent and gets to the right people include:

- Working with the NHS Tayside and Perth & Kinross Council communications teams to make sure our messaging is easily understood, accurate, consistent and accessible;
- Developing materials to share with staff, key statutory, third, and independent sector stakeholders and with the general public, which will set out our position for the winter 2023/24 period, highlight our main areas of focus and reinforce the part our stakeholders can plan in supporting our services by seeking care at the right time and from the right place; and
- Signposting patients and their families to the Perth & Kinross Association of Voluntary Services directory of community services as appropriate.

Intended Impact:

- Ensure the right care is delivered by the right person, in the right place, at the right time, improving both patient and staff satisfaction and outcomes; and
- Reduce inappropriate presentation by making the public aware of the appropriate ways to access services.

3.7 **Staff wellbeing and culture change (supporting Portfolios 1-5)**

We will continue with programmes of work to remind staff of the importance of kindness, respect and understanding, while supporting them to maintain their own wellbeing and resilience through the challenging winter period. Actions we are taking to support staff include:

- Staff wellbeing and culture change: investment in What Matters to You? events and the P&K Offer to promote a culture of collaboration and understanding and maintain staff wellbeing and resilience through the challenging winter period and beyond;
- Encouraging staff uptake of Covid and flu vaccinations, and sharing information on how they can access the vaccinations service; and
- Ensuring community staff have appropriate warm, safe uniforms for the winter period, including warm jackets.

Intended Impact:

- Maintenance of staff wellbeing and resilience and working together as a team that feels valued and respected and supported by our Wellbeing Champions;
- Develops leadership at all levels and though out all sectors, through the What Matters to You ambassador programme;
- Enhanced safety for staff while delivering care in adverse weather;
- Enhances the public health messaging about self care for all; and
- Psychological safety for staff to raise any concerns.

4. FINANCIAL IMPLICATIONS

4.1 The absence of additional Scottish Government funding for the 2023/24 winter period means that the focus in Perth & Kinross will be on refining, enhancing and improving processes, promoting staff resilience while providing limited additional and increased services until end of March 2024 as noted below. Partly due to the success of our programmes of work to focus on preventative measures, shift the balance of care and support capacity and flow, the older people admitted to hospital are frailer and present a more complex clinical picture than might have been seen in previous years. This has contributed to a continuation of winter demand across the (traditionally quieter) summer months; for that reason, and to continue to support capacity and flow over the forthcoming winter period, we are seeking to support our system and staff resilience by:

- Continuing the use of seven (7) additional beds opened in Tay ward in PRI as winter surge beds at an expected additional cost of £0.286m;
- Continuation and expansion of the Early Discharge Project at an additional cost of £0.819m; and
- Supporting community groups to provide winter home safety advice and support (for example on hearing aid maintenance, home safety, simple exercise advice and winter grants).

4.2 As reported to the Audit & Performance Committee in September (Report G/23/113), the IJB is forecasting a significant unplanned overspend in 2023/24. Based on the latest expenditure and emerging financial risks, the

IJB's general reserves are projected to reduce to £2.7m (c1% of IJB net expenditure) by 31st March 2024. This is below the IJB's policy to maintain a 2% reserve level.

The actions proposed in the HSCP winter plan will increase expenditure by c£1.1m. This will further reduce the IJB's general reserve level to c£1.6m and 0.6% of expenditure, resulting in an increased financial risk in-year and impacting on the ability to assist with balancing the budget in 2024/25.

5. CONCLUSIONS

The Perth & Kinross winter plan sets out the PKHSCP approach to respond strategically and operationally to increased demand for health and social care services over the winter period. It acknowledges the potential for additional resource requirements, and the impact on the IJB budget for 2023/24.

This plan has been developed using financial resources available to the HSCP. However, the IJB should note that it is not possible to predict, with absolute certainty, the demand for inpatient beds over the winter. If demand exceeds capacity additional resource may be required to mitigate any risk by ensuring adequate flow through the hospitals.

To ensure the necessary capacity, flow and winter resilience across the system, the HSCP will incur additional expenditure of c£1.1m.

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NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	
HSCP Strategic Commissioning Plan	YES
Transformation Programme	NO
Resource Implications	
Financial	YES
Workforce	YES
Assessments	
Equality Impact Assessment	YES
Risk	YES
Other assessments (enter here from para 3.3)	NO
Consultation	
External	YES
Internal	YES
Legal & Governance	
Legal	NO
Clinical/Care/Professional Governance	YES
Corporate Governance	N/A
Directions	YES
Communication	
Communications Plan	YES

1. Strategic Implications

Strategic Commissioning Plan

1.1 By coordinating our winter planning approaches via a collaborative planning approach across Tayside and within P&K HSCP we will support the objectives set out within the Perth & Kinross Strategic Delivery Plan:

1 prevention and early intervention,
2 person centred health, care and support
3 work together with communities
4 inequality, inequity and healthy living
5 best use of facilities, people and resources

In order to meet increasing demand, provide high quality, effective support for older people and meet the strategic objectives outlined in the Strategic Commissioning Plan over the winter period, Perth & Kinross HSCP will focus on supporting staff and system resilience and continuing to prioritise early intervention and prevention, shifting the balance of care and optimising capacity and flow.

2. Resource Implications

Financial

2.1 There is no additional Scottish Government winter funding allocated this year; as such our winter plan must focus on supporting staff and system resilience,

including programmes of work which are already funded. The financial implications are noted in Section 4 of the report.

Workforce

2.2 Human Resources and Partnership Representatives will be consulted directly on any proposals that may contain workforce implications pertaining to the winter planning approach.

3. Assessments

Equality Impact Assessment

3.1 Under the Equality Act 2010, PKC and NHS Tayside is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Carrying out Equality Impact Assessments for plans and policies allows the HSCP to demonstrate that it is meeting these duties.

3.2 This section should reflect that the proposals have been considered under the Corporate Equalities Impact Assessment process (EQIA) with the following outcome:

(i) Assessed as **relevant** previously and the following positive outcomes expected following implementation: to continue taking into account the statutory obligation to ensure due regard to the removal of inequity of outcomes as a result of socioeconomic disadvantage or characteristics protected under the Equality Act (2010). Each programme of work will complete an Equality and Fairness Impact Assessment to allow the early identification of risks in this regard, and enable the implementation of satisfactory mitigations.

Risk

3.3 Current risks within the winter plan are:

- Financial: demand above the level allowed for in the plan will incur additional expenditure;
- Patient health and wellbeing outcomes: there are inherent risks to future health and wellbeing if people are unable to access the right care at the right time and in the right place;
- Reputational; there is a risk to the organisational reputations of both PKHSCP and NHST if people's health is adversely impacted due to avoidable delay;
- Staff wellbeing: there is a risk to staff wellbeing inherent in the creation of additional stress if they are unable to provide the best standard of care for the people they look after.

4. Consultation

External

4.1 Patient/Service user feedback will be obtained during the course of the winter months via various methods, including online feedback (Care Opinion).

Internal

4.2 This paper has been prepared in conjunction with PKHSCP Executive Management Team. It will also be shared with the PKC and NHST Executive Leadership Teams as part of the NHST winter plan.

Impact of Recommendation

4.3 By simplifying and streamlining the winter planning process, patients will receive the right care, in the right place ensuring safe person-centred care. Additionally, optimising flow by aligning capacity with demand will have a positive impact on the whole system.

5. Legal and Governance

There are no specific legal or governance issues at this stage.

6. Directions

Directions required for NHS Tayside and Perth and Kinross Council in relation to the contents of this paper. See appendix 1.

7. Communication

Communication with key stakeholders (statutory, independent and third sector) and members of the public will be ongoing, and supported by social media, posters and leaflets. These will focus on providing advice on where to seek help for a range of common health conditions experienced over winter, to support efforts to enable people to seek help in their communities and avoid hospital admission wherever possible.

2. BACKGROUND PAPERS/REFERENCES

N/A

3. APPENDICES

Appendix 1 – Direction to NHS Tayside and Perth and Kinross Council.