NHSGGC WINTER PLAN 2021/22

30/09/21

1 Executive Summary

1.1 Introduction

Preparations for the 2021/22 Winter Plan take place within a continuing context of uncertainty caused by the COVID pandemic.

The reach of the vaccination programme is providing protection to the population but the ongoing prevalence requires continuing precautionary measures and contingencies in addition to normal winter planning preparations. At the time of writing, admissions of COVID positive patients have surged to levels not experienced since January and have disrupted routine elective admissions.

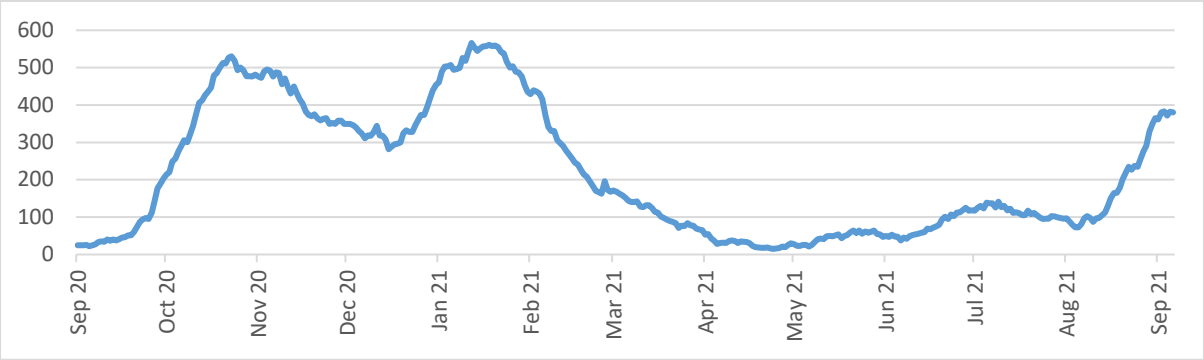

Fig. 1 Daily number of confirmed COVID19 patients in GGC hospitals

Winter Planning normally focuses on the period from December through to March with specific arrangements around the Festive public holidays and surge of demand from early January. In early November, preparedness of our contingencies and escalation processes will also be required for the COP26 Conference which will see an estimated 30,000 international visitors to Glasgow over the two week period.

1.2 Key Risks

The winter plan has been developed in the context of the following key risks:

Risk	Impact Description
Continuing COVID demand on Healthcare Services	Urgent and Emergency care services across primary and secondary care continue to manage high numbers of COVID related activity.
Accumulative impact of COVID stresses the interfaces between Health & Social Care	Services at the interface of Health & Social Care, where interdependencies need to be at their most resilient are weakened, compounding disruption to delivery of care.
Surge in Non COVID related demand	Resurgence of other chronic respiratory and seasonal related conditions stretch existing capacity.

	Delays in treatment for routine conditions results in increasing acuity requirements.
COP26 related demand	Resources diverted to address infrastructure requirements related to the COP26 conference. Potential surge in urgent/emergency care demand related to visiting population.
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.
COVID related absence impacts on staffing levels.	Service capacity disrupted by challenges maintaining staffing levels due to requirements to isolate following positive tests.
Reduced resilience of workforce	Ongoing impact of working through pandemic impacts on staff wellbeing leading to burnout, absence and reduced flexibility for extended hours/overtime.

1.3 Summary of Actions

Our preparations for Winter are built around:

Prevention & Mitigation:	The vaccination programmes and Test & Protect
Primary Care:	Specifically escalation arrangements to support GPs, including 'buddy' practices; COVID Community Pathways, GPOOHs, Secondary Care Interface and support to Care Homes.
Redesign of Urgent Care:	Flow Navigation and Redirection
Acute Division:	Provision of surge bed capacity Enhanced arrangements to support inpatient flow (Boarding Team, 'bed busting' teams, 7 day working and additional staffing at peak periods)
Delayed Discharge	Refocused trajectory for reduction Discharge to Assess Escalated Management arrangements to mobilise care plans
Royal Hospital for Children	Contingency capacity to manage RSV demand
Community Services	Community Nursing/AHP teams admission prevention & early discharge Glasgow South pilot: Hospital @ Home Care Homes support Home Care prioritisation of discharge
Mental Health Services	Mental Health Assessment Units 24/7 Crisis response

	Remobilisation of routine services
Workforce	Recruitment to substantive workforce, reducing vacancies Recruitment to staff bank Maintaining staff availability and mitigating impact of absence.

2 Prevention & Mitigation

Rising prevalence of respiratory illness such as flu and pneumonia are central drivers of winter demand. Last winter saw negligible rates but there is concern that there will be a significant surge. Consequently, the Flu Vaccination programme has been brought forward to commence from 6 September 2021.

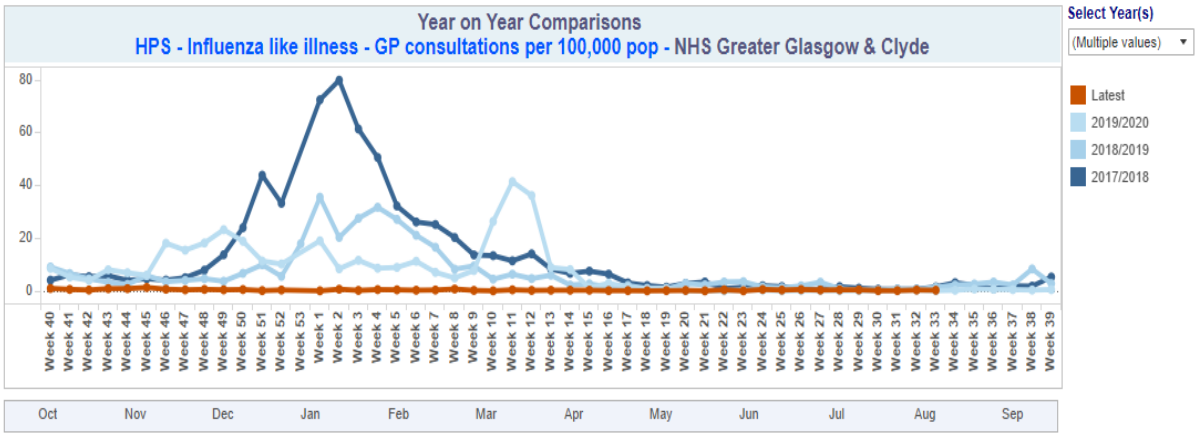

Fig.2 Influenza like illness, Annual trends 2017/18 to 2019/20 [Source: SystemWatch]

2.1 Vaccination Programme

The Vaccination Programme for Flu and the COVID booster commenced early September as per direction received from the FVCV Programme and the majority of the flu programme is expected to complete by early December.

Last year, the COVID restrictions determined that the adult flu programme adopt a mixed model with GPs focusing on the 18 to 64 'at risk' cohort and HSCPs establishing 32 community vaccination centres for the population cohorts over 65 years of age. The COVID Vaccination Programme continued with a mixed model but this time GPs focused on the over 70s and 'at risk' population with the Board establishing a GGC-wide network of 18 large community vaccination centres. This year's programme will be delivered through a centrally managed network of 19 community vaccination centres. The exceptions being individuals who are unable to travel to a clinic or those within institutional care such as care homes and prisons. HSCP Community Teams will provide a service to those who are unable to attend community vaccination centres and dedicated teams will support care homes and prisons.

Childhood and School Age Immunisation teams will provide an expanded flu programme in schools and the community.

Frontline Health and Social Care staff, including contractors and their staff, pupil facing teaching staff and prison officers will be able to book their vaccination either at the Community Vaccination Centres or be vaccinated at their workplaces

The combined Flu and COVID Booster Vaccination Programme is planned to reach 660,000 people by the week beginning 6 December.

	GGC
COVID only	
Severely Immuno Suppressed cohort	**13719**
12 to 15 years	46154
Total	**59873**
Flu & COVID	
frontline health and social care workers (incl. independent contractors)	90999
those living in residential care homes for older adults	11044
80+	43405
75+	33769
70+	47791
adults aged 16 years and over who are considered clinically extremely vulnerable	26970
65+	53392
Adults aged 16 to 65 years in an at-risk group	84725
plus adult household contacts of people with immunosuppression	no data
plus unpaid carers	10509
60+	57957
55+	52722
50+	57392
Total	**570675**
FLU Only	
children aged 2-5 years (not yet at school)	19338
primary school children	84805
secondary school children, under 18 years (including 18 year olds if at school)	64059
Independent NHS contractors not otherwise eligible	
Teachers, incl. nursery, pupil facing support staff	13006
Prison officers and support staff in close contact with prison population	
delivering direct detention services	1230
prison population	2250
	184688

Table 1: Estimated Eligible Vaccination Population.

2.2 Test & Protect

The COVID19 testing capacity established over the last year will continue to operate until further notice. The key components of this are:

- The community testing programme, in partnership with local authorities, offering localised asymptomatic testing at asymptomatic testing sites, with a focus on communities with high prevalence and areas of deprivation.
- Point of Care testing for emergency admissions,

- The West of Scotland Regional Testing Hub, established as part of a network of three large regional laboratories, with capacity for up to 84,000 tests per week (or 12,000 per day).
- Lateral Flow Testing for all Health & Social care staff.
- Routine care home testing is a fully established programme of work in NHS Greater Glasgow and Clyde. All care home staff are offered weekly PCR testing, processed at the West of Scotland Hub, and also undertake twice weekly LFTs in the care home.

The NHS GGC Test and Protect contact tracing service will continue to operate at scale until further notice. From its commencement in May, this service has developed a high degree of expertise, working with both Local Authority Environmental Health teams and the National Tier 2 contact tracing service. This service continues to experience extremely high levels of demand as a consequence of the removal of COVID restrictions and the commencement of the new school year. Whilst the success of the vaccination programme has reduced the level of risk, the very high transmission rates and consequent positive test results have required a revision of contact tracing protocol to be agreed nationally.

We are continuing to strengthen this capability to ensure sufficient resilience for the continuing levels of high demand.

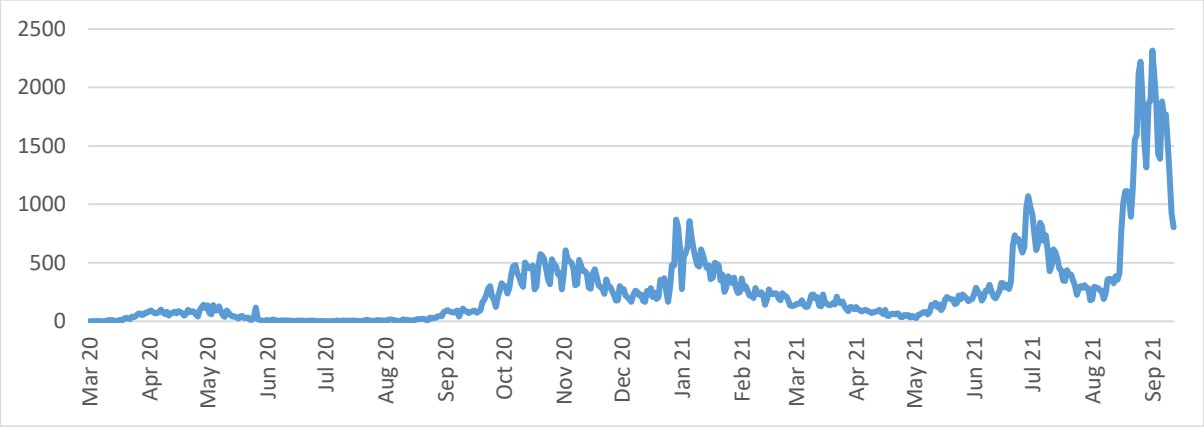

Fig.3 NHS GGC Daily rate of People Testing Positive

3 Primary Care

3.1 General Practice

General Practice is critical to the urgent care response in the community setting as the first point of contact for many patients. In NHSGGC there are 233 GP practices across the six HSCPs. Throughout the pandemic, GPs have adapted to the restrictive conditions and maintained access, responding to increased demand. In addition to daytime core duties, critical services such as GPOOHs and Community Assessment Centres are also supported by our GP workforce.

For daytime practice, there is no available NHSGGC data but the latest national figures [21 June 2021] show a continuing upward trend in overall appointments in the period December 2020 to May 2021. The figure of around 500,000 appointments per week for Scotland is equivalent to approximately 120,000 weekly appointments for NHSGGC. Local data is not readily available but specific practice audits have substantiated the national trends.

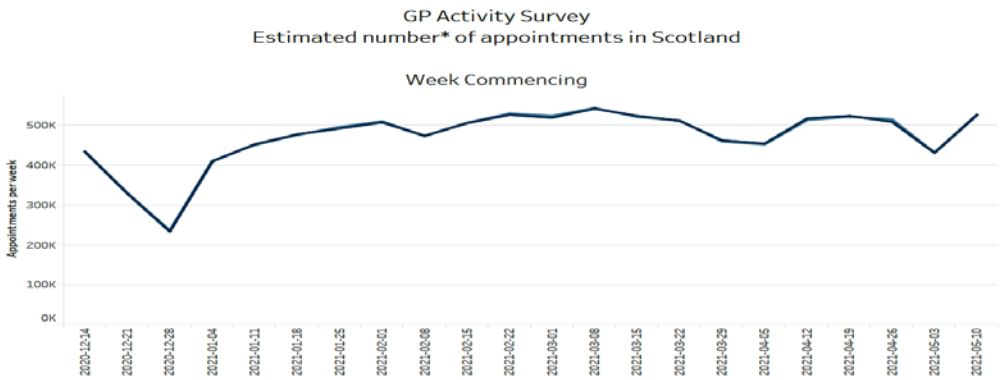

Fig.4 Estimated number of GP appointments in Scotland

Preparations for the winter have focused on two broad concerns:

- Continued high levels of demand in primary care combined with concerns that many patients are presenting later or have not received routine monitoring due to access restrictions across health services.
- Workforce capacity constrained by COVID related absence and limitations on the capability of staff to maintain the overtime and additional hours that have been invested over the duration of the pandemic.

Preparations for winter have progressed through our established interface arrangements bringing together corporate, HSCP and GP Sub-committee primary care leadership with secondary care governance arrangements at corporate and Acute Sector levels.

The priority areas of work are:

- **Escalation arrangements** in General Practice including support for remote working and established buddy practice arrangements as part of business continuity arrangements.
- Supporting continuation of the **Covid community pathway** – our GPs and community staff continue to support our Covid Hub and CACs. A strategy to incrementally step-down resource and embed the current pathways as business as usual by April 2022 is being progressed (see below).
- **Interface working** with a focus on urgent care and the Flow Navigation arrangements, ACRT, USOC, phlebotomy and Mental Health.
- **Care Homes -** Updated guidance to practices with patients in Care Homes incorporating learning and changes from the support provided during Covid such as clarity on pathways and referral routes, prescribing, ACPs and palliative care.
- Further increase the use of ACPs and eKIS by practical support and promotion of the national KIS guidance, including working with GP clusters to share good practice and tailored QI tools.
- **PCIP implementation and consolidation of multi-disciplinary teams.** Continuing recruitment to the extended Multi-disciplinary team to further develop the expert medical generalist role, focusing particularly on Pharmacotherapy and CTAC development. Adoption of new ways of working to maximise MDT capacity including hub models across multiple practices and effective use of virtual consultations.

- **Chronic Disease Management** - continued focus on effective chronic disease management including prioritisation of patients for review and addressing any backlog.

3.2 GP Out of Hours

Our GPOOH service is drawn from our core GP workforce and competing pressures involved in increasing daytime activity and providing staff to continue to support the CACs are impacting on the ability to secure staff to maintain service delivery which is the primary risk going into this winter.

The GPOOHs team are engaged in the Covid response over the 24 hour period and at the current time the team continue to provide a home visiting response and transport service as part of the pathway. In order to mitigate the risk as we move into winter the service has permanently embedded changes introduced from April 2020 with GP triage via the NHS111 single point of access, increased use of telephone consultations and a fully appointed service on our sites with signposting/redirection used when patients attend inappropriately.

Specific actions being taken in preparation for winter and to improve sustainability of the service are:

- Actively engaging with all GPs on the performers list to encourage uptake of sessions in the GPOOH service
- Supporting increased numbers of sessions being carried out by GP ST3s as per recent SG guidance
- Supporting training of ANPs in the service and looking how we can open recruitment for sessional commitment from ANPs working in HSCPs and Primary care
- We will be flexing resource in the service over the four day public holidays
- We are increasing educational and peer support for clinicians working in the service

3.3 COVID Hub & Community Assessment Centres

Demand for access via the COVID Hub and CACs has fluctuated in line with community infection rates through the different stages of the pandemic. Activity is increasing again as we enter a further wave of community infection with the removal of most restrictions and return of schools. The return of colleges and university students during September is expected to prolong this demand.

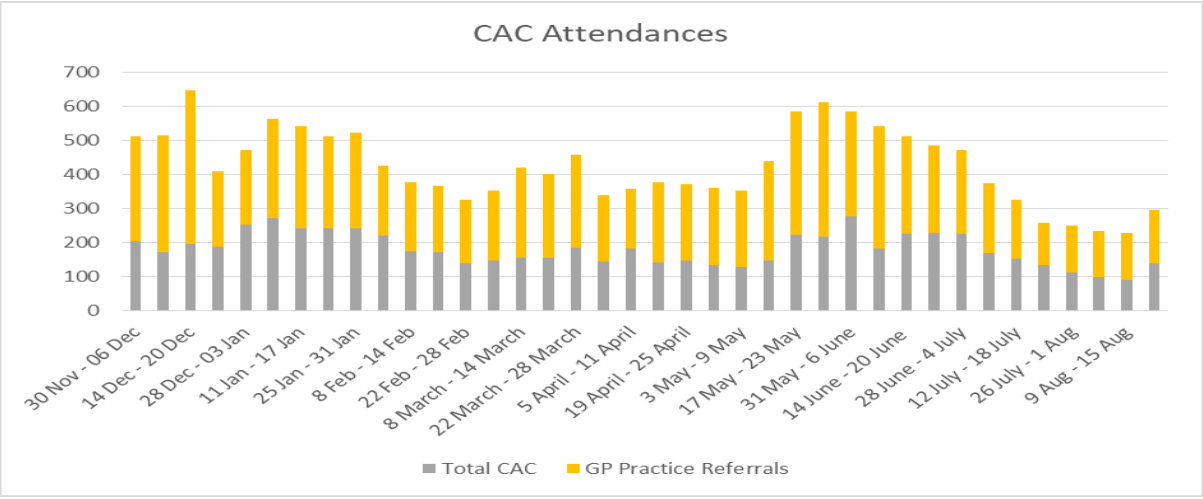

Fig.5 CAC Attendances

Combined with Covid referrals through GPOOHs, the total weekly demand across our red community pathways reached around 1000 during the summer peak and the current wave is proving equally as demanding with attendance rates higher in early June than they were through January, mirroring the higher level of community infection.

Our winter and longer term demands for the community COVID pathways are shaped around:

- Expectation of increased respiratory type illness during the autumn
- Continuing workforce pressures associated with the wider response
- Learning indicating alternatives to the COVID pathways, particularly for children where a higher incidence of RSV and parainfluenza is predicted
- Reviewing case definition and referral criteria to focus CAC capacity appropriately
- Maximising potential for clinical assessment by patient's own GP

Immediate priorities for this work are:

- Home Visiting Pathway
- Changes to ensure appropriate pathway for children including RSV
- Telephone assessment / hub model

Through to April 2022 we will move towards the management of Covid19 as 'business as usual' within core primary care services, recognising that further escalation may still be necessary at times depending on Covid case numbers.

Through the winter period we will:

- Develop an exit strategy for each element of the Covid community pathways. The timing of these will depend on national guidance, current volumes and operational feasibility over the winter period. De-escalation of the face to face part of the pathway is anticipated if it becomes possible to safely accommodate face to face clinical assessment within GP practices.

- Scope any additional support which would be required in other core services including General Practice and GP Out of Hours as the pathway is scaled down. This will include any support requirement for the management of face to face assessments, including escalation and surge capacity, as part of wider winter planning arrangements.

- Implement an agreed flexible resourcing plan for the period running through to March 22 for core staffing and premises, with responsibility for staff provision shared across the HSCPs. This is based on:

    - GP provision for core hours through existing sessional GP commitment, with the number of sessions linked to demand (reviewed on a rolling basis)

    - Each HSCP to provide an agreed proportionate contribution to nursing and administrative staffing

    - Further consideration of appointment / secondments for a fixed period to March 22 for all staff groups.

- Maintain escalation plans to enable response to future peaks in demand if required

3.4 Community Pharmacy

Community pharmacy has a key role in managing urgent care demands and we are developing a range of actions as part of the winter planning process that would enhance the response and remove activity from general practice. These include:

- Establishment of a LES with additional PGDs to allow a wider range of treatment options which could include sore throats and chest infections.
- Streamlined communications between GP and CP to reduce time wasted.
- OOH – explore opportunities to incentivise the Pharmacist Independent Prescribers to work in the extended hours pharmacies at the weekends/evenings with referral links to and from GPOOH.
- Promotion of Serial Prescribing - this should reduce the need for patients/pharmacies to contact practices and reduce footfall

4 Redesign of Urgent Care

4.1 Delivering the National Priorities

Last winter, Phase 1 including the Flow Navigation Centres and the Mental Health Assessment Unit Pathways were implemented.

The Flow Navigation Centres established the mechanism for the public to access clinical triage via NHS24 as a means to avoid ED attendance. To date, around a third of calls are being effectively managed without need for MIU/ED attendance. This work is progressing with a trajectory of care pathways to be implemented to ensure effective direction of patients to appropriate clinical care in place of ED.

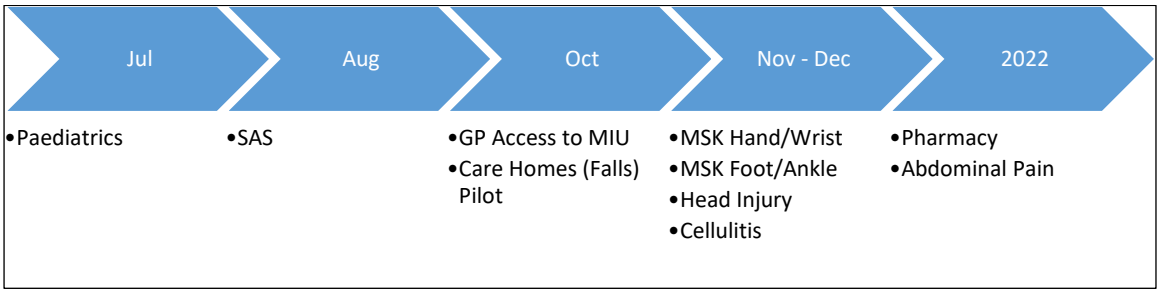

Fig.6: Trajectory of Flow Navigation Pathway Implementation

Mental Health – Embedding the Mental Health Assessment Unit pathway in phase 1 involved a full redesign of urgent care access pathways across the mental health service. Through phase 2, pathway development will aim to enable referrals from GP in/out of hours including options for prof to prof, and to consider scheduled virtual assessments.

Primary Care/Acute Interface – joint decision-making through pathway development to convert unplanned to planned care with particular focus on scheduling urgent care within AU's Pathways under review/development include:

- Care Homes (Falls**)** - a nursing home test of change for FNC is launching during September involving up to six nursing homes. The output from this will be used to quantify the capacity required to deliver prof to prof to nursing homes to avoid conveyance.

- GP Access – work is being progressed that will afford GPs access to MIU slots via the FNH. It is anticipated this pathway will be delivered in advance of the winter period.

Community Pharmacy - Integration with GP in/out of hours and the FNH to include signposting and direction to community pharmacy from MIU/ED for minor ailments.

SAS – The initial phase of the work has focused on Flow 1 patients who have suffered a minor injury and a new pathway was launched in August giving SAS direct access to book patients into the MIU hub. This pathway is under joint review to ensure it delivers to its full potential in advance of winter.

Our top 20 high volume conditions have been reviewed enabling identification of pathways with greatest potential impact, these include MSK, Head Injuries and Cellulitis. Work is being expedited to bring forward implementation as soon as possible, adopting protocols developed in other Boards where appropriate.

4.2 Redirection

There is definite potential to assess and direct patients away from EDs within the priority pathways identified. However, the current increasing demands across all our urgent care pathways to pre-pandemic levels would indicate that demands on EDs will continue, despite awareness-raising of alternative options.

To ensure that patients are seen and treated in an appropriate setting, our EDs need to have the ability to signpost and re-direct patient to more appropriate care outwith our emergency departments. This includes minor injury units, Primary Care, Community Pharmacy. MSK Physio and dental.

Within NHSGGC a redirection policy has been developed and formed part of the broader consideration in the development of Scotland-wide re-direction guidance. The guidance is due to be considered at the RCEM and thereafter it is anticipated the NHSGGC policy can be implemented, subject to agreement with the Scottish Government.

We have prepared our operational readiness for implementation, building on existing arrangements such as nurses within ED teams who are signposting. These posts are seen as key to highlighting patients who could be safely re-directed as part of an initial triage.

5 Acute Services

The challenge for our hospitals will be ensuring access to our emergency and urgent care entry points can be delivered effectively, within the 4-hour emergency care standard, and that there is sufficient bed capacity to accommodate expected demand.

5.1 Emergency Department

Our ‘front door’ comprises of Emergency Departments (including Minor Injuries Units), Assessment Units (receiving GP referrals) and the SATA units established (from April 2020) for managing patients with suspected a COVID diagnosis. Over the first 12 months of the pandemic, demand fell considerably but is now returning to pre-COVID levels. Operating COVID pathways alongside routine pathways as volumes return to pre-COVID levels, stretches our existing capacity.

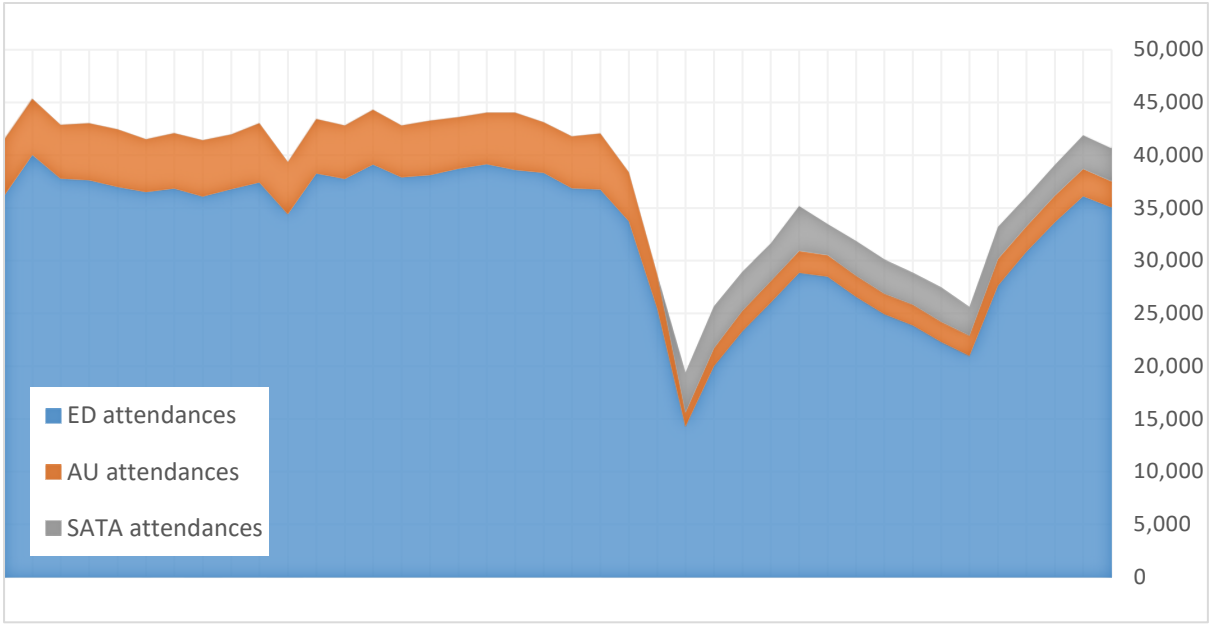

Fig.7 Monthly Emergency Presentations to NHSGGC [Apr 2018 to Aug 2021]

Our contingency actions to manage ‘front door’ demand will comprise:

- Managing demand differently utilising the Flow Navigation Hub and Redirection as outlined above.
- Consultant Connect across a broad range of specialties, enabling professional to professional dialogue between General Practice and Consultants.
- Strengthening of ED medical and nurse staffing to cover periods of the day with known higher levels of demand, weekends and evenings.
- Extended access to diagnostics.
- Introduction of Physio/OT staff in ED as well as providing 7 day/out of hours cover in the Acute Receiving areas.

5.2 Acute Inpatient Care

Emergency Admissions from mid-June have been around 92% of pre-COVID weekly volumes but emergency bed occupancy is now at levels comparable with 2019. Daily admissions for patients with COVID have surged during August and September running at 40 to 50 per day and with a peak 64, equivalent to rates back in January. As noted above, the requirement to ensure ‘red’ and ‘green’ pathways stretches our capacity, with dedicated staffing and facilities necessary for infection control. Continuing unpredictability implies that contingency for similar surges will need to be maintained through the winter.

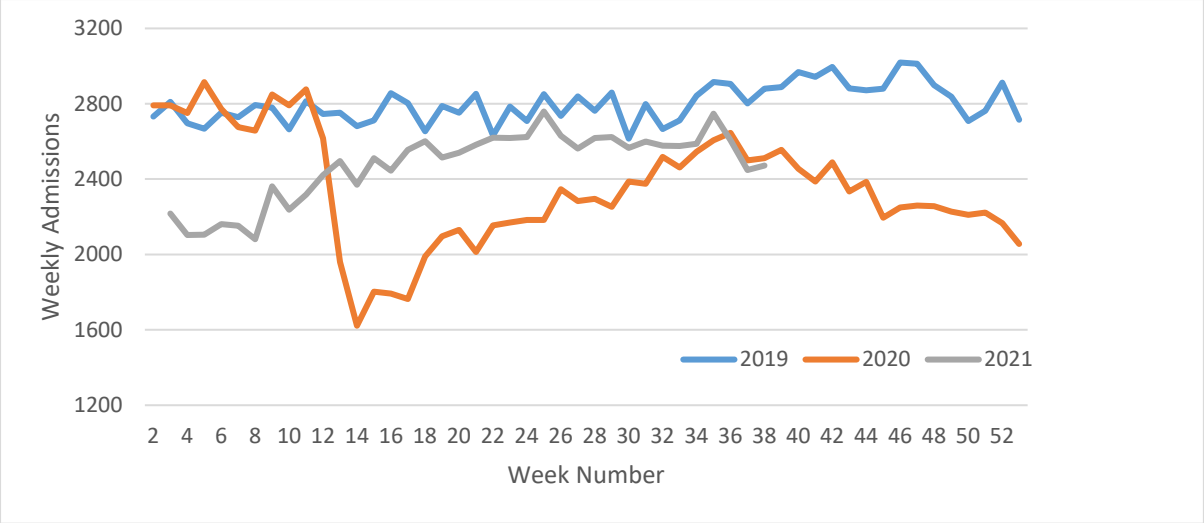

Fig.8: 3 Year trend of emergency admissions by week number (current week 38 – 12 Sept)

Length of stay over the last two years has fluctuated but the monthly variability within this suggests it would be prudent to assume this will not contribute positively during the winter months, particularly given concerns that many patients are presenting with increased acuity due to limited access to routine care over the last year.

Our planning assumption for the winter months is that unscheduled care demand will return to pre-COVID levels of around 2800 admissions per week (all specialties).

5.3 Flow Management

Our hospital sites have well established processes to manage patient flow, with dedicated site management teams supported by dashboards with real-time data on available beds, and patients waiting and ready for discharge. Over the winter period, provision will be made for:

- Multi-disciplinary Boarding teams.
- Extended hours and 7-day operation for AHPs, Pharmacy and Phlebotomy.
- 'Bed busting' teams to reduce delay in turning around beds between occupants.
- Additional transport provision (SAS, Red Cross and other independent/Third Sector) capacity to facilitate discharge and intra site transfers.
- Extension of Discharge Lounges.

A pilot scheme will also operate in North Glasgow working with Community Pharmacy to provide Discharge Medication and remove delays associated with provision within hospital pharmacy.

5.4 Discharge Management

Considerable cross system work was progressed earlier in the year to revise and develop a common discharge policy which aligns practice across the six HSCPs and hospital sites. This interfaces with established Estimated Date of Discharge practice and continued extension of "criteria led discharge" within our hospitals.

The common approach and policies are being implemented through localised initiatives established by the HSCPs to focus on closer working with hospital teams and address unnecessary delays, such

as the “Focused Intervention Team” (West Dunbartonshire), “Hospital to Home” (East Renfrewshire), “Home 1st” (Inverclyde) and “Home for me” (East Dunbartonshire) with dedicated multi-disciplinary teams including AHPs, Elderly Care Advanced Nurses or Specialist Nurses.

The ‘Discharge to Assess’ policy introduced last year is being embedded and continually improved upon to:

- Establish early in-reach and acute identification of the need for community support.
- Early engagement of individuals and families by HSCP teams to expedite discharge.
- Completion of full assessment out of hospital and provision of community rehabilitation via new localised pathways.
- Strengthen links with Commissioning Teams to support transfers to appropriate settings.

Notwithstanding these developments, delayed discharges continue to be a pressure within our system occupying upwards of 200-250 beds a day, in comparison to pre COVID levels of 120 beds a day. In recognition of this, a trajectory for improvement has been agreed and included as part of the RMP4 submission. In addition to the measures described above, further management action includes:

- Daily HSCP/Acute Senior Management scrutiny of delays.
- Focus on 11b (SW assessment) and 27a (awaiting IC place).
- Focus on 24c (awaiting care home placement) – in line with maximising capacity and flow to care homes.
- Tracking process for AWI to minimise delays in process and a robust AWI Improvement Plan.

5.5 Bed Capacity and Winter Additionality

Bed capacity requirements have been modelled on 2019/20 daily occupancy with specific focus on Medicine, Elderly and Surgical beds. We have assumed planned care continues at 60% of pre-COVID levels. The output to our modelling suggests that to maintain occupancy levels of around 85%, we would require up to 240 beds additional to a base capacity of 3288. This is consistent with projections informing the plans for winter in 2018/19 and 2019/20. In both years, provision was planned around a core volume of beds with a flexible cohort to be used in extremis of c. 70 beds.

The surge of COVID admissions this September accounted for 10-12% of USC bed occupancy. Contingency will be necessary should this replicated during the winter months.

As discussed above, expectation is management action reduces the level of delayed discharges, releasing beds back to Acute care. Failing this, we will seek to develop additional non-acute managed bed capacity of 2 to 3 wards within the NHSGGC estate, potentially run by HSCPs with a skill mix which reflects rehabilitation requirements rather than acute clinical care needs.

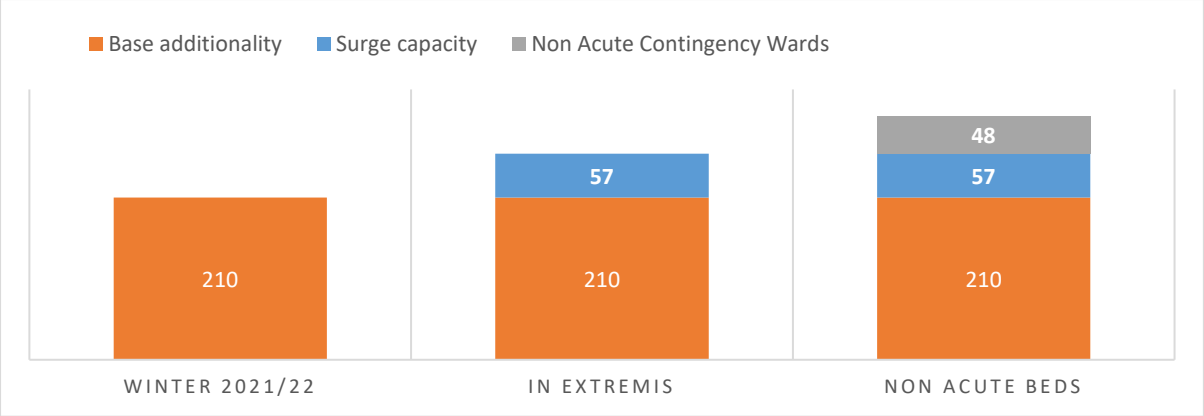

Fig 9. Winter Plan Bed Additionality.

Escalation management operates on a daily basis with cross-system dialogue to address specific pressures. Continuing COVID governance structures with Strategic Executive Group meeting 3 days per week, enabling considered decision-making should circumstances indicate capacity requirements beyond the winter bed additionality of 315 beds outlined above, such as restrictions on planned care and staffing reprioritisation.

5.6 Women & Children's Services

Paediatric ED attendances returned to pre-COVID levels in the spring with August experiencing high numbers coupled with a higher admission rate. PHS have cautioned that Children's Services should prepare for higher and earlier demand caused by Respiratory Syncytial Virus (RSV) illness, supporting modelling is informed by rates in the southern hemisphere earlier this year. Current activity levels demonstrate the accuracy of this projection.

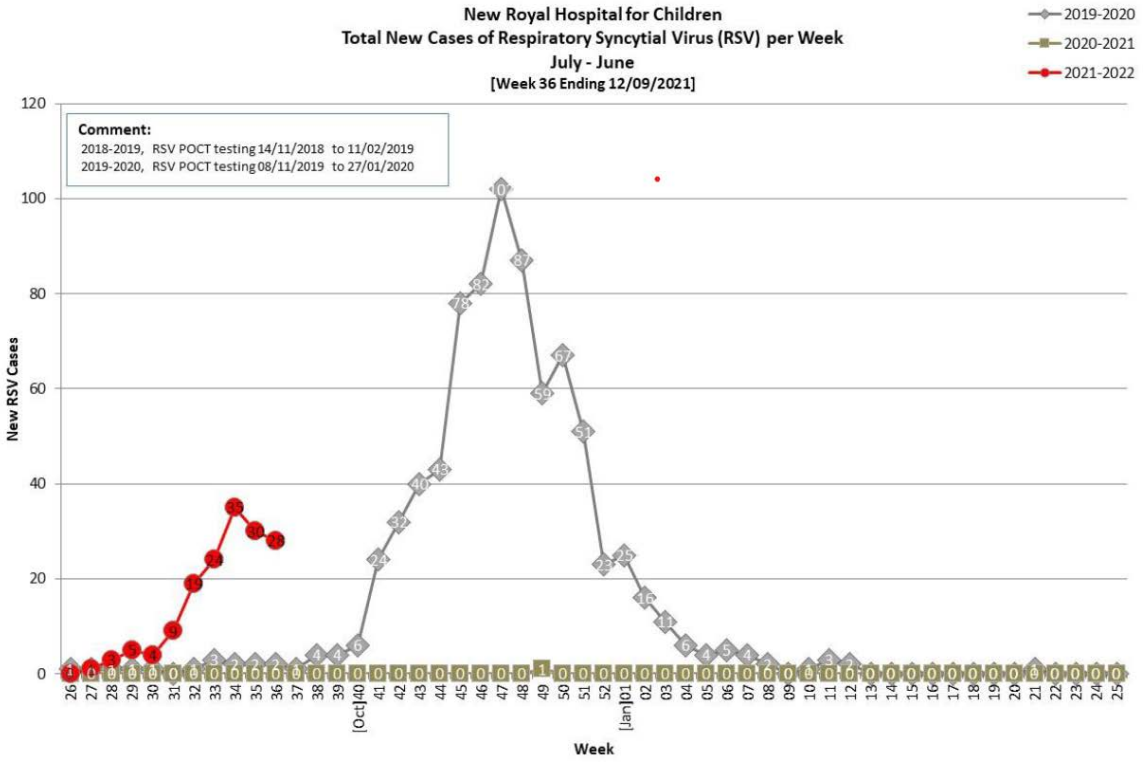

Fig.10: RHC New Cases of RSV per week

Annual contingency plans for RSV demand have been brought forward with escalation processes reviewed and updated. We are also monitoring the situation in England and Wales.

Additional beds, nursing and medical capacity will ensure service readiness to respond to increased demand for urgent care, unscheduled admissions and to strengthen flow management. We are working with NSD to ensure capacity and to address early winter pressures for those regional and national services delivered in RHC which would see impact beyond NHSGGC.

We continue to foster our strong interphase with primary care including our GP hotline and have strengthened the Flow Navigation Centre with the implementation of paediatric pathway and presence of experienced ENP and medical staff within the model.

We have introduced a new website and app for RHC https://www.rhcg.org.uk/ which has a dedicated sections for GPs and parents on the management of bronchiolitis. This includes on line bar codes to current pathways and guidelines etc.

The key areas below have been prioritised:

- Increased response for RSV/Bronchiolitis discharge.
- Increased testing to enable cohorting in PICU and improve adherence to appropriate red and green pathways across both HPN and Obstetrics and Gynaecology.
- Strengthening of Front Door medical and nursing capacity to meet increased demand and patient flow.
- ED waiting room surveillance and 24/7 ED greeting to facilitate the flow of patients from the waiting room, ensure patient safety and detect clinical deterioration.
- Opening of additional beds to respond to increased unscheduled admissions and flow management through Acute Receiving, Hi Flo, Clinical Decisions Unit (CDU) and additional capacity within ITU/HDU.
- Extending evening and weekend capacity for emergency gynaecology and Early Pregnancy Assessment Service (EPAS) to alleviate pressures on adult ED.

Our Directorate level and clinical site winter escalation process builds contingency and is managed through the daily Safety Huddles, Bed Managers, 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. A specific regional escalation policy is in place for the Neonatal ITU.

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5.7 Critical Care

The COVID-19 pandemic led to an increased requirement for Level 3 support for patients and required rapid increases in the number of beds. At the peak GGC had 86 patients in Level 3 beds compared to an adult baseline capacity of 45 beds. Despite the many pressures for our ICU teams, they continued to work collaboratively to continue to deliver the highest quality of care to their patients, transferring patients across units where this was required.

NHS GGC has been allocated funding for 7 additional ICU level 3 beds to be allocated to the GRI (3 beds) and RAH (4 beds). This is in addition to additional beds funded as part of the Major Trauma Centre and National Burns Hub.

5.8 Planned Care

As in previous years, elective activity will be planned to scale back over the peak winter period whilst maintaining elective capacity for urgent cancer and highest priority patients.

This approach is enhanced by our use of the nationally agreed clinical prioritisation framework providing an effective mechanism to ensure the most appropriate inpatients are identified.

Where possible, elective patients are managed on a day case or short stay basis. A number of arrangements have been put in place in response to the COVID-19 pandemic which gives more resilience to fluctuations in unscheduled care demand, for example use of ACH sites for intermediate surgery, and use of day case facilities.

Waiting list initiatives are being used where possible to increase capacity and this will include the period up to December/January.

A clear surgical cancellation process is in place across NHSGGC, re-enforced through Directors and General Managers.

6 Community Services

6.1 HSCP Community Teams

Community nursing and AHP teams have been increasingly stretched over the pandemic period, supporting patients in their homes and meeting demands generated by the restriction of routine services in primary and secondary care. As with all other workforce groups, COVID related absence and staff welfare makes maintaining operational capacity a priority. HSCPs have continued to develop practice to strengthen the intermediate care and rehabilitation that is necessary to create the capability and capacity required to support admission prevention and early discharge. This includes support from community Advanced Nurse Practitioners aligned with District Nursing services to enhance clinical care and decision-making, which allows the team to manage highly complex patients within the community and prevent avoidable hospital admissions while improving patient outcomes. Optimising the use of community pharmacy is also key, e.g. prescribing rescue medication for COPD patients decreases pressure on GPs and community/acute services.

Glasgow City will pilot a Hospital at Home model in South Glasgow from October. This is planned to manage a caseload equivalent to a 25-bed ward, supported by DME Consultants in the QEUH. Progress with this pilot will be carefully monitored to determine potential impact of wider adoption.

6.2 Care Homes

Across GGC we have 187 care homes with 9,287 residents and approximately 15,000 staff. Care Homes and their staff are supported with routine COVID testing and are prioritised in the vaccination programmes. Infection rates remain a concern and are carefully monitored.

Governance structures and arrangements have been strengthened over the last year with systems now in place within care homes and at system level. Clear reporting lines are in place to the Board and council Chief Executives as well as Scottish Government.

Local care home level Daily Safety Huddles are undertaken and completed electronically using the TURAS system. These completed templates combined with local intelligence then informs daily Huddles within each of the six HSCP's. Regular updates are also provided at the Strategic Executive Group. Thereafter each HSCP has in place a weekly oversight meeting where care home information is analysed including; infection control, testing, training and support. Each care home is then classified using the DPH Scottish Government agreed RAG rating. An SBAR is completed and discussed for each Red or Amber rated care home. All HSCP returns are then collated for the board's weekly return to Scottish Government.

In order to review all red and amber care homes a Governance sub group meets fortnightly and reviews any resulting action plans or improvements required. These measures build upon collaborative working in recent years contributing to better management of patient care at the interface with hospital.

HSCPs have a 'dashboard' allowing tracking and targeting of admissions to expedite care plans and the 'red bag' scheme ensures key information, medication and belongings are with care home patients on admission. As with many other services, the use of digital means of communication and adoption of 'Near Me' is helping to bring specialist clinical review to patients, limiting the necessity of hospital attendances.

6.3 Home Care

The priority for winter planning is to deliver a quality service for everyone involved with and/or directly receiving care packages (staff, service users, families, and communities). Our HSCPs work with a network of partners in the third sector and wider communities to deliver care. Planning has been progressing through locality engagement forums to build a common understanding of needs and the responses that can be delivered.

Staffing levels are the primary consideration, with absence levels between 34–50% (Aug '21) due to increased infection rates and isolation requirements. Continued COVID testing and vaccination will be offered to staff in the autumn to mitigate this. A review of available training (including refresher courses) and strategic recruitment drives have supported the service in maintaining quality throughout the year and further recruitment to return to pre-COVID staffing levels is intended in time for the winter.

Care at Home has a history of prioritising Delayed Discharges and as such, we continue to prioritise planning for discharges into the winter months and beyond.

7 Mental Health

Last year saw the establishment of two Mental Health Assessment Units (MHAU) in response to the COVID-19 pandemic, specifically to reduce demand on secondary care services by reducing footfall through hospital Emergency Departments. They provide an immediate route out of ED for those who present directly, with vulnerable patients largely being managed away from the stressful ED

environment. They also provide an alternative to patients who would otherwise have been conveyed to ED by SAS or Police Scotland.

Specialist community mental health teams have seen an increase in contacts with people throughout 2021, coupled with an increase in occupancy for acute inpatient care. Feedback from front line services highlights increasing acuity - possibly as an impact of Covid 19; people delaying seeking support; communities returning to more open styles of living; or a combination of these factors.

These concerns amplify the importance of remobilisation of routine services and continued progression of our Renewal Programme, to ensure our core capacity is resilient and people can access appropriate services through the established mainstream unscheduled care and out of hour's services rather than default through EDs.

Services have been employing a full range of recovery and mitigation approaches flexibly, including peripatetic support, consideration of location movements of staff, service and specialties to meet needs. Communication routes and processes for escalation have also been refreshed and are in place for winter 2021/2022.

There have been significant increases in demand for unscheduled care and a gap analysis has identified the need to expand the capacity to manage the out of hours and crisis response. This will be achieved through additional provision to enable a 24/7 Crisis Service offering emergency mental health assessment and support to those aged under 18 years. This would predominantly be a nursing service, but the addition of Consultant Child and Adolescent Psychiatrist time would support these services and mirror the unscheduled care adult mental health services in the Board. The renewal fund will be used to support the expansion of Children and Adolescent Services in the MHAUs.

In summary, the key areas on which winter and recovery plans focus on are:

- Promoting and supporting the conditions for good mental health and wellbeing at a population level.
- Providing accessible signposting to help, advice and support.
- Providing a rapid and easily accessible response to those in distress.
- Ensuring safe, effective treatment and care of people living with mental illness.

8 Workforce

8.1 Overview

Summarised below are key areas of focus for NHSGGC throughout the winter period.

The primary focus is a continuation to ensure we have a sustainable workforce with appropriate additionality to meet our winter surge capacity. In particular our focus has been on our nursing cohort for all areas of the Board.

8.2 Additionality and Recruitment

We have sought to accelerate start dates for Newly Qualified Nurses. This has already delivered 467 NQNs into our Acute services with a further 81 joining during October 2021. This has also been used to increase capacity within HSCPs, specifically mental health roles, with 106 already started and a further 16 ready to start during October 2021. This has the added benefit of improving NQN skillset and experience before they commence their registered role.

The Human Resources team has also launched a range of targeted, location specific, recruitment campaigns for mental health nursing, which will see 49 registered nurses and 12 HCSWs take up roles by the end of November 2021. A similar campaign for theatre nurses will see 22 registered nurses join within the same timeframe.

Workforce planning assumptions on medical staff will see 19 Acute and 24 HSCP roles filled by end December and a further 28 Acute and 12 HSCP roles filled by the end of March 2022. Winter additionality will be further enhanced by the use of our established medical bank and where necessary locums.

Our Allied Health Professionals will continue to be reassigned to key areas, in particular COVID wards to support patient rehabilitation and to conduct mobility and frailty assessments within the emergency departments to avoid admission and promote faster discharge.

In the past 6 months we have also recruited 301 additional domestic and portering staff.
The Test and Protect function is resourced with over 150 contact tracers in post, maintaining the minimum resource requirement of 750 hours per day. There is a dedicated support and management hierarchy in place to support this operation. We are continuing to strengthen this capability to ensure sufficient resilience for the continuing levels of high demand.

8.3 Supplementary Workforce

The Nursing & Midwifery bank is expected to have 21,000 workers confirmed available for shifts by the end of October 2021. 14,235 of our current bank staff hold a substantive role within NHSGGC. 500 registered nurses and 600 HCSWs have been added to the bank this year. A further 800 HCSWs have applied to join as bank only staff and we can expect to recruit the majority of them. A fast track process has been deployed to allow our 670 NQNs to join the bank as soon as they are registered. A further 50 registered nurses are expected to be recruited into bank only positions by end December.
Nevertheless, the Staff Bank is under considerable pressure, with a significant ongoing number of requests. The increase in substantive staff post the arrival of NQNs should reduce the volume of requests.

The staff bank will be key to the successful resourcing of the centrally managed network of 19 community vaccination centres. The planned sustainable workforce model utilises Band 3 vaccinators, reducing the requirement for registered staff. This approach ensures we have adequate staffing available to deliver the planned volumes of combined Flu and COVID boosters.
532 Administrative Bank staff are available to provide additional support in clinical settings, allowing clinical colleagues to focus on patient care. This includes supporting wards and vaccination clinics.

8.4 Staff availability and Absence Scenario Planning:

Date	Self-Isolating (Own Symptoms)	Underlying Health Conditions	Self-Isolating (H/hold)	Carers / Parental Leave	Positive Cases	Long COVID	Test & Protect Isolating	Quarantine	Total Absent (COVID Related)	% of workforce absent
Mid-September Peak	49	64	240	18	359	242	51	2	1025	2.55%
Current	52	65	52	12	186	288	19	0	674	1.68%
Scenario A	30	65	40	10	50	250	20	0	465	1.16%
Scenario B	50	65	150	15	150	350	75	0	855	2.13%

Table 2: Staff availability & scenarios

RMP3 predicted an increase in COVID related staff absence to 3.5%. The winter peak was 4.6% in January, but has returned to below 3% for the past 3 months. Current predictions are:

- Scenario A assumes an increase of COVID positive cases of approximately 25%
- Scenario B assumes an increase of COVID positive cases of approximately 75%
- Each scenario illustrates a knock on effect to Long COVID and Isolating.
- Self-Isolating due to own symptoms scenarios are not expected to increase due to the ease of access to testing facilities
- Household isolating is more susceptible to increase and this has been reflected above.
- Underlying Health Concerns will not return to previous levels due to updated government advice.

The most likely scenario is that COVID related absence will remain stable and then reduce slightly further, impacting less than 2% of the workforce.

RMP3 predicted staff availability averaging 80%. This position is forecast to worsen in coming months, with staff availability reducing to 75%. This is due to increased sickness absence, annual leave usage at a higher level than last winter and COVID absence which remains significant despite a reducing trend. However we will be focussing on supporting staff at work to minimise this forecast. A suite of management reporting is available at all operational levels supporting the monitoring, evaluation and management of key performance metrics. Dedicated staff within the Human Resources Support and Advice Unit will continue to facilitate staff return to work where appropriate.

Annualised staff turnover within the Board has remained relatively constant over the past two years at 7.5%. This equates to approximately 0.7% or 225 WTE leaving each month. There has been an observable increase in the past 3 months, to an average of 300 WTE per month. The age profile and reasons for leaving are being monitored and assessed, in particular for any increase in rates of retirement or reduction in age of retirees. Dedicated staff within Human Resources are liaising with retirees regarding opportunities to 'retire and return'.

9 COP26

Glasgow will host the United Nations Climate Change Conference (COP26) from Sunday 31st October to Friday 12th November, with significant build-up to the event in the preceding 6 weeks. It is anticipated that up to 30,000 people will attend the conference itself. Disruption to parts of the city and our services can be expected as a consequence of the many planned and unplanned events that

will take place. The event will have dedicated on site paramedic and GP cover for delegates with the aim of managing demand and minimising onward referral locally.

Contingency planning is progressing to mitigate the routine disruption, with major incident and business continuity readiness updated for untoward events.

A further concern will be a potential surge in COVID prevalence following COP26 associated with the influx of people from across the world.

10 Communications

The Communications and Public Engagement Directorate will be providing support to key winter programmes, including influenza vaccinations. As with previous years, this will centre on patient and public engagement activity using digital, traditional media and community outreach means. Learning has been taken from the 2020 flu and COVID-19 communications and engagement campaigns and there will be a greater focus on proactive awareness raising activity as well as working closely with community partners, including local Councils and HSCP communications teams to respond effectively to emerging local issues.

As with previously, national, Scottish Government campaigns will be utilised to complement NHSGGC communications activity which will be more targeted towards the communities in which we operate. This approach will be adopted for key remobilisation projects over the winter period and we are actively working with our Primary Care colleagues to ensure consistency of engagement approach and messaging within these areas. This will include a specific focus on the promotion of the Right Care Right Place campaign.

The PEPI team will continue to provide support and insight regarding patient and public feedback and this will be utilised to help shape key messaging and campaign focus across the winter programme. This will be of particular prevalence for the Redesign of Urgent Care programme of work where NHSGGC is actively supporting the Scottish Government as the test Board for the gathering of patient experience data.

11 Finance

The Board's winter plan has identified a range of plans including opening additional beds and supporting the flow with in the Acute Division. The cost of the Acute Division winter plan is £7.5m, which will be supported by the funding allocation received from Scottish Government of £2.2m. However there will remain a financial gap of £5.3m which is in addition to the above financial challenge. Discussions are ongoing regarding for the IJB's winter plan.

12 Conclusions

This plan represents continued service change to improve and adapt our pathways, converting emergency where possible into 'urgent' planned care. Last year the COVID pandemic provided a catalyst to accelerate change through necessity. The severity of the pandemic has receded but high COVID prevalence in the population continues to challenge our health and social care services both directly and indirectly by:

- Requiring additional and duplicate resources and pathways to maintain COVID pathways
- Impacting on the well-being of our workforce
- Disrupting endeavours to remobilise routine care
- Late presentation of patients with deteriorating conditions

Gold Command structures introduced at the start of the pandemic continue to support rapid and cross-system escalation and decision-making. They will be integral to ensuring that the interdependencies between health and social care services are supported as all parts of the system respond to the winter pressures.