A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

ARGYLL AND BUTE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) WINTER PLAN

2023-2024

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Introduction

This report provides a summary of the overall winter plan for the Argyll and Bute Health and Social Care Partnership (HSCP). The plan spans the period from 30 November 2023 to 1 April 2024. The report highlights specific elements of planning and is intended to both guide work streams and provide assurance for relevant Boards. The plan is a whole system health and social care plan, recognising the interdependencies of the system to meet the needs of the local population. It is an annual national planning requirement and provides assurance that the system and partners have the necessary measures in place to deliver health and care for the local population during winter months.

Background

The HSCP system faces an extremely challenging winter. Locally and nationally, health and care systems are experiencing significant operational pressures across many of their services. Some patients are experiencing delays in accessing both planned and unplanned healthcare, despite the best efforts of our workforce. There has been little/no reduction in operational pressures over the summer months and providers are entering winter with significant capacity pressures (availability of workforce and service capacity) across a number of service delivery areas.

The partnership is experiencing higher levels of vacancy and staff absence in both NHS and local authority posts against a pre-COVID baseline(s). This is particularly challenging where vacancies impact on skillsets which are critical to whole system working such as District Nursing and Social Worker (i.e. Mental Health Officer) specialisms. Above expected vacancy levels across several pinch point roles continues to drive overspends in bank and agency staff usage that further pressurise depleted HSCP budgets.

In addition to the current pressures, we face a range of hard to quantify risks such as the potential for further Covid-19 pressures, high incidence of flu cases, increases in respiratory illnesses and the impact of the cost of living on both our workforce and our patients.

Scottish Government has described the actions they expected all systems and providers to take to increase capacity and operational resilience in planned, urgent and emergency care ahead of winter.

A review of winter planning processes and priorities has been undertaken in early autumn 2023. Our winter plan is set out in a format which considers:

1. **Current Position:** An outline for services, describing the current position regarding system pressures and preparatory actions we will undertake to mitigate for these, and;
2. **Action Plan:** An action plan setting out the specific whole system actions we will undertake to support and manage winter pressures. The whole systems action plan sets out a description of the action, the intended impact of each action and how we propose to measure the successful delivery of each action.

DRAFT

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Table of Contents

Introduction 1
1. Overarching Principles and Governance 3
2. Resilience Preparedness 4
3. Infection Control - Seasonal Outbreak 6
4. Communication Plan 9
5. Urgent and Unscheduled Care 11
6. Planned Care Services 13
6.1 Professional Areas in Focus 14
6.2 Integrated Community Care Services 16
6.3 General Practice 17
6.4 Hospitals 18
6.5 Children and Families 19
6.6 Mental Health Services 20
6.7 Care Homes and Housing 21
6.8 Care at Home 23
7. Workforce 25
8 Finance and Resources 27
8.1 Digital Support 27
8.2 Technology Enabled Care (TEC) 28

DRAFT

Version Control	
Version	3.0
Date	6 November 2023
Accountable Officer	Caroline Cherry, Winter Planning Executive Lead and Head of Service
Professional Lead	Elizabeth Higgins, Associate Nurse Director – Professional Lead
Programme Lead	Karl McLeish, Urgent and Unscheduled Care Programme Lead
Governance Route	SLT 8 November 2023 (approved). UUSC Programme Board 15 November 2023 (Approved) IJB 29 November 2023
Status	Final Draft 21 November 2023

1. Overarching Principles and Governance

Development of the Winter Plan

The HSCP has developed its Winter Plan in conjunction with key stakeholders from across the system to ensure that we can maximise our shared knowledge, resilience and resources with a view to delivering safe and effective services throughout the winter months. Initial engagement meetings were held in late autumn 2023. The plan has been developed taking into account feedback and learning following evaluation of the Winter Plan for 2022/23.

Governance

Governance of The Winter Plan will be led by the Executive Lead for winter planning. A cycle of system wide meetings are to be implemented to ensure we have a mechanism for escalating issues and making decisions on critical issues, in a joined-up way, across system partners. Along with regular data insights, we plan to operationalise a bespoke weekly data file which facilitates the monitoring of/responding to emerging risks, trends and compliance against agreed actions. The progress of the plan, together with risks and challenges, will be reportable to the NHS Highland Urgent and Unscheduled Care Programme Board and Clinical Care Governance.

We recognise that there will be challenging decisions to be taken over the course of this winter and robust governance processes will ensure a mechanism to do that in a way that considers the needs of our entire population, and the needs of staff working across both health and social care.

This plan is considered in line with the following key overarching principles:

- **Enhancing Community Services** and Planned Care.
- **Optimising discharge** home as first choice, ensuring patients are discharged as soon as they are medically fit, wherever appropriate and enhancing care in the community to reduce unmet need and associated delays.
- **Avoiding admission** with services developed to provide care at home across 7 days, hospital at home, discharge to assess, rapid access to assessment and a single point of access for health and social care (including technology and digital solutions).
- **Reducing attendances** by managing care closer to home or at home wherever possible including community step-up facilities for assessment, reablement and rehabilitation, prof-to-prof referral services, support for OOH, managing long term conditions to avoid unnecessary exacerbation utilising digital and remote monitoring where possible.
- **Sufficient staffing** across acute, primary and social care settings, including over the weekends and festive period, with access to senior decision makers to prevent delays in discharge and ensure patient flow. This includes recruitment and wellbeing priorities.
- **Surge Capacity** with the ability to flex up capacity when required including a surge plan.

DRAFT

2. Resilience Preparedness

Partnership Working

Structures are in place via planning and performance to ensure that the HSCP works collaboratively with all partner organisations, including in Greater Glasgow and Clyde and System Resilience leads. Care at Home and Care Home Assurance functions are in place, on a multi-disciplinary team basis, with clear escalations and protocols for risk management. Daily Huddle meetings will take place at system level and can be adjusted in line with demand. Any escalations relating to workforce/capacity are logged, directed and managed via that process. Weekly System Pressures Oversight Group (and by way of this, direct access to SLT) is in place. Heads of Service and Professional Leaders from across the HSCP are core attendees. These will link very closely with acute/hospital based ward rounds/virtual wards to ensure flow is maximised and maintained, with appropriate escalation management where required.

Business Continuity

Business Continuity Plans are in place across all areas and services. A priority piece of work is underway to ensure that these are updated, visible and practicable. This work is due to be finalised by 30 November 2023. Links with the Local Resilience Partnership (LRP) are clear. There is also wide engagement with multi-agency partners through the Local Resilience Partnerships in Argyll & Bute, with a particular emphasis on Caring for People arrangements across our areas of responsibility.

Operational Management and Local Plans

Management structures across the HSCP have led on the development of local winter delivery plans, which are calibrated to respond to both area-based pressures and system priorities. These local planning processes include a focus on key community, primary care, acute, mental health and social care services to address the expected and unexpected challenges in demand across the winter months, reflecting on learning from experience of last winter.

As in previous years these locality plans are expected to consider the following areas:

- Staff rotas including Public Holiday Cover for health and social work/social care (as per agreed NHS and Council Public Holiday Rates).
- Virtual wards of multi-disciplinary standard including SAS input where possible.
- Business Continuity Plans for each site.
- Monitoring of unmet need protocols are in place (where people are waiting for care at home).
- Vulnerable patient lists and associated planning is updated, with processes to access this list in the event of system failure. Ensure interface with OOH teams.

DRAFT

Capacity Surge Management

All community services, community hospitals and the RGH have very limited capacity to offer a response to surge escalation, in the form of contingency beds and limited flexibility in staffing resources. The focus for A&B will be on effective approaches to admission avoidance and bolstering care at home/within a homely setting where appropriate. Continuous flow models, including effective discharge without delay are a critical focus for the HSCP. Further work streams, including intermediate care beds will also be critical to managing surges in capacity and demand.

Adverse Weather Policy and Planning

NHS Highland/Argyll and Bute Council has an adverse weather policy in place which serves as an overarching guideline for all managers and teams. Service impact assessments and business continuity plans will also outline appropriate responses to enact the policy, and respective timescales. Managers are advised to access and revise the policy provisions.

Adult Support and Protection

All protection functions are in place and are reviewed through professional leadership and forums such as the Adult Protection Committee. A clear escalation process is in place to manage pressures and provide a responsive service. This is a key priority.

Unpaid Carers

There are 6 Organisations providing Carer Support across A&B, with offices based in; Oban, Helensburgh, Dunoon, Lochgilphead and Campbeltown. Carer support workers are also physically based on; Mull, Tiree, Islay, and Bute with outreach support covering the other remaining islands. Across the 6 organisations there are 80 FT/PT staff who provide Carers support, with one current vacancy. This vacancy is for the Isle of Coll and will be re-advertised. The vacant post is currently covered by the team in Oban.

Over 2,000+ Carers are registered with Carer Organisations. Information can be and is quickly shared with Carers via email and social media posts. Carer registrations have grown since last winter, meaning more carers are now accessing the support available.

Adult Carer Support Plans and Young Carer Statements are completed by Carer Centres. Emergency planning is discussed with every Carer as part of ACSP/YCS. Information regarding Carer Support has been shared with GP practises, raising the awareness of available local services.

Carer centres are creative about increasing the choice of groups that carers can access; these groups enable Carers to meet other Carers for peer support.

3. Infection Control - Seasonal Outbreak

A key priority for the HSCP is to undertake a robust approach to vaccination and infection prevention control in order to:

- ✓ Minimise seasonal influenza transmission/Covid-19.
- ✓ Minimise the risk and impact of outbreak and transmission on patients and services.

Vaccination Programme – Seasonal Flu

The winter vaccination programme for commenced in September 2023 for seasonal Flu. A high percentage of people across our population will be eligible for vaccination - we aim to offer all those eligible an appointment by the 11th December 2023, however, as flu is seasonal, this will continue to be offered until the end of March 2024. The flu programme will include:

- All school age young people, those aged 2-5, 5-16 (and those aged 6 months to 2 years who are at risk).
- Adults aged 50 and over and those aged 16 and over at risk due to certain health conditions will also be eligible.
- A wide range of health and social care staff, with a focus on those delivering 'front-line' services.
- Teachers and Childcare Workers.
- Care Home Residents.
- Unpaid Carers and household contacts of those who are immunosuppressed.
- Those who are pregnant.

Vaccination Programme – Covid 19 (Boosters)

In terms of the Winter Covid Programme, a further COVID booster is expected to be offered to:

- Those aged 5 and over at higher risk.
- Adults 65 years old and over.
- A wide range of health and social care, prioritising those who deliver 'front-line' services.
- Unpaid Carers and Care Home Staff.

Delivery

The Seasonal Flu and COVID vaccinations programme is delivered via a mix of scheduled appointments, drop-ins and peer vaccinations. Availability/communications are made available to all staff and teams. In addition to this the programme will be delivered through the following methods:

- Appointing of over 75s by the National Scheduling Team.

DRAFT

- Prompts to all others who are eligible from the National Scheduling Team:
    - Access is given to a national booking portal. Clinics are available in all Argyll & Bute community hospital settings. There are also local community clinics accessible to all staff including non-hospital based.
- Drop in clinics for those aged 2-5.
- School age children will receive vaccinations within the school setting. School age children will be offered the flu vaccine at school and younger children at children's community clinics. Community pharmacies will also offer the Flu vaccine to older people and those at higher risk from flu including those with well controlled asthma.
- Vaccination Clinics are being held close to GP surgeries.
- HSCP Community Teams will provide a service to those who are unable to attend community vaccination centres and will support care homes
- Maternity services will offer pregnant women the flu and COVID vaccines.
- For staff: The flu vaccine programme will be publicised through local managers, pay slips, NHS/Council Intranet site, and HSCP Bulletins.

Infection Prevention Control

From a staffing, services and resources perspective, surges in infection outbreak which impacts capacity would be anticipated, monitored and managed via the system huddles and system pressures oversight group. This would include end-to-end management, with multi-professional input, from onset of outbreak through to the implementation of lessons learned. There are close links with established communication mechanisms and business continuity plans. A formal process map is to be agreed to support and standardise local process of escalation and management.

Cluster management policies are in place and are accessible on all locations. Covid prevention requirements, i.e. face coverings as per guidance, reducing crowding in departments, hand hygiene, cough etiquette, social distancing is in place.
Care Home and Care at Home Guidance is managed through local process management protocols, and adheres to national guidance.

Increased use on non-face to face appointments/contacts can be used to manage outbreak where appropriate. Visiting would be restricted where required, and safe staffing arrangements would be held in review in line with business continuity plans.

In summary our key actions for winter are as follows:

Summary of Key Actions for Infection Prevention Control:
✓ Flu and Covid-19 vaccination programme implemented across the area as a part of preparing for winter, managed through local vaccination group.
✓ The majority of individuals eligible for flu immunisation should be offered the opportunity to be vaccinated during the period Sep-November 2023, though it is noted that clinics may be

DRAFT

required into February-March 2024.

- ✓ Majority of staff will be offered the opportunity to be vaccinated at their place of work, or as close as possible.
- ✓ Care Home residents, clinically vulnerable groups and front line staff are prioritised.
- ✓ Care home residents vaccinated at care homes.
- ✓ Consideration should be given to undertaking targeted immunisation campaigns in areas of high flu incidence & low vaccine uptake.
- ✓ In the event of a flu outbreak on any site there will be further promotion of staff flu vaccination and encouragement of uptake within those teams (and those affected more widely).
- ✓ Winter infection Prevention and control guidance, outbreaks and management is to be a core agenda item at system meetings – it is an expectation that all relevant guidance is proactively promoted and adhered to within local area teams, and that escalations are managed in close collaboration with Infection Control and Public Health colleagues.

DRAFT

4. Communication Plan

Communication and public messaging is central to our 2023/24 winter plan. There are a number of key areas of focus within to our communication and engagement plan for winter 2023/24. These are as follows:

Internally Focussed Communication:

- **Governance and Management Structure** – we will work closely with winter planning governance groups and Planning and Performance to effectively adapt messaging based on developing service needs. We will strive to ensure that our messaging remains as responsive and current as possible.
- **Staff Communications** - we will continue utilise internal communications to staff e.g. core briefs and staff social media pages. We will also make extensive use of the intranet to provide information and resources for colleagues across Argyll and Bute concerning winter planning and management. We will endeavour to facilitate targeted communication aimed at those who are most impacted by winter pressures, i.e. those working in isolated, remote and/or rural communities, in circumstances such as adverse weather, where connectivity may be reduced as a result.

  In addition to standard winter messaging, we will focus on messaging to support attendance avoidance and early discharge of patients wherever possible, alongside promoting the uptake of power of attorney, self-management materials and Technologically Enabled Care (TEC). We will also continue to promote our Flow Navigation Centres (via NHS 24) and vaccine programmes, supporting Right Care Right Place messaging to our workforce and service users.

Externally Focussed Communication:

- **Public Messaging** – Winter Planning and Urgent and Unscheduled Care management has a critical dependency on effective public communications. In line with national Scottish Government campaigns, we will continue to run local messaging to support national campaigns. This includes our 'Right Care, Right Place' campaign for urgent and unscheduled care, where we are actively promoting alternatives to attendance at A&E. We will also deliver strong public messaging around the importance of the vaccination programme for both Flu and the COVID vaccination booster. We will continue to raise awareness around power of attorney.
- **Patient and Public Feedback** – We will continue to facilitate patient and public feedback and this will be utilised to help shape and focus our key public messaging throughout the winter programme. Engagement with key communities will continue, via our focussed worksteeams, Locality Planning Groups (LPGs).

- **Partnership Working** - We will continue to work closely with community partners, including Primary Care, Mental Health and Local Authority colleagues, to ensure a joined-up approach to system messaging and communication. We will continue to engage Third Sector partners in order to maximise our ability to coordinate and share information, respond effectively to emerging local challenges and help facilitate resolution where possible.

In summary our key actions for winter 2023/24 are as follows:

Priorities for Internal Communication:
✓ Ensure robust and consistent membership from communications at relevant system forums.
✓ Agree and establish clear roles, responsibilities and escalation structures. Within this approach we will agree and action communication activity according to agreed priorities.
✓ Articulate clear process for authorising communication internally and externally.
✓ Development of single implementation plan/schedule of outcomes from changes, with associated information on go live dates, governance and SRO/Sponsors
✓ Every plan for change implementation as part of winter planning to include staff communication as an implementation step
✓ Recommunicate the roles and functions of Gold, Silver and relevant Bronze meetings
✓ Review and refresh Intranet materials for staff relating to safety, pathways, reference materials, etc.
✓ Ensure Argyll And Bute HSCP council employees receive the same messages as NHS Highland employees simultaneously (N.B with appropriate caveats)
✓ Continue to work in a system-focussed way to adapt communication for both staff and service users in a way which is responsive to changing service pressures and needs.
Priorities for External Communication:
✓ In partnerships with other providers review and refresh materials distributed in health and social care settings (posters, leaflets, etc.).
✓ 3rd Sector providers briefed/engaged in implementation of the changes
✓ Continue to deliver campaign 'Right Care Right Place' targeted messaging, to ensure communities are able to make greater use of alternatives to attendance and admission. This includes the promotion of pharmacy and self-management.
✓ Continue to develop and build on our public messaging campaign about the importance of being vaccinated for both Flu and COVID from 2022/23.
✓ Continue to develop and build on our public messaging around Power of attorney to increase awareness of the importance of having this in place.
✓ Every plan for change implementation as part of winter planning to include public communication as an implementation step.

5. Urgent and Unscheduled Care

Urgent and Unscheduled Care pressures continue to be considerable at a National Level. Within A&B HSCP our redesign of urgent and unscheduled care continues, in line with the Scottish Government Collaborative for Urgent and Unscheduled Care. This is intended to transform the way in which people access urgent and unscheduled care, enabling patients to receive the right care at the right time.

Key priorities that will make the greatest impact during winter 2023/24 includes:

- **The reduction and/or avoidance of admissions** – including signposting and redirection (of those whose care requirements are not an emergency) to more appropriate and safer care, closer to home, by optimizing clinical consultations through telephone and virtual 'Near Me' consultations. Those who require a face to face appointment will have their attendance scheduled, where appropriate and possible,
- **Increased virtual capacity** - to support the assessment of patients at home or within a homely setting, avoiding the need to attend services. Increased capacity for virtual monitoring and ongoing treatment, preventing admission.
- **Focus on Hospital at Home** provision, where available.
- **Supporting 'Out of Hours' (OOH) care** – sustainable, responsive, safe provision.
- **Optimising flow** - within our hospital settings, through the embedding of our DwD programme, including effective planned date of discharge management. Reducing length of stay on admission – increasing the number of patients on a rapid assessment and short stay pathway, focussing on lower risk – high impact presentations supporting safe and early discharge home

Discharge without Delay (DwD)

As part of the redesign of Urgent and Unscheduled Care programme we are in the process of fully reviewing and implementing the DwD process within our inpatient areas. Our key priority arears for DwD over winter months are to:

- **Limit hospital length of stay (LoS)** - to what is clinically and functionally essential, getting patients' home at the earliest and safest opportunity, with the right care and support in place. This links with step down and discharge to assess frameworks.
- **Improve and expedite the patient journey**, from the initial point of a hospital admission, via effective access to services, planning and implementation of resources to support ongoing care at home, or in a homely setting, where needed.
- **Preventing delays** through early and effective discharge planning which includes robust and standardised approaches to all areas assessment and communication – including key aspects such as financial planning and AWI processes.
- **Ensure appropriate escalation and management** structures are in place to support resolutions to any barriers as they arise.

DRAFT

The immediate focus ahead of winter is to support care services to realise full resource potential and fully implement effective discharge with minimum delay. This includes the procurement of additional short-term resources where required.

Out of Hours Provision (OOH)

The Out of Hours service is working effectively to provide access to urgent care during out of hours periods. As we approach winter months, a number of key system pressures are known which present a risk for sustainable out of hours provision. Beyond rurality and transport issues, other significant risks include increases in unplanned attendance, breakdowns in care packages, access to pharmacy and increasing needs relating to the management of palliative care and complex presentations. There is also a priority need to focus on/refresh Key Information Summaries and Future Care Plans, to ensure effective OOH and partnership working and care.

Priority Actions for Admission Avoidance and Signposting
✓ Continue to promote access to Flow Navigation Centre for Urgent Care.
✓ Continue to prioritise attendances for urgent/emergency care as scheduled attendance.
✓ A focus on our ability to receive and effectively manage referrals from NHS 24 & schedule face to face appointments for urgent care in acute settings as required.
✓ Continue to promote and facilitate access and triage through 111, 24/7.
✓ Maintain a clear focus on supported self-management - Clear and concise public and staff information – ensure appropriate co-production with Comms team.
✓ Continue to drive worksteeams which expand the role of the Third Sector/localised support.
Priority Actions for Virtual Capacity
✓ Ensure contingency arrangements in place to support patient consultations from home etc. if required – this will be critical in the event of adverse weather.
Priority Actions for Out of Hours Care
✓ Ensuring that the Professional to Professional line is available OOH to all pharmacists, paramedics etc. and is well used throughout the year.
✓ Ensure OOH clinicians have pan Highland ECS access. NHS24 Patients appointed via Hub.
✓ Ensure that emergency Social Work Service are in place for all public holidays and OOH periods as usual. Referral is direct to Emergency SWES.
✓ Ensure that all relevant paperwork is in place; including the prescribing of 'just in case' medications (ensure that the medication is in the house, rather than in a pharmacy).
Priority Actions for Optimising Flow
✓ Prioritise the use of Technology Enabled Care (TEC) including ''Near Me'' – ensure process & kit is available in A&E ensuring that technology solutions for urgent care are optimised.
Priority Actions for Discharge without Delay
✓ A pathway which has resilience, resource and governance to meet anticipated greater demand from Winter Pressures-monitor weekly through the Winter Planning Group.
✓ Ensuring that Planned Date of Discharge (PDD) is implemented and effectively managed through virtual wards and board rounds (including clear escalation strategies).
✓ Continue to promote the role of/inclusion of unpaid carers and/or carers' services in discharge planning.

6. Planned Care Services

An integrated approach to community health and social care planning for winter supports and maintains capacity for Community Hospitals, Primary and Secondary care services and enables patients to remain in community settings where clinically appropriate. This approach should focus on initiatives which preserve and prioritise capacity for those most in need, under the principles of 'Right Care, Right Time'.

The HSCP envisages a repeat of the increased demand for community health and social care services as experienced in previous years. Particular pressure around care demand for our older adult population is anticipated, given the demographic profile for Argyll and Bute. In order to achieve this work, particular focus is required from all areas of planned care on:

- **Future Care Planning** and **Key Information Summaries** (accurate content and access).
- **Admission Prevention/Avoidance,** including alternatives to admission and self-care.
- **Single Point of Access,** with effective referral coordination and management.
- **Optimisation of Flow,** Including integrated discharge management and resource planning.

Planned episodes of care are expected to continue across all community Outpatient Services during winter months. Business continuity/service impact planning will be regularly reviewed to take account of the risks of reduced capacity, increased admissions, etc. with a view to minimising any associated impacts.

Home care (Care at Home) provision continues to present challenge for occupancy and flow. This will continue to be a pressure and runs risk of impacting on the need to cancel some planned activity. H@H and the introduction of additional rapid response/care at home capacity in Oban is expected to have an impact on reducing unmet need.

Close partnership working is currently in place via Discharge without Delay (DwD) frameworks, including package funding decision making groups, to ensure that care needs and resource are managed effectively within scope of capacity and matched need. This includes core system partners but could be further expanded to include third and independent sectors. Cases defined as Adults with Impairment (AWI) continue to present a significant challenge for occupancy and flow across the system.

Overarching Priority Actions for Planned Care Services
✓ A refresh of core workload and adjust capacity in line with current need and resources.
✓ Increasing staffing for predicted peak times across the actual public holidays and weekends.
✓ Identification of Service users who are defined as vulnerable and/or complex – these individuals should be an area of key focus, with appropriate MDT arrangements to manage ongoing care.
✓ Palliative and End of Life Pathways and Caseloads, in all areas, should be reviewed, with appropriate contingency plans in place to manage increased pressures which may result due to seasonal outbreak and/or the impacts of adverse weather.

DRAFT

6.1 Professional Areas in Focus

Nursing

The focus for nursing workforce as we approach winter 2023/24 is on quality and safety. Falls prevention within hospital and homely environments, with improvement work supported by Lead Nurses is a key area of work. In addition to this work, the roll out of Daily Care Plan in Inpatient areas is moving at pace to enhance and maintain quality care delivery and assurance. Work will also focus on tissue viability training and standards of practice to reduce risks around pressure ulcers for patients in hospital and at home with restricted mobility. Infection Prevention and Control Nurses (IPCNs): Ongoing training programme in preparation for winter, including continued support from IPCNs in the management of outbreaks.

3 Key Challenges
1. Recruitment generally but also to key leadership (SCN) posts.
2. Maintaining quality with the level of system pressures.
3. Staffing wellbeing and morale.
3 Priority Actions
1. Expand International Recruitment to more areas with A&B. Review hard to recruit roles and identify viable alternatives.
2. Targeted support from Lead Nurses to support quality agenda. Also planned QI support for TV in high prevalence Acute areas
3. Learning from Development Events - share and spread. Wellbeing challenges such a bespoke Step Count Challenge.

Allied Health Professionals

Focus on surge and real-time staffing through described escalation routes, including short-term increases to staffing by utilising winter pressures funding. Continue to focus attention around falls in in-patients units, including a meaningful activity project on all wards to increase activity, reduce deconditioning/falls, as well as increasing purposeful occupation and reducing distress for patients during their hospital stay. Refresh the response to uninjured fallers in community by our newly appointed Lead AHP alongside system partners. Continue to provide AHP leadership on in the HSCP's Living Well programme with recruitment to posts to support proactive frailty prevention work and increase community rehab and wellbeing programmes, with expected reduction in primary and secondary care visits, and increased levels of physical activity and independence in our communities.

3 Key Challenges
1. Recruitment and staffing gaps in very small teams.
2. Lengthy waiting times in community with lower priority work being particularly impacted.
3. Staffing wellbeing & morale.
3 Priority Actions
1. Progress proactive early intervention work at pace.
2. Roll-out of work planning tool to ensure staff have appropriate work plans and time for CPD.
3. Roll-out of digital dictation across teams at pace.

Social Work

Within Social Care services there has been significant amount of work undertaken in relation to smarter commissioning within the HSCP and Care at Home providers, working in partnership to deliver essential services. Challenges to this, which are also seen nationally, are the recruitment and retention difficulties faced across the sector. Smarter commissioning enables daily oversight and scrutiny of required services and actual delivery.

Following the agreement to implement a Central Adult Support and Protection Team, the operational model of Adult Social Work is being reviewed and this work is ongoing. A review framework has been drafted for care homes and work is underway to develop a review framework for clients in receipt of social work and or social care support in the community. Work is currently underway to develop a programme to increase our qualified Social Work Workforce over the next 4 years per the workforce projections.

Interface with the Third and Independent Sector

The independent sector (mainly care homes and care at home) are engaged for winter with the HSCP through provider meetings whether one to one or through, for example, the Care Home Task Force. Third sector initiatives for winter such as warm rooms, sits within the governance of the Local Authority, but small amounts to support warm boxes for older people can be made available

Medical Workforce

There are currently 200 medical professionals working across Argyll and Bute. There are 120 GPs providing primary care - 50 of these are in REP (rural emergency practitioner) who also contribute to Unscheduled/Acute /Rehab care in their community hospital roles. A further 10 work in unscheduled care across Oban and Dunoon. GPs continue to provide OOH standalone services for Oban, Dunoon and the islands.

Increased demand over winter inevitably impacts relatively small teams, whose input is needed across the traditional primary/secondary care interface. In RGH and mental health, rotas are also reliant on very small Consultant teams, supported by a junior medical workforce. Sustainability of services is considerably enhanced by multi-professional working and ensuring that roles and skills are carefully planned and utilised to maximum impact.

3 Priority Actions:
1. Review and ensure business critical protocols are updated, available and visible to on local and on call managers. This includes a clear process to fill last minute gaps on rotas, especially for junior workforce and GP OOH.
2. Efficient recruitment processes ensuring workforce availability- we have progressed recruitment for REPs and need to see these people available to work ASAP and preferably pre winter surge.
3. Oban: ensure that staff responsible for admissions (juniors and locum Consultants, especially those who are temporary or rotate) have a full understanding of hospital at home uses and criteria, and other facilities to reduce need for admission. Also encourage ownership of prevention of admission in ED nurses.

DRAFT

6.2 Integrated Community Care Services

Community Services are managed and delivered within 6 local areas:

Area	Helensburgh and Lomond	Cowal	Bute	Mid-Argyll	Kintyre, Islay and Jura	Oban, Lorne and the Isles
Community Hospital Beds (Contingency)	SLA GGC	11 (3)	8 (1)	15 (0)	10 (2)	
					Islay 6 (0)	Mull 3 (0)
Rural General Hospital (Contingency)						LIH RGH 46 (6)
GP Practices* (List Count)	5 24,185	8 21,690		8 21,125		8 23,207
Care Homes No of Beds	4 169	4 141	2 15	1 16	2 56	4 118

*4 practices are not included as work is ongoing to evaluate list sizes.

Key Challenges for Community Services:

- **Demography** - A total population of 85,430 people with 26% were aged over 65. 11% of people live 8.7% lived in the most deprived quintiles. Access to services, health management, housing, and employment are among the highest ratings.
- **Rurality** – Argyll and Bute covers 691,000 hectares, and has 23 inhabited islands, making it the second largest local authority and one of the most geographically complex areas to deliver services within. 43% of the population live in remote and rural areas.
- **Health Needs** - In the financial year 2020/21, in Argyll and Bute HSCP, 24% of the total population had at least one physical long-term condition (LTC). 4.5 in 10 of those aged 65 to 74, 6 in 3 of those aged 75 to 84 and 7 in 6 of those 85+ have at least 1 LTC. These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. among the people who have a LTC, 21% of those under the age of 65 have more than one, compared to 50% of those aged over 65.
- **Transport/Access** – sustainable delivery of services in remote and rural areas is an existing challenge which is made more challenging by staffing gaps, adverse weather and availability of public and emergency transport.

Key Actions for winter 23/24:

Community Services Priority Actions:
✓ Ensure that resource is maximised by holding system pressure in regular review and continuing to signpost the public through the media, social media and online to the most appropriate services for their needs and to ensure our wider public messaging campaign remains credible and effective and aligned with pressures
✓ Undertake a review of district nursing hours to ensure alignment with GP practices.
✓ Ensure adequate equipment (including beds and mattresses) available in the community to enable the management of more acute conditions at home and facilitate discharge without delay. Private transport will also be agreed on a needs basis.

6.3 General Practice

As winter months approach, Primary Care, alongside other Community Services is at the forefront of pressures, particularly General Practice and Community Pharmacy. Both services are reporting ever increasing numbers of patient contacts and increasing complexity and frailty within their communities. It is also recognised that the geographical and demographical challenges for Argyll and Bute are acutely reflected in Primary Care service delivery - every Practice is different and there is no single solution for all.

Workload pressures are currently being experienced across the whole of the health and social care system. Such pressures are expected to escalate during winter months.

Practices are asked to consider key priorities that will make the greatest impact during winter 2023/24 which includes:

- The length of each clinical surgery and length of appointments.
- The mix of appointment types- face to face, video, telephone (this may differ between days and between clinicians).
- The availability to pre-book appointments, and how far ahead this can/should be supported.
- The knowledge and skills of administrative teams, who are often the most effective at identifying issues and redirecting patients where appropriate.
- The Practice website(s), ensuring up to date/appropriate links for patients and to avoid the need to call the Practice.
- The recognition that no practice is able to carry out everything in times of unusual pressures - enable practices to prioritise within available capacity and use the escalation framework to request exceptional departure from contractual activity.
- Consider use of extended hours/Saturday opening to enhance capacity where appropriate and feasible (LES in negotiation)

Key Actions for winter 2023/24:

Priority Actions for General Practice:
✓ Continually review demand and capacity - allocate resource based on complexity and urgency.
✓ Focus on those most at risk of deterioration that require support and intervention.
✓ Focus on those at risk of admission to hospital, care home or significant risk in a community setting e.g. self-harm, or requiring enhanced support package.
✓ Focus capacity where there is a clinical need for same day response, to reduce risk of demand being deferred to the out of hours period and protect hospital resources.
✓ Delay some activities where this can be done without immediate significant adverse health impact or impact on other parts of the system.
✓ Use of Pharmacy first and the advertising of Clinical Pharmacy opening hours during bank holiday periods.
✓ Continue to facilitate and prioritise MDT/Partnership working to coordinate and focus resources.

DRAFT

6.4 Hospitals

Additional Winter Capacity

Our ability to create additional acute capacity by opening 'winter beds' is limited by the availability of staff, in particular, registrant staff to provide the level of care and rehabilitation required.

Although this is carefully planned ahead of the winter period, the provision of true additionality of resource into wards is extremely challenging. All community services, community hospitals and the RGH have very limited capacity to offer a response to surge escalation, in the form of contingency beds and resources. The focus for A&B will be on effective approaches to admission avoidance and bolstering care at home/within a homely setting where appropriate. Continuous flow models, including effective discharge without delay planning are a critical focus for the HSCP. Further work streams, including intermediate care beds will also be critical to managing surges in capacity and demand.

Alternatives to Admission and Admission Avoidance

A critical focus for the supporting the hospitals across Argyll and Bute is alternatives to attendance at A&E and admission avoidance. For Oban locality, this will include a focus on the Hospital at Home pilot, which will aim to work with complex medical patients – supporting them to remain in their own home rather than being treated in an Emergency Department or Hospital ward.

Flow Navigation Centre (FNC) arrangements are in place to respond to emergency treatment needs, including appropriate signposting. Current local provision is in place to direct medically urgent assessments to non-by-pass A&E departments for assessment by a senior clinical decision maker. The majority of A&Es have Business to Business contracts with an on-call GP link. Out Of Hours provision is in place. Routine cases are directed via local Single Points of Access (SPOA) under business as usual arrangements. These are allocated on needs-based priority to appropriate services. Self-care and attendance avoidance is advised where appropriate. Examples of good practice for multi-agency Multi-disciplinary working exist across A&B communities.

Community responder services will also play a critical role in providing alternatives to attendance, by way of appropriate signposting and alternative assessment and treatment models. Services are developing improved access and responsiveness to non-injurious falls, including supporting call outs to Care Homes. ''Call before convey'' and ''Professional to Professional Conversations'' are also a critical focus to maintain flow throughout the winter months. This aims to support referrals into community services and/or stabilise existing care options as an alternative to conveyance, attendance and ultimately admission.

Where clinically appropriate, we will aim to provide remote medical consultations to NHS24/111 patients. This avoids the patient having to attend in person, and frees up face to face capacity for those with more urgent or complex needs.

DRAFT

6.5 Children and Families

Child Health Services

As winter months approach, Child Health Services, alongside other Community Services is at the forefront of pressures. During winter pressures teams will continue to use the Traffic Light Tool to prioritise delivery of the Universal Health Visiting Pathway. Our Allied Health Professionals as well as Community Paediatrics teams continue to see an increase in demand for services - in particular, Neurodevelopmental Assessments. In the approach to winter, there has been a requirement to review demand and prioritise the need within caseloads. All of child health teams are seeing an increase in presentation complexity within the community. With the added pressure of a national shortage of ADHD medication, recruitment struggles and an increase in complex presentations the need for considered resource management is of vital importance. The uses of assistive technology for consultations in remote and rural areas will continue to be utilised to extend scope and maximise impact of pressured service areas.

Key priorities that will make the greatest impact during winter 2023/24 includes consideration of:

- Supporting professionals and increasing the range and types of care available to reduce the risk of burn out and further pressures as a consequence.
- The mix of appointment types- face to face, video, telephone (this may differ between days and between clinicians and client based needs).
- Ensuring a timely and robust model to reduce and manage waitlists and provide a responsive and timely service according to complexity of needs.
- Remodelling of neurodevelopmental service to provide biggest impact to families and communities
- Accessible self-help resources within HSCP websites.
- The recognition that no service can carry out everything in times of unusual pressures - enable service to prioritise within available capacity.

Key Actions for winter 2023/24:

Child Health Priority Actions:
✓ Continually review demand and capacity and allocate resource based on clinical priority, complexity, and urgency.
✓ Focus on those most at risk of deterioration that require support and intervention.
✓ Continue to keep child safety central to all child health work.
Continue to work collaboratively to meet needs of children and families
✓ Delay some activities where this can be done without immediate significant adverse health impact or impact on other parts of the system.
✓ Continue to facilitate and prioritise MDT/Partnership working to coordinate and focus resources.

DRAFT

6.6 Mental Health Services

The challenges for Mental Health Services in relation to the winter period continue. Particular pressure emanates from RMN nursing and MHO vacancies across the localities. In addition, our Mental Health psychological therapies service continues to experience long waiting times with current waiting lists at a 2 year wait for secondary care services, and an additional waitlist for primary care mental health services. This pressure represents significant challenges for the provision of timely and responsive interventions, and to step-up care across the localities. Increasingly, Mental Health teams are focusing their limited resources on preventative measures in order to minimise an escalation of crisis and attendances presenting to A&E. Our Urgent and Emergency team continue to ensure that a timely and robust response and assessment is available to appropriate patients.

Argyll and Bute Mental Health Services recognise the concerns around recruitment and are committed to proactively developing more innovative ways to extend the reach of services with the introduction of partner agencies, particularly in relation to accessing psychological interventions; we are currently completing the commissioning of new partners to assist us to deliver services across both primary and secondary care services. These approaches are of particular focus in the approach to winter, and are aimed towards:

- Promoting resilience for those patients with a mental health need by ensuring appropriate models of care which support self-management and access to care at home,
- Ensuring a timely and robust model to reduce and manage waitlists, and provide a responsive and timely service according to complexity of needs.
- Support discharge without delay, where there is a mental health component, by facilitating appropriate care in the right place, at the right time.
- Supporting professionals and increasing the range and types of care available to reduce the risk of burn out and further pressures as a consequence.

Key Actions for winter 2023/24:

Mental Health Priority Actions:
✓ Ensure a timely pathway for access to a Mental Health Assessment if attending Emergency Department, Police Scotland and SAS.
✓ Continue to focus on preventative measures, to reduce pressures on services and maintain patient care in appropriate settings.
✓ Proactively manage ongoing recruitment issues, working collaboratively with relevant partner organisations.
✓ Promote a joint-working, with innovative approaches to practice and shared responsibility ensuring that people experiencing distress receive appropriate and timely response.
✓ Maintain a clear focus on the reduction in the number of crisis/emergency admissions.
✓ Maintain a clear focus on reduction in the number of people attending the A&E in crisis.
✓ Continue to work collaboratively in supporting with the resolution of AWI related difficulties – assessment, discharge, placement and general care planning.

DRAFT

6.7 Care Homes and Housing

As at October 1st the Care Home Bed occupancy by area shows the following:

Helensburgh and Lomond **169 Beds** **147 Occupied** **90% Occupancy**		**Cowal** **156** **137** **87% Occupancy**		**Bute** **(Included in Cowal Totals)**	
Northwood Occupied % Occupied	20 20 100%	**Struan Lodge** Occupied % Occupied	12 11 92%	**Thomson C** Occupied % Occupied	8 8 89%
Argyll C Centre Occupied % Occupied	56 48 86%	**Ardenlee** Occupied % Occupied	33 22 67%	**Palm Court** Occupied % Occupied	7 6 86%
Hermitage House Occupied % Occupied	64 51 80%	**Ardnahein** Occupied % Occupied	30 28 93%		
Morar Lodge Occupied % Occupied	29 28 97%	**Ash Grove** Occupied % Occupied	65 52 95%		
Mid Argyll **(Included in Kintyre Totals)**		**Kintyre, Islay and Jura** **72 Beds** **62 Occupied** **83% Occupancy**		**Oban, Lorne and The Isles** **118 Beds** **89 Occupied** **71% Occupancy**	
Ardfenaig Occupied % Occupied	16 15 94%	**Gortanvogie** Occupied % Occupied	16 10 63%	**Eadar Glinn** Occupied % Occupied	22 17 77%
		KCC Occupied % Occupied	40 37 92%	**Tigh A Rudha** Occupied % Occupied	12 6 50%
				North Argyll Occupied % Occupied	25 19 76%
				Etive House Occupied % Occupied	59 47 80%

*Source: Care Home Assurance Data Reporting. Not all beds are able to occupied and numbers should be interpreted accordingly in line with most recent data.

Key	
(light blue)	**Local Authority Owned Managed**
(light yellow)	**Privately Owned/Managed**

Overall bed occupancy for Local Authority owned homes is currently 104 out of 127 beds, with 3 vacancies that can be filled. The remaining 23 vacancies are being reviewed. Overall bed occupancy for Private and Independent Sector Managed Care Homes is 331 out of 388 beds, with 30 vacancies that can be filled. The remaining 57 vacancies are being reviewed.

Total bed occupancy is 435 occupied beds, from of an overall total of 515 (80 actual vacancies and 33 vacancies that can be filled), giving an overall occupancy of 84% for Argyll and Bute.

DRAFT

Care Planning

The majority of care homes across Argyll and Bute have a weekly review with a GP. Any concerns or issues raised can be escalated. All care homes have their own future care plans in place, and there is a lead nurse for care homes in place to advise on clinical issues. A home first approach is in place to facilitate admission avoidance.

Occupancy and Resources

In order to meet the known additional winter pressures, we are reviewing our care home bed occupancy to explore potential capacity for winter bed surge planning. Approximately 33 additional beds may be available this winter, these have been included within the winter plan costs as being opened on a spot purchase basis from December to March. Please note the costs within the winter plan are for opening the winter surge beds only and do not include the costs of the beds that remain open and have been historically been in place for some time.

Intermediate Care Options

Step up and step down care, or intermediate care options are currently being scoped at pace. The HSCP will establish a working group to look at options for models of care. This will be a key focus for HSCP winter planning/strategic development and will feature in the final plan. Although Interim Beds (a side move with no rehabilitation whilst waiting for care at home) are now not in scope as a formal offer, step down arrangements of up to 6 weeks are in place and can be agreed to facilitate intermediate care where appropriate (and where there is a realistic prospect of reablement and/or where the longer term care needs are known, and are being proactively managed).

Key actions for winter 2023/24

✓ Care Homes: Monitored and assured through the Care Home Assurance process, communication through the Task Force.
✓ Weekly review of high risk health issues to be developed by the Associate Lead Nurse Care Homes
✓ Interim care (where care at home is not available: confirm spot purchase arrangements with existing care homes. Take up and use monitored through the Care Home/Care at Home Assurance.
✓ Scope potential growth and options for intermediate care through a SLWG.
✓ Staff and care home staff offered vaccination in situ
✓ At pace review of KIS and ACPs for all residents.

DRAFT

6.8 Care at Home

As at 31 October 2023, the following information relating to total clients and total care delivery hours was available.

Helensburgh and Lomond Grand Total Service Users: 306 Grand Total Average Hours: 3297 Percentage with 2 Carers: 16% **Unmet Clients/Hours: 6/99.5**		**Cowal** Grand Total Service Users: 130 Grand Total Average Hours: 1136 Percentage with 2 Carers: 25% **Unmet Clients/Hours: 5/39.5**		**Bute** Grand Total Service Users: 124 Grand Total Average Hours: 1594 Percentage with 2 Carers: 24% **Unmet Clients/Hours: 1/7**	
Service Users: -	**Average Hours:** -	**Service Users:** -	**Average Hours:** -	**Service Users:** -	**Average Hours:** -
287	3032.25	120	967.13	121	1549.5
22	264.75	12	160.25	3	44.75
Mid Argyll Grand Total Service Users: 102 Grand Total Average Hours: 1503.5 Percentage with 2 Carers: 31.5% **Unmet Clients/Hours:**		**Kintyre, Islay and Jura** Grand Total Service Users: 177 Grand Total Average Hours: 1790 Percentage with 2 Carers: 22% **Unmet Clients/Hours:**		**Oban, Lorne and The Isles** Grand Total Service Users: 197 Grand Total Average Hours: 2412 Percentage with 2 Carers: 24.6% **Unmet Clients/Hours: 17/128.5**	
Service Users: 45	**Average Hours:** 594	**Service Users:** Kintyre: 42 Islay & Jura: 47	**Average Hours:** 456.75 370.25	**Service Users:** Lorn: - Mull & Iona: 28 Tiree/Coll: 10	**Average Hours:** - 393 69.75
52	659.5	Kintyre: 87	755.5	Lorn: 103 Mull & Iona: 9 Tiree: -	1024.5 69.25 -
13	250	Kintyre: 7 Islay & Jura: 4	153 55.5	Lorn: 46 Mull & Iona: 2 Tiree/Coll: 2	803 22.75 38.25

Key	
(light blue)	Internally Provided
(light yellow)	Externally Commissioned
(orange)	Direct Payments

Summary of Care Hours and Delivery by Area

As at the end of August 2023, the Care at Home service was being delivered to 1036 people in total, with 1004 of these people aged over 65 years. Services delivered per-week were approximately 9572 hours across all types of delivery, across the HSCP.

Of this number, 111 people opted for Self-Directed Support – Option 1 (Direct Payment) and were in receipt of approximately 1566 hours per week.

779 people received care from externally commissioned service – Self Directed Support Option 3, delivering approximately 6546 hours per week.

172 people were in receipt of care delivered through internally managed services - Self Directed Support Option 3, with approximately 1460 hours of service being delivered.

Overall, the average hours per person being delivered per week were 9.24 hours per week.

As at the 31 October, unmet need stood at a total of 40 clients with 382.8 hours unfulfilled.

DRAFT

Resources

The internal care at home service currently employs 86 permanent care staff with varying contracted hours. There are also 67 casual/bank staff. The total workforce has approximately 23% of staff aged over 60 years, with 27% of the carers aged over 60 years.

The externally commissioned services employ approximately 416 staff through 12 organisations. All areas now employ mobile responder teams (Oban, Lorne and Isles progressing through commissioning at pace as at 31 October 2023).

Key Challenges

As we move to winter 2023/24, the key pressures for care at home are:

- **Unmet need** – with a high percentage of newly identified clients requiring long-term care at home provision (a high percentage require intensive support (i.e. 4x double-up daily visits). The most significant pressure for unmet need centres on the Oban, Lorn and Isles locality.
- **Delayed discharge** – as at 31 October 2023, 61% of current delayed discharges (21 of 34) related to Care at Home. Of the 21 delays relating to Care at Home, 57% (12) related to Oban, Lorn and Isles locality.
- **Recruitment/Accommodation** – a number of posts remain vacant across Argyll and Bute, for both registrant and non-registrant roles. Difficulties in recruitment are further exasperated by lack of affordable/suitable accommodation in key areas of pressure, such as Oban. A working group is reviewing this provision at pace.

Key Actions for winter 2023/24

Priority Actions for Care at Home
✓ The recruitment and deployment of a mobile team for Oban Locality. Agency staffing is being implemented in the interim to support/alleviate hospital pressures.
✓ Bolstering/additional support for responder teams to ensure appropriate use and ability to provide holistic approaches to care – this in turn supports quality of care at home and ability to maintain care in the home/homely setting.
✓ Interim/intermediate care options to both support admission avoidance and reduce length of stay/support discharge.
✓ Future Care Planning and Key Information summaries to support winter plans for service users in receipt of Care at Home.
✓ Focussed monitoring and review for Unmet Need through Care at Home assurance frameworks – this incudes closer working with CRGs, DwD pathways and provider relationships.
✓ A rapid review of all Care at Home services, to ensure efficiency and high quality delivery (and reduction in pressures for other services, i.e. hospitals and DwD).
✓ Reviews of packages of care – to ensure that input remains appropriate and that resource is appropriately managed.

DRAFT

7. Workforce

At the end of March 2023, the HSCP employed 1,568 substantive staff (1,277wte). 53% of staff held full-time contracts. Nursing and Midwifery held the highest numbers of vacancies across all divisions, followed closely by Allied Health Professionals – this trend is echoed in the table below.

Vacancies and Recruitment

The winter workforce plan considers the impact of winter pressures across the partnership. As at 1 November 2023, the HSCP is operating with the following vacancies. These are detailed for the entire division and then by service area:

Vacancies by Division & Job Family

				Number of Vacancies	
				Count	Sum
Division	A&B Children Families & Justice	Job Family	Administrative Services	1	1
			Allied Health Professions	2	2
			Medical and Dental	1	1
			Nursing and Midwifery	1	2
			Total	5	6
	A&B MH LD & Addiction Services	Job Family	Medical and Dental	1	1
			Nursing and Midwifery	2	2
			Total	3	3
	A&B Older Adults & Hospital Services	Job Family	Administrative Services	2	2
			Allied Health Professions	9	9
			Healthcare Sciences	1	1
			Medical and Dental	3	7
			Nursing and Midwifery	13	14
			Other Therapeutic	2	2
			Total	30	35
	Argyll & Bute Central	Job Family	Nursing and Midwifery	1	1
			Total	1	1
	Total	Job Family	Administrative Services	3	3
			Allied Health Professions	11	11
			Healthcare Sciences	1	1
			Medical and Dental	5	9
			Nursing and Midwifery	17	19
			Other Therapeutic	2	2
			Total	39	45

Count is the number of job adverts; sum is the total number of vacancies across those adverts

In response to the current challenges and pressures within all Health and Social Care divisions, there have been a number of actions implemented which in order to ensure quality care can be maintained and staffing vacancies can be recruited to. A workforce establishment tool process has taken place with our Community Team and our Specialist Teams. The aim is to right size the workforce and is part of the preparation for the enactment of the H&C Staffing Act. Other improvements related to this are: Real Time Staffing implementation, including risk mitigation and escalation and the introduction of e-roster which is currently being rolled out throughout the Board. International recruitment within Mental Health of Registered Nurses (RNs) is ongoing.

Growing Our Own RNs is also proving effective, with 24 nurses currently in various stages of training via the Open University. Similar initiatives are in place for Social Work and AHPs. Board wide work on expanding Band 4 roles within more clinical areas is also a priority focus. This includes a comprehensive review of roles, responsibilities, competencies and training ahead of winter.

Sickness and Planned Absence

The challenges of winter are carefully thought through and the planned mitigations have been developed in collaboration with key stakeholders. Traditionally, staff availability is impacted further in the peak winter months as a result of higher sickness absence levels.

Key Actions for winter 23/24

Vacancies and Recruitment:
✓ Ahead of winter this year we are proactively working with Higher Education Institutions (HEI's) to develop a communication to students to promote working in HSCP roles during academic gaps such as festive breaks and between placements.
✓ Dedicated winter recruitment is underway, ensuring that additional resources are recruited to facilitate the provision of increased capacity.
✓ Ensuring Safe Staffing - Enhanced rates for key shifts and now sourcing agency locums for outstanding remote & rural shift periods. Workforce provision under continual review.
✓ Consideration is also being given as to how we could further develop our staff bank to provide support to all Allied Health Professionals (AHPs) and Registered Nurses.
✓ We continue to support colleagues wishing to retire and Return, with this now being managed via the flexible working process.

Staff Wellbeing

A range of staff wellbeing and mental health initiatives have been deployed and will be maintained throughout winter. The HSCP has a focused culture and wellbeing group which meets bi-monthly. Staff wellbeing is a priority for HSCP; both employing partners take an integrated approach to ensure an ability to maximise the resources and support available. This forum is well supported, action focused and inputs and outputs are well communicated.

A priority area of focus within our strategy is to ensure there are a number of preventative interventions in place to ensure that our workforce has access to a range of services that support and improve their physical and mental health.

Key Actions for winter 23/24

Priority Actions for Staff Wellbeing:
✓ Continue to promote access to support through the Argyll and Bute Wellbeing Programme.
✓ Continue to prioritise clinical and management supervision frameworks so that colleagues continue to have a safe space to escalate and co-manage any concerns.
✓ Ensure clear provision and routes of access for confidential support and access to counselling services, etc.
✓ Remote Working – Ensure that appropriate arrangements are in place for remote working both in terms of network capabilities and availability of hardware – this will be a critical action to maintain safe staffing in the event of adverse weather.

DRAFT

8 Finance and Resources

Allocation of winter funding is in place. A process has been established to collate and approve requests for additional support, relating to the KPIs for winter planning, as set out by Scottish Government. Ad-hoc requests will be agreed via established governance channels and committed spend will be collated and submitted to Scottish Government as required.

8.1 Digital Support

As we move towards winter months, the HSCP's E-Health function continues to complete work to create an environment that supports flexible/remote and agile working as well as ensuring that the core infrastructure is optimised to ensure it is effective to support clinical, care and non-clinical services.

The HSCP Team continue to work closely with Argyll and Bute Council's ICT department to ensure our social care and health staff have seamless access to systems and information as well as improved communication across the health and care "technological organisational boundaries" to deliver integrated care.

The prioritised programme of work in the winter period 2023/24 includes:

Digital Priority Actions:
✓ Federation of Microsoft Teams and 365 e-mail to provide seamless functionality re calendar access "free busy" video and voice messaging and presence status across council and NHS Highland instances so we are a single "connected organisation". Second phase of this project to be led by the digital office, which will include further exploration of using SharePoint between 365 tenancies.
✓ Eclipse phase 2. The project is moving towards Phase 2 with Discovery days scheduled for October to support our four community health teams; Mental Health, Community Nursing, Allied Health Professionals and Child Health. Discovery sessions with each of the community continue, to ensure that the partnership agreement meets all the technical requirements of the teams.
✓ Completion of business case to support the use of the North of Scotland Care Portal to include both social care and health information from March 2023. – Ongoing.
✓ CIVICA data-sync is now in place and this means that all new clients added to Eclipse will appear in CIVICA.
✓ Completed the electronic scanning of general medical records in Lorn and Islands Hospital RGH, Mid Argyll Community Hospital and Integrated Care Centre and Cowal community hospital to SCI store. Work continues to further enhance Electronic Patient Record to provide clinical staff with faster access to enhanced clinical information.

DRAFT

8.2 Technology Enabled Care (TEC)

Technology Enabled Care plays a critical role in keeping people safe at home. Our remote health monitoring and online CBT programmes promote supported self-management, preventing illness or worsening of patients' conditions and lead to improved longer-term outcomes.

The Telecare service is vital in facilitating timely discharge from hospital and in preventing admissions, important especially throughout the coming months as our hospitals face winter pressures. The service also supports and evidence reviews of care package needs via "Just Checking" service to ensure the correct level of care is provided to clients meeting needs.

Key areas of focus for TEC for the winter period 2023/24 includes the following primary areas of work:

- **Increase Telecare provision**, awareness and training, particularly among front facing teams who support care at home, admission avoidance and timely hospital discharges.
- **Expanding the use of 'Just Checking'** to ensure delivery of the right levels of care and support, in the right setting at the right time.
- **Analogue to Digital – Progress project**, ensuring readiness of the digital platform for roll out.

DRAFT

TEC Priority Actions:
✓ Continue closer working with hospital sites, promoting Telecare team presence at board round, virtual ward etc.
✓ Identify referral patterns and provide familiarisation resources to increase awareness and referral rates among staff.
✓ Ensure purpose of Telecare is clear – response to emergency alarms and not a personal care service or a replacement to Home Care.
✓ Ensure Just Checking is being fully utilised to support reablement and support decision making with appropriate care packages, leading to improved outcomes.
✓ Ensure that clients who transfers to a digital line have continuity in service/remain supported with Telecare.
✓ Continue to test and work towards long term digital solution.
✓ Establish and develop Near Me link from ED/MIUs with EMRS for clinical advice/patient retrieval. Set up Near Me hubs on Islay, Iona, Coll & Tiree enabling patients to be seen virtually and avoid unnecessary journeys.
✓ Transition to Connect Me system (remote health monitoring) and continue expansion of Silvercloud cCBT programmes, conduct training and advertising.
✓ Work with Mental Health to develop SOP for directing patients waiting for treatment into cCBT programmes.
✓ Provide operational management with access to activity and trend information to assist performance management and monitoring of service delivery across health and social care.