Date: 17 September 2021
When calling please ask for: Eamonn Daly (0141-577-3023)
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TO: **MEMBERS OF THE EAST RENFREWSHIRE INTEGRATION JOINT BOARD**

Dear Board Member

EAST RENFREWSHIRE INTEGRATION JOINT BOARD – 22 SEPTEMBER 2021

Please find attached the undernoted additional paper for consideration at the meeting of the Integration Joint Board on Wednesday 22 September 2021.

Yours faithfully

Councillor Caroline Bamforth

Chair

Undernote referred to:-

Draft GGC Unscheduled Care Commissioning Plan (copy attached, pages).

AGENDA ITEM No. 17

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council | NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 22 September 2021
Agenda Item	17
Title	Draft Unscheduled Care Joint Commissioning Plan: Design & Delivery Plan

Summary

To present the draft Design and Delivery Plan as the updated and refreshed Board-wide strategic commissioning plan for unscheduled care.

At its meeting in June 2020 the IJB received a report on the Board-wide draft unscheduled care plan, which was subsequently agreed by the other five HSCPs in Greater Glasgow & Clyde. Since then unscheduled care services have changed in response to the coronavirus pandemic, including a national redesign of urgent care. A programme of engagement has also taken place, and further work undertaken on the financial and performance frameworks to support delivery of the strategy. This report presents the updated unscheduled care programme in the form of the draft Design and Delivery Plan for the period 2021/22 to 2023/24. Similar reports are being considered by the other five HSCPs in GG&C and the Health Board.

Presented by	Julie Murray, Chief Officer

Action Required

1. The Integration Joint Board is asked to:-
   a) note the content of the draft Design and Delivery Plan 2021/22-2023/24 attached as the updated and re-freshed Board-wide unscheduled care improvement programme; and,
   b) note that the IJB will receive a further update on the draft Design and Delivery Plan including the financial framework towards the end of 2021/22.

Directions	Implications	
☒ No Directions Required	☐ Finance	☐ Risk
☐ Directions to East Renfrewshire Council (ERC)	☐ Policy	☐ Legal
☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)	☐ Workforce	☐ Infrastructure
☐ Directions to both ERC and NHSGGC	☐ Equalities	☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

22 SEPTEMBER 2021

Report by Chief Officer

DRAFT UNSCHEDULED CARE STRATEGIC COMMISSIONING PLAN: DESIGN AND DELIVERY PLAN

PURPOSE OF REPORT

2. The purpose of this report is to update the Integration Joint Board on progress in taking forward the Greater Glasgow and Clyde unscheduled care programme, and asks the Board to note the content of this draft Design and Delivery Plan including financial framework and governance arrangements.

RECOMMENDATION

3. The Integration Joint Board is asked to:-
   a) note the content of the draft Design and Delivery Plan 2021/22-2023/24 attached as the updated and re-freshed Board-wide unscheduled care improvement programme; and,
   b) note that the IJB will receive a further update on the draft Design and Delivery Plan including the financial framework towards the end of 2021/22.

BACKGROUND

4. The IJB at its meeting in June 2020 considered and approved a draft strategic commissioning plan for unscheduled care. That plan fulfilled the IJB's strategic planning responsibility for unscheduled care services as described in the Integration Scheme.

5. The draft was subsequently approved by the other five HSCPs in GG&C. The plan was developed in partnership with the NHS Board and Acute Services Division and built on the GG&C Board-wide Unscheduled Care Improvement Programme which was integral to the Board-wide Moving Forward Together programme.

6. Since the plan was developed in early 2020 there has been considerable change in the health and social care system overall as a result of the coronavirus pandemic, and a national redesign of urgent care implemented. While many of the actions in the draft plan approved by IJBs remain relevant, some need updating to reflect the changed circumstances arising from our response to the pandemic, and additional actions added on the new challenges being faced by the health and social care system. This is a reflection of the need for the constant review and updating of such a large scale strategic system wide change programme as unscheduled care in Scotland's biggest, most complex and diverse health and social care economy with many moving and inter related parts.

7. In addition further work has been undertaken on engagement and the development of financial and performance frameworks to support delivery of the programme overall.

REPORT

Draft Unscheduled Care Commissioning Plan

8. The purpose of the draft plan presented to the IJB in June 2020 was to show how we aim to respond to the pressures on health and social care services in GG&C and meet future demand. The draft explained that with an ageing population and changes in how and when people chose to access services, change was needed and patients' needs met in different ways, and with services that were more clearly integrated and with better understanding amongst the public of how to use them.

9. The programme outlined in the plan was based on evidence of what works and estimates of patient needs in GG&C. The programme was focused on three key themes following the patient journey:
    - **early intervention and prevention** of admission to hospital to better support people in the community;
    - **improving hospital discharge** and better supporting people to transfer from acute care to community supports; and,
    - **improving the primary / secondary care interface** jointly with acute to better manage patient care in the most appropriate setting.

10. The draft also described how we needed to communicate more directly with patients and the general public to ensure that people knew what service is best for them and can access the right service at the right time and in the right place.

11. Further work was also outlined on the financial and performance frameworks to support delivery of the plan, and engagement with key stakeholders including service users, partners, staff and clinicians.

Covid-19 pandemic

12. The scale and pace of change in the health and social care system as a result of the pandemic has exceeded anything we have experienced in the past. In the space of a few short months in the spring of 2020 services changed dramatically. So much so that some services may not return to their former delivery models. It is important therefore that we build on the successful new models of care and apply the learning to our change programme from our experience over the past few months. As part of this we need to review and evaluate new service models and pathways to ensure that the patient experience is maximised.

National Urgent Care Redesign

13. The Scottish Government has launched a national redesign of urgent care (RUC) to improve performance in response to the pandemic. All Health Boards were required to implement the national redesign in preparation for winter 2020/21. The key components of the RUC were:
    - the redesign of urgent care pathways to deliver a more planned response for patients who self-present to emergency departments where this is clinically appropriate and safe to do so via:
        - initial call handling delivered nationally by new NHS24 111 service;
        - developing 'call MIA' - a pathway to schedule minor injuries – to be piloted at Glasgow Royal Infirmary; and,

    - developing options for non-minor injuries that will enable scheduling of 'Near Me' patient assessment through a clinical decision maker.
- implementation of a Flow Navigation Centre (Hub) at the main acute sites with both admin and clinical resources established to support the redesign and streaming of patients referred from NHS24;
- continuation of the Mental Health Assessment Units; and
- all underpinned by a national communications campaign to introduce service change and inform the way patients access primary and acute care service

Design and Delivery Plan (Draft)

14. The draft Design & Delivery Plan attached updates the actions in the unscheduled care plan reported to IJBs in 2020, new actions that have arisen from the response to the pandemic and implementation of the RUC. The refreshed programme follows through on the three key themes from the 2020 plan, and shows the key priorities to be progressed this year (phase 1), actions for 2022/23 (phase 2) and future years (phase 3).

15. Further work is included on:

- **Engagement:** the programme includes engagement with other key stakeholders including primary and secondary care clinicians, Scottish Ambulance Service, NHS24, and the third and independent sectors. The draft plan has been discussed at various events and fora across GG&C; and,

- the **performance framework** including the key impact measures to be used to demonstrate improvements in performance with a focus specifically on:
    - emergency admissions;
    - acute unscheduled hospital bed days;
    - A&E attendances; and,
    - bed days lost due to delayed discharges.

16. Projections for emergency admissions for aged 65+ for 2022/23 and future years, recognizing the demographic changes forecast are included. Emergency admissions 65+ account for approximately 40% of all emergency admissions in GG&C.

Financial Framework

17. A financial framework has been developed in partnership with all six IJBs and Greater Glasgow and Clyde NHS Board to support the implementation of the Design and Delivery Plan. It should be noted that this has been completed on a 2021/22 cost base. This Plan represents the first step in moving towards delegated hospital budgets and set aside arrangements within GG&C.

18. This draft Design and Delivery Plan outlines a number of step change projects which have been implemented as part of Phase 1 and has resulted in investment of circa £14m in unscheduled care within IJBs and the Health Board during 2020-21, some of which has been funded non-recurrently.

19. A number of key actions have been identified which require financial investment to deliver on Phase 2 and Phase 3 priorities. The recurring funding gap for Phase 1 and the investment

required to deliver Phase 2 has been fully costed and is included in the Financial Framework (see annex F of the Design and Delivery Plan). This highlights the need for £28.862m of investment across Greater Glasgow and Clyde, of which £7.337m is required on a recurring basis and £21.525m is required non-recurrently. Full funding for the non-recurring investment has been found with partner bodies utilising reserve balances or managing within existing budgets to deliver the funding required. The financial framework includes a one-off investment of £20m which has been identified by the Health Board to support this programme. This will be used to kick-start this programme by delivering waiting times activity which was delayed due to Covid-19. This will have a positive impact on unscheduled care levels and support delivery of the Design and Delivery Plan reducing the time patients are waiting for procedures and thereby the likelihood of them attending A&E.

20. Of the recurring funding of £7.337m required, only £2.704m of funding has been able to be identified on a recurring basis. This funding gap recognises the challenge which all IJBs and the Health Board have had in securing full funding for Phase 2. This has implications for the delivery of the plan, even for Phase 2, with actions not able to be fully implemented in all IJBs until funding is secured.

21. Appendix A provides details of key actions identified to be implemented in East Renfrewshire at a total cost of £350,303, all of which is recurring. However, so far only £68,701 has been identified to meet these costs, all of which is allocated to the current year (Phase 1). At the East Renfrewshire level the funding gap of £281,602 clearly has implications for the delivery of the plan and we will struggle to implement Phase 2 actions locally until funding is available.

22. Phase 3 will be costed fully as tests of change and work streams further develop their proposals. Some actions in Phase 3 have funding which has already been secured in some IJBs. As a result, this investment is planned to proceed now as part of an early adoption of Phase 3. Details can be found in the draft Design and Delivery Plan.

23. A further update on the draft Design & Delivery Plan including the financial framework, will be provided to the IJB towards the end of 2021/22.

RECOMMENDATIONS

24. The Integration Joint Board is asked to:-

a) note the content of the draft Design and Delivery Plan 2021/22-2023/24 attached as the updated and re-freshed Board-wide unscheduled care improvement programme; and,
b) note that the IJB will receive a further update on the draft Design and Delivery Plan including the financial framework towards the end of 2021/22.

REPORT AUTHOR AND PERSON TO CONTACT

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0141 451 0749

BACKGROUND PAPERS

Draft Unscheduled Care Strategic Commissioning Plan, IJB Paper, 24 June 2020

Greater Glasgow and Clyde Board wide Unscheduled Care Improvement Programme
http://www.nhsggc.org.uk/media/245268/10-unscheduled-care-update.pdf

Board-wide Moving Forward Together programme
https://www.nhsggc.org.uk/media/251904/item-10a-paper-18_60-mft-update.pdf

APPENDIX A

Unscheduled Care : Financial Framework		East Renfrewshire IA						
		Recurring (R)/ Non Recurring (N/R)	2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Phase 2								
Communications								
1	We will take forward a major campaign across a range of media to better inform the public about which service to access for what and when. The campaign will also raise awareness about issues such as anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.	R	£0	£7,000	£15,000	£0	£0	£22,000
Prevention & Early Intervention								
2	We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions.	R	£0	£0	£28,028	£0	£0	£28,028
3	We will work with the SAS and patient groups to develop a care pathway to safely manage the care of patients who have had a fall but do not need to be seen in an A&E department.		£0	£0	£0	£0	£0	£0
4	We will through the frailty collaborative develop an integrated frailty pathway with secondary care, GPs and community teams to provide alternatives to hospital or to reduce length of stay for patients admitted with frailty and that contributes to a reduction in emergency admissions.		£0	£0	£0	£0	£0	£0
5	We will increase support to carers as part of implementation of the Carer's Act.		£0	£0	£0	£0	£0	£0
6	We will increase the number of community links workers working with Primary Care to 50 by the end of 20/21.		£0	£0	£0	£0	£0	£0
9	We will further develop access to "step up" services for GPs as an alternative to hospital admission.	R	£0	£27,733	£83,200	£0	£0	£110,934
10	We will continue the work with the independent sector, GPs and others to further reduce avoidable emergency department attendances and admissions from care homes.	R	£0	£30,160	£90,480	£0	£0	£120,640
Primary Care & Secondary Care Interface								
12	We will develop and apply a policy of re-direction to ensure patients see the right person in the right place at the right time.		£0	£0	£0	£0	£0	£0
13	We will test a service in Emergency Departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service.		£0	£0	£0	£0	£0	£0
14	To improve the management of minor injuries and flow within Emergency Departments and access for patients, separate and distinct minor injury units (MIUs) will be established at all main acute sites.		£0	£0	£0	£0	£0	£0
17	We will improve urgent access to mental health services.	R	£0	£68,701	£0	£0	£0	£68,701
20	We will develop hospital at home approaches that strengthen joint working between consultant geriatricians and GPs in order to better support patients in the community at most at risk of admission to hospital. Specific populations will be prioritised, including care home residents and people with frailty. (PILOT ONLY - SOUTH).		£0	£0	£0	£0	£0	£0

APPENDIX A

Unscheduled Care : Financial Framework		East Renfrewshire IA					
	Recurring (R)/ Non Recurring (N/R)	2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Phase 2							
Primary Care & Secondary Care Interface							
21 Improving access and waiting times for scheduled care at QEUH and GRI to reduce the time patients are waiting for procedures and thereby the likelihood of them attending A&E		£0	£0	£0	£0	£0	£0
Improving Discharge							
23 Working closely with acute teams, HSCP staff will proactively begin care planning as soon as possible after a patient is admitted to hospital with the aim of expediting discharge at the earliest opportunity once the person it medically fit.		£0	£0	£0	£0	£0	£0
24 We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.		£0	£0	£0	£0	£0	£0
Total		**£0**	**£133,594**	**£216,708**	**£0**	**£0**	**£350,303**

	2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Recurring	£0	£133,594	£216,708	£0	£0	£350,303
Non Recurring	£0	£0	£0	£0	£0	£0
Total	**£0**	**£133,594**	**£216,708**	**£0**	**£0**	**£350,303**

Funding : Recurring Expenditure	2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Mental Health Assessment Unit - LMP/Additional Scottish Government Funding (to be confirmed)	£0	£68,701	£0	£0	£0	£68,701
Scottish Government Funding : HB	£0	£0	£0	£0	£0	£0
HB Budget						
IJB Budget	£0	£0	£0	£0	£0	£0
PCIP Funding	£0	£0	£0	£0	£0	£0
Total Funding Recurring	**£0**	**£68,701**	**£0**	**£0**	**£0**	**£68,701**

Funding Gap	**£0**	**£64,893**	**£216,708**	**£0**	**£0**	**£281,602**

NHS GREATER GLASGOW & CLYDE

UNSCHEDULED CARE
JOINT COMISSIONING PLAN

DESIGN & DELIVERY PLAN
2021/22-2023/24

DRAFT

August 2021

EXECUTIVE SUMMARY

Integration Authorities have responsibility for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway, alongside primary and community health care and social care. This is known as unscheduled hospital care and is reflected in the set aside budget. The objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.

In recent years unscheduled care services in Greater Glasgow & Clyde have faced an unprecedented level of demand. The health and social care system, including primary and social care, has not seen such consistently high levels of demand before. While we perform well compared to other health and social care systems nationally, and overall the system is relatively efficient in managing high levels of demand, we struggle to meet key targets consistently and deliver the high standards of care we aspire to. Change is needed therefore if we are to meet the challenges ahead.

This unscheduled care commissioning plan represents the first step in moving towards delegated budgets and set aside arrangements for Greater Glasgow and Clyde. The draft updates the unscheduled care Joint Commissioning Plan agreed by IJBs in 2020, and refreshes this Board-wide programme in the light of national changes introduced last year and to take account of the impact of COVID-19. Our objective in re-freshing this plan is to ensure that the programme remains relevant and tackles the challenges that face us now.

The plan is focused on three main themes reflecting the patient pathway:

- **prevention and early intervention with the aim of better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible;**
- **improving the primary and secondary care interface by providing GPs with better access to clinical advice and designing integrated patient pathways for specific conditions; and,**
- **improving hospital discharge and better supporting people to transfer from acute care to appropriate support in the community.**

Essentially our aim is that each patient is seen by the right person at the right time and in the right place. For acute hospitals that means ensuring their resources are directed only towards people that require hospital-level care.

The emphasis is on seeing more people at home or in other community settings when it is safe and appropriate to do so.

The plan includes proposals for a major and ongoing public awareness campaign so that people know what services to access when, where and how. We will also work with patients to ensure they get the right care at the right time.

Analysis shows that a number of services could be better utilised by patients such as community pharmacists. But we also need to change and improve a range of services to better meet patients' needs e.g. falls prevention services.

Not all the changes in this plan will take effect at the same time. Some need to be tested further and others need time to be fully implemented. Work to measure the overall impact of the programme is in hand and we will issue regular updates and reports on progress.

CONTENTS

1. PURPOSE

1.1 The purpose of this draft is to re-fresh and update the Joint Strategic Commissioning Plan approved by IJBs in early 2020, and to present a revised Design and Delivery Plan for the period 2021/22-2023/24.

2. INTRODUCTION

2.1 This plan builds on the draft Joint Strategic Commissioning Plan approved by Integration Joint Boards (IJBs) (https://glasgowcity.hscp.scot/sites/default/files/publications/ITEM%20No%2012%20-%20Draft%20Unscheduled%20Care%20commissioning%20Plan.pdf. updates the programme to take account of the impact of the Coronavirus pandemic, and the delivery of key improvements introduced in 2020.

2.2 This Board-wide programme was developed by all six Health and Social Care Partnerships (HSCPs) jointly with the Acute Services Division and the NHS Board in response to an unprecedented level of demand on unscheduled care services, and as a first step towards delegated budgets and to developing set aside arrangements for Greater Glasgow and Clyde. While NHSGGC performs well compared to other health and social care systems nationally, and the system is relatively efficient in managing significantly higher levels of demand than in other Boards, we struggled to meet key performance targets. In particular we have struggled to deliver the four hour standard of 95% on a consistent basis and in 2019/20 we reported performance at 85.7%.

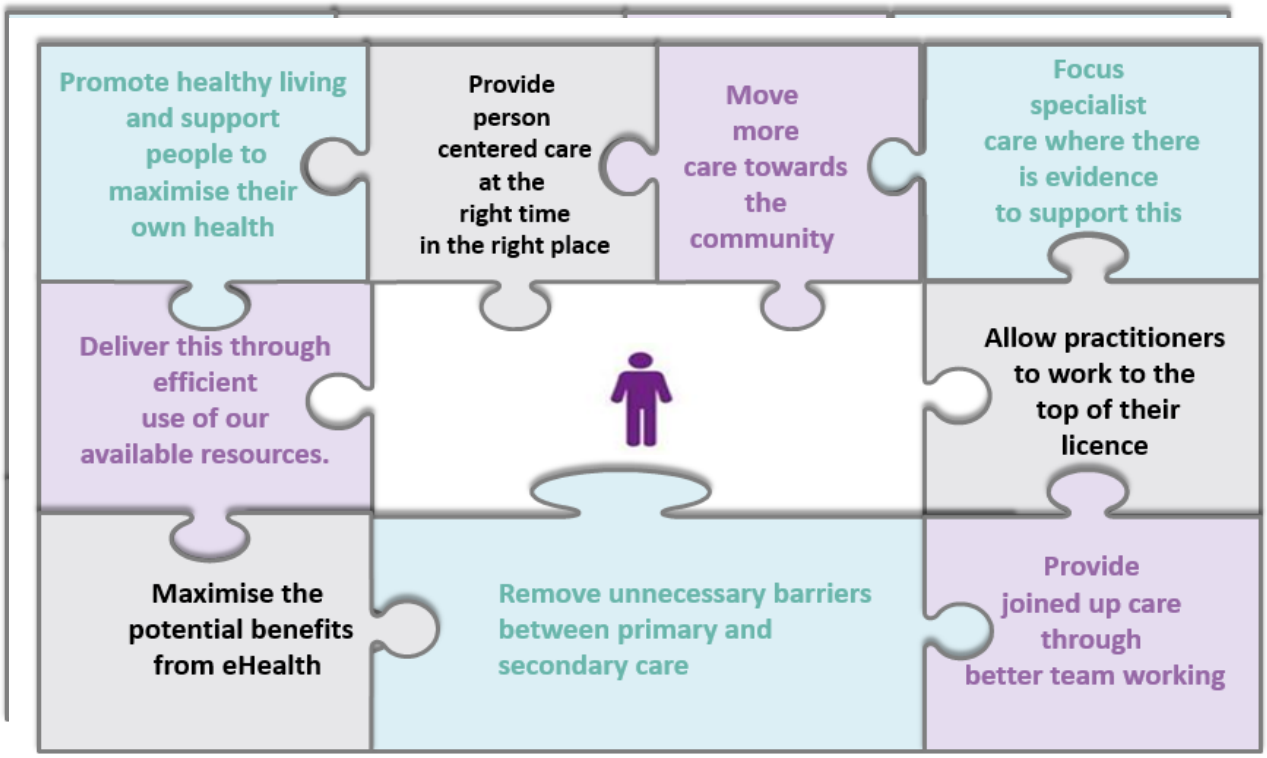
2.3 The COVID-19 pandemic has brought a series of new challenges, some of which will be explored further in this plan. And because of this it is difficult to make activity and performance comparisons with previous years. At the time of writing NHSGGC was at Level 2 escalation for performance in recognition of the Board's performance during the pandemic, and evidence of whole system step change and improvement. The combination of reduced demand as a result of COVID-19 and new or redesigned services has resulted in an improvement in performance against the four hour standard reporting 92.0% for 2020/21. Section 4 and annexes B and C details performance pre, during and post pandemic and illustrates that although demand reduced during COVID-19 there is evidence that demand is on a rapid trajectory towards pre pandemic levels in the first quarter of 2021/22.

2.4 The 2020 draft plan outlined a major change programme to meet the challenge of what was then considered to be a continual year on year increase in urgent care demand. The aim of the programme was and remains to change the system so that patients are seen by the right person at the right time and in the right place, and in this way be more responsive to patients' needs. The emphasis continues

to be on seeing more people at home or in other community settings when it is safe and appropriate to do so and this has been further substantiated through a national programme of service redesign.

2.5 This direction of travel outlined in the Board-wide *Moving Forward Together* strategy continues to be the overarching ambition of our collective improvement efforts (https://www.nhsggc.org.uk/media/251904/item-10a-paper-18_60-mft-update.pdf) and as illustrated in figure 1 below.

Figure 1 – Moving Forward Together



2.6 The 2020 global pandemic changed everything. Levels of unscheduled care attendances were significantly reduced and admissions also reduced albeit not to the same extent. Emergency activity reduced overall as a direct consequence of the 'lockdown' measures and the significant restrictions on delivering elective procedures in a safe way for both patients and staff, as we focused on reducing the spread of the virus. New pathways and responses were introduced for COVID-19 patients and suspected COVID-19 patients. GPs, community health services, acute hospital services and other services changed how they delivered services to the public. Patient behaviour also changed. And new services such as the Mental Health Assessment Units, Community Assessment Centres and Specialist Assessment and Treatment Areas were established.

2.7 During this period NHSGGC introduced emergency governance arrangements to reflect the situation and established a series of Tactical Groups (HSCP, Acute and Recovery) to support the Strategic Executive Group to deliver timely decision making. In addition the Scottish Government have introduced Remobilisation Planning and our collective progress and next steps towards recovery are also evidenced in Remobilisation Plan 3 (RMP3) (item-13-paper-21_45-rmp3-update.pdf (nhsggc.org.uk).

2.8 While some aspects of the original programme were progressed, albeit not as quickly as previously planned, other aspects were paused, modified or accelerated. It is right then at this juncture to re-fresh and update the programme to reflect the changed circumstances we are now operating in.

2.9 The remainder of this Design and Delivery plan is therefore designed to:

- update on progress against the actions in the 2020 programme agreed by IJBs;
- reflect on the impact of the pandemic on unscheduled care activity;
- update on what was delivered in 2020 including the national redesign of urgent care and has been included in RMP3 ;
- describe the re-freshed programme to be continued, and the content of the design and delivery phases;
- explain our proposals for ongoing engagement with clinicians, staff, patients and carers;
- outline the supporting performance and financial framework to support the delivery; and,
- describe the organisational governance arrangements that have been developed to ensure appropriate oversight of implementation of the plan.

3. UNSCHEDULED CARE JOINT COMMISSIONING PLAN 2020

3.1 The original unscheduled care improvement programme approved by IJBs in 2020 was prepared in and informed by the pre-pandemic days during 2019 and 2018. At that time unscheduled care services in NHSGGC were experiencing year on year increases in demand (e.g. A&E attendances, emergency admissions etc.) and there was evidence that some patients who attended A&E could be seen appropriately and safely by other services. In analysing demand at that time it was also acknowledged that the health and social care system was confusing for both patients and clinicians, with routes to access services not always clear or consistent. In addition we were also missing some key national and local targets (e.g. A&E four hour standard and delayed discharges). The conclusion was that to meet this challenge we needed to improve priority areas

across the unscheduled care delivery system so that we could better meet current and future demand, and provide improved outcomes for patients.

3.2 The 2020 programme had 25 actions that were constructed around the patient pathway. The programme focused on three key themes:

- **prevention and early intervention** with the aim of better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible;
- **improving the primary and secondary care interface** by providing GPs with better access to clinical advice and designing integrated patient pathways for specific conditions; and,
- **improving hospital discharge** and better supporting people to transfer from acute care to appropriate support in the community.

3.3 The pandemic had a huge impact on the programme. Some of the original actions were paused during the pandemic (e.g. anticipatory care plans) some were overtaken by events (e.g. shorter waiting times in MIUs) and others were progressed but to a revised timeline (e.g. frailty pathway). The programme was described as a five year change programme with some actions being implemented sooner than others (e.g. improving delays), and some that required testing and evaluation before wider implementation (e.g. hospital at home).

3.4 Key achievements over the past 12 months have been:

- the introduction of a policy of signposting and re-direction in Emergency Departments for patients who could safely and appropriately be seen by other services;
- improvements in urgent access to mental health services through the introduction of mental health assessment units;
- improvements to discharge planning by the implementation of our discharge to assess policy;
- increased access to professional to professional advice across multiple specialties allowing GPs to make direct contact with clinical decision makers to obtain advice on further treatment for patients avoiding unnecessary hospital attendances; and,
- the Board has introduced and maintained new services and access routes to deliver a dedicated COVID-19 pathway as part of the pandemic response and national remobilisation plans.

3.5 Annex A provides more detail on the key achievements outlined above.

4. IMPACT OF THE PANDEMIC

4.1 As explained above the global pandemic has had a massive impact on services, patients and the unscheduled care demand. The situation we face now in 2021 is significantly different from that in 2019 or early 2020. The data presented in annex B shows that during 2020 compared to the years before the pandemic our traditional access routes experienced a significant reduction as a consequence of the public lockdown as demonstrated in the 2020/21 activity data below:

- A&E reduced by 32.6% and MIU attendances reduced by 45.3%;
- GP referrals to the acute hospital assessment units (AUs) reduced by 55.7% however this is largely due to a change in access routes associated with COVID-19 and is further explained in 4.3 below; and,
- overall emergency admissions reduced by 17.7% compared to 2019/20.

4.2 As part of the COVID-19 response we did however see increases in hospital and primary care activity due to COVID-19. The introduction of a designated access route for patients with COVID-19 symptoms was established in April 2020 in the form of:

- **Community Assessment Centres** (CACs) - dealing with COVID-19 and suspected COVID-19 patients taking referrals directly from GPs and the national NHS24 public access route. During the 2020/2021 year there were 21,673 attendances to the eight Covid-19 centres in GG&C allowing GPs to maintain a service avoiding symptomatic patients; and,
- **Specialist Assessment and Treatment Areas** (SATAs) – providing a designated acute hospital pathway receiving patients from all urgent care services including GPs, A&Es and NHS24. During the 2020/21 year there were 40,802 attendances to acute hospital assessment units. In total the AUs and SATAs reported 71,553 attendances an overall increase of 3%.

4.3 To ensure direct access for patients who required access to mental health service the Board established two new Mental Health Assessment Units (MHAUs). This provides direct access to specialty avoiding more traditional referral routes from A&E, Scottish Ambulance Service and the Police. During the period April 2020 to February 2021 there were 7,474 direct attendances to MHAUs.

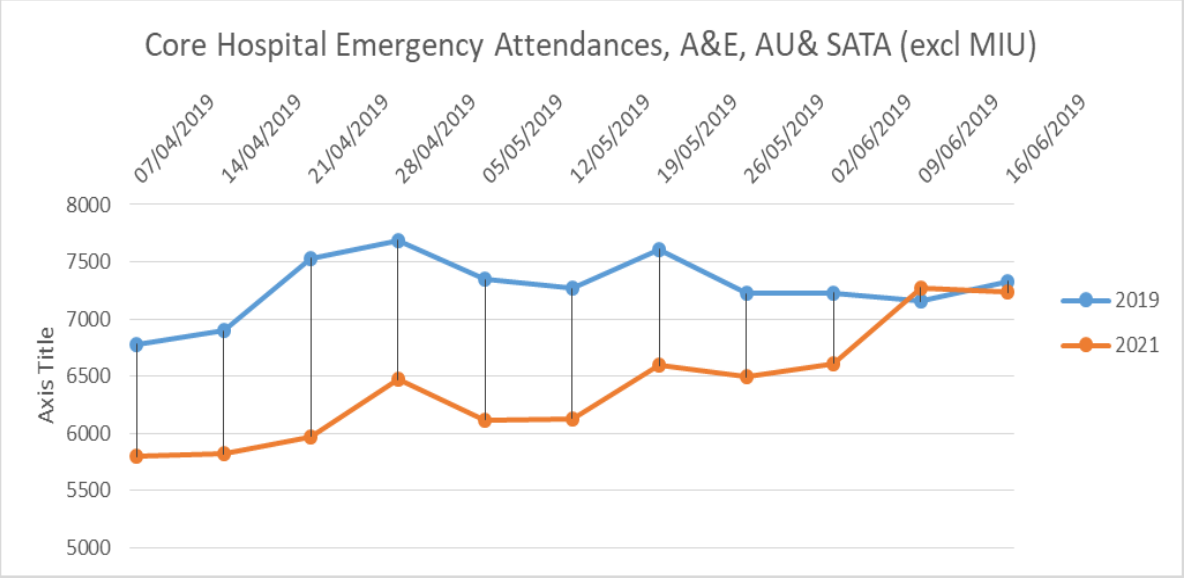
4.4 The demand profile for unscheduled care has however changed over recent months, and the Board is now experiencing a step change in demand in line with the success of the vaccination programme and easing of restrictions. At the time of writing an activity review for urgent care services was completed at 11 weeks

into the 2021/22 year (the full review paper is provided at annex C, and includes comparisons with activity pre-Covid).

4.5 Figure 2 below shows activity over the first 11 weeks of 2021/22 for emergency hospital attendances including A&E, Assessment Units, and SATA (for COVID-19) and excluding the minor injury units (MIU).

4.6 This profile confirms that the cumulative emergency attendance has reached the equivalent rate for the same period in 2019/20. This suggests that attendance rates will continue to increase as we come out of the pandemic and demonstrates the increased importance on the need to deliver on the improvement actions to ensure patients are seen in the right place by the right service at the right time.

Figure 2 - Core Hospital Emergence Attendances Chart



4.7 Innovation in how we deliver services to our patients has been accelerated through the use of digital technology and there have been significant step changes in service:

- GPs introduced telephone triage and Near Me consultations;
- mental health and other services introduced virtual patient management arrangements; and,
- specific pathways were introduced for COVID-19 patients in both acute and primary care settings across a range of service and specialties to allow patient consultations to continue.

4.8 These changes will continue to evolve as we deliver further opportunities for service design as the programme progresses. The changing profile of demand, and evidence from the pandemic recovery phase, means we will need to continually assess the impact of the pandemic on services as we go forward.

4.9 The impact of the pandemic recovery phase is resulting in an increase in demand for community services including community nursing, rehabilitation and care at home services. As well as an increase in demand the level of complexity within current caseloads including discharges being supported is greater than that before the pandemic. Evidence to illustrate this is outlined below. East Renfrewshire HSCP provided the following analysis to illustrate the impact:

- the district nursing has caseload increased from March 2020 450 (avg) to June 2021 700 (avg). Monthly home visits have increased from March 2019 n2134 to n3627 March 2021;
- increase in palliative, end of life care and home deaths;
- increase in more complex health conditions being managed at home;
- referral numbers to locality community rehabilitation teams has increased from:
    - an average of 180 per month (2019) to 277 (2020) between January to April 2021;
    - in 2021 the average referrals received was 305 per month.
    - previously 15% of referrals were categorised as high priority for visit within 0-5 days from referral, this is currently 25%. This is due to increased number of GP referrals requesting urgent assessment/ prevention of hospital admission, plus increased number of urgent requests for follow up on discharge from hospital.
- a recent complexity trend analysis completed within the East Renfrewshire Care@home service illustrated an increase in the number of in-house service users requiring support from two members of staff from November 2019 to November 2020. In November 2019 n43 (8.4%) of service users required a visit requiring two staff members due to complexity rising to n65 (11.7%) November 2020.

4.10 East Dunbartonshire HSCP has evidenced a 20% increase in referrals to their rehabilitation service from 2017 to 2020. The team is reporting seeing more patients with higher levels of acuity as a result of individuals not wishing to attend hospital departments and earlier discharge from hospital. As many people are often waiting longer before seeking input this means they are often more unwell and require more input. There have been few referrals for long Covid with the biggest impact being generalised deconditioning resulting in more falls etc. and more protracted period of rehab. The HSCP has noted an increase in demand for community nursing services, in particular support for palliative care. The number of people being supported to die at home has increased over the last year.

4.11 As a consequence of the significant impact of the pandemic and the associated changes in unscheduled care demand and activity during 2020 we have re-visited the original timescales as described in the Joint Commissioning Plan (JCP) and refreshed the actions to reflect the current position. We outline these in the next section.

5 DESIGN AND DELIVERY PLAN

5.1 In this section we describe the revised and updated programme to take into account of the changed circumstances we now face. The revised programme now has three phases of delivery:

- **Phase 1 - 2020/21** – implementation of the national redesign of urgent care and associated actions from the 2020 programme;
- **Phase 2 – 2021/23** – consolidation of the national programme and implementation of the remaining actions from the 2020 programme; and,
- **Phase 3 – 2023** onwards – further development of the programme including evaluation and roll out of pilots and tests of change.

Phase 1 – 2020/21

5.2 In phase one of this programme the focus and delivery of change and improvement was on responding to the pandemic and implementation of the emerging National Redesign of Urgent Care Programme. A number of step change projects that were grounded in the ambitions of the JCP have been implemented, these include:

5.3 **Flow Navigation Centre (FNC) implementation** - Our Flow Navigation Centre went live on 1st December 2020 supported by a soft launch. The admin hub operates 24/7 receiving all Urgent Care Referrals from NHS24. The clinical triage team currently operate from 10am – 10pm, with this deemed optimal based on a review of attendance profiles.

5.4 During this phase we have delivered a **Minor Injury Pathway** which incorporated a direct referral for remote triage and review. This provides the opportunity to deliver a scheduled care approach for individuals who do not require an urgent response/intervention. A temporary winter pathway to GGH (GGH MIU went live on 18th January 2021) to provide an alternative service within Glasgow however this has been largely underutilised as patients have now become more accustomed to the designate centres in Stobhill and the Victoria.

5.5 In the first six months of operation the FNC has completed virtual consultations for 7,000 patients with 32% of those being seen, treated and discharged without the need for further assessment.

5.6 **Signposting and Redirection Policy** - our signposting and redirection policy for Emergency Departments within NHS Greater Glasgow & Clyde was approved October 2020. Implementation of this policy and supporting standard operating procedures aim to ensure Emergency Department attendees are appropriately reviewed in line with their presentation. The purpose of the policy is not to turn attendees away from the ED, but to direct patients to another appropriate service where their healthcare need can be met, and minimising the risk to themselves and others in overcrowded EDs. These processes also reduce the potential for crowding in the ED by maximising use of safe alternatives for attendees to access care.

5.7 It is recognised that ED signposting and redirection form part of a broader aim across the health and social care environment to ensure patients receive the right care, at the right time and in the right place. NHSGGC have contributed to the development of national policy and guidance on this and we anticipate this will be released later in 2021.

5.8 **Primary Care Interface: alternatives to admission** has been extended to multiple specialties across NHSGGC**.** Professional to Professional Advice services through telephone and app technology are in place and working well. Surgical hot clinics and rapid access to frail elderly clinics are in place as well as the ability for GPs to request advice about patients rather than a direct referral. A pathway to provide access to the Assessment Unit (AU) for patients with DVT and cellulitis has also been implemented.

5.9 Across NHSGGC 212 GP practices have accessed advice via a telecoms application and the number of professional to professional calls made continues to increase month on month. The successful launch of Medical Paediatric Triage Referral Service in March 2020 has contributed to an overall rise since July 2020 and this service continues to receive the highest number of calls relative to other specialties. In addition from June 2021 the Mental Health Assessment Units have implemented the professional to professional advice service complimented by a new SCI Gateway referral process and uptake has been strong.

5.10 **Mental Health Assessment Units (MHAUs)** our two MHAUs were established last year in response to the COVID-19 pandemic and consolidated through the winter period with a full redesign of the urgent care pathways and access routes. These units have continued to reduce demand on secondary care services by reducing footfall through Emergency Departments. The referral pathway provides an immediate route out of ED for those who present directly, with vulnerable patients largely being managed away from the stressful ED

environment. The MHAUs also provide an alternative to patients who would otherwise have been conveyed to ED by SAS or Police Scotland. Between December 2020 and March 2021 there were a total of 4,400 patients seen through our MHAUs.

5.11 **COVID-19 Community Assessment Centres (CACs) –** these centres were also developed in response to the COVID-19 pandemic, and directed symptomatic patients who are potentially COVID-19 positive to separate facilities for assessment away from primary care and acute hospital services. Access to CACs is via NHS24. At the peak week in January 2021 there were a total of 566 attendances with 74% of these being maintained within the community with no hospital follow up required.

5.12 **Restructuring of GP Out of Hours (GPOOH)** - a new operating model introduced an appointments based service with access via NHS24 offering telephone triage. Those requiring a 4 hour response receive an initial telephone consultation by Advances Nurse Practitioners or GPs working in the service, including the use of 'Near me' consultation. This reduced the need for in person attendances by 60% freeing capacity to deal flexibly with other competing demands.

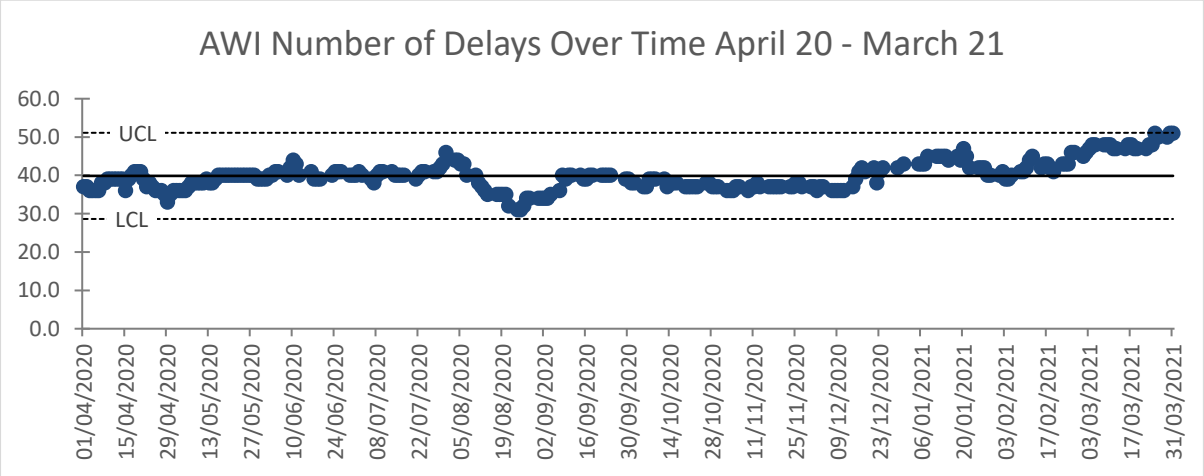
5.13 **Urgent Care Resource Hub Model -** HSCPs launched their Urgent Care Resource Hub models in January 2021. This model was established to bring together OOHs services in the community, enhancing integration and the co-ordination of care. The hub provides direct professional to professional access across the health and social care OOHs system and delivers a whole system approach to unscheduled and/ or emergency care via NHS 24.

5.14 **Delayed Discharge** we developed a response to delays that has seen a reduction in our non AWI delays in hospital across all of our sites. HSCPs adopted daily huddle approaches to problem solve and remove roadblocks to delays. Additionally we adopted process changes to the discharge process leading to the development and implementation of a new Discharge to Assess Policy as part of the overall discharge process. Joint working led to agreement with all six HSCPs and Acute on a standard operating procedure to improve effectiveness and reduce the risk of potential delays. This response builds on our 'Home First', if not home, why not ethos. A suite of patient communication materials have been developed and distributed to key areas within the acute setting launching the Home First branding and outlining the benefits of being cared for at home or in a homely setting, once medical care is no longer required.

5.15 **AWI delays** have been a particular challenge during 2020/21 as shown in figure 3. Since the Equality and Human Rights Commission ruling we have not been able to discharge patients to off-site beds with the consequence that the

proportion of AWI delays is disproportionate to the overall number of delayed discharge patients. A peer review process is planned with a view to identify if there is learning and best practice clinical to ensure our process is as effective and efficient as possible. As there is constant pressure on the system to effectively manage the inpatient capacity across NHSGGC the aim is to ensure that the practice and process adopted is optimised for both patients and the overall health care service.

Figure 3 – AWI delays 2020/21 Glasgow City HSCP



5.16 **HSCP response** - HSCPs focused attention on reducing patients delayed in hospital over the winter period and invested in in-reach services to commence discharge planning early with acute colleagues. Teams were co-located on acute sites. The utilisation of real-time dashboards supported community teams to identify patients early during their admission and to proactively plan discharge arrangements. Approaches such as the "Focused Intervention Team" (West Dunbartonshire), "Hospital to Home" (East Renfrewshire), "Home 1st" (Inverclyde) and "Home for me" (East Dunbartonshire) are examples of dedicated multidisciplinary teams including AHPs, Elderly Care Advanced or Specialist Nurses.

5.17 During the 1st and 2nd wave of the pandemic there were a number of care homes within **East Dunbartonshire** who experienced significant outbreaks of Covid-19. In response to this, the HSCP provided enhanced clinical support utilising ANPs during weekends to cover the OOHs period. This enhanced level of clinical support included virtual and face to face consultations, prescribing and supporting good end of life care. As well as taking referrals from the care homes directly the service liaised with OOHs GPs advising that they were available and would accept referrals. Prior to the introduction of this service, 20% of Covid 19 related deaths for care home residents occurred in hospital compared to only 7% following the introduction of the enhanced service. It is

worth noting that the deaths that occurred in hospital were all referrals to acute via GP OOHs following remote consultation.

5.18 During the pandemic **West Dunbartonshire** HSCP district nursing staff continued to provide training and support to staff in care homes with a programme of bite size modules on various subjects including infection control, UTI, recognising sepsis etc. This helped care home staff to recognise the early signs of infection and with earlier intervention helped to prevent admissions to hospital. The Older Adult Community Psychiatric Liaison Nurse has provided training on stress/distress behaviour, which enables staff to identify and support residents within the care home, avoiding admissions to hospital from the mental health team. The care home residents have average fluid intake recorded. This is calculated and indicates whether residents' hydration has increased or decreased enabling care staff to review residents' health and wellbeing and identify if infection is fluid related. West Dunbartonshire care homes introduced refreshment trollies which are decorated to look like an old "Ice Cream Van", and this is to create an interest around fluid. There are a variety of flavoured drinks. This has assisted to increase fluid intake and therefore minimise dehydration and also made this a meaningful interaction.

5.19 **Renfrewshire** HSCP has implemented Alcohol Outreach Nurse Posts at the Royal Alexandria Hospital. These nurses are also called Alcohol and Liver Frequent Attenders (ALFA) Nurses. These posts were created following analysis of the HSCP Emergency Department Frequent Attendee list. This work highlighted a group of alcohol addicted patients who only used ED as the source of medical care, rarely attending their GP and never attending outpatient alcohol appointments. The nurses are be based in the RAH and mainly clinically managed by the Liver Consultant, but are part of the Addictions team based at Back Sneddon St and employed by the HSCP. The nurses will identify alcohol related frequent attenders and then contact them proactively to try and help sort out their problems and reduce their alcohol intake and ED attendances and RAH admittances.

5.20 Renfrewshire HSCP has also established the District Nursing ANP role within all care homes across Renfrewshire. ANPs within the service are aligned to, and work closely with, the Care Home teams; collaborating as necessary with local GPs and acute care. They use focused MDT meetings with care home teams, RES, MH and dieticians. They assist greatly with the proactive and reactive response to care homes as well as the provision of the right professional to meet that person's needs. The service allows for care to be completed within the service, promoting person centred care and prevention of admission. In March 2021 there were 222 patients reviewed by the ANPs.

5.21 **Inverclyde** HSCP continued to maintain its focus on Home 1st and Getting it Right 1st Time managing to maintain performance except at times of lower capacity in care@home services. When the care@home service was impacted during the initial months of the pandemic the HSCP admitted over 50 services users on an interim basis to Care Homes of their choice to facilitate discharge from hospital or avoid hospital admission. After an average stay of 8 weeks the service users were able to return home with the care @ home service they required in place to support their needs.

5.22 Inverclyde also utilised available capacity around day service transport to support discharge to home or care home, the team also provided a meals service to older people in the community. The day service team and community connectors kept in contact with a number of service users by telephone, this helped to reduce the impact of isolation and anxiety which are key factors in preventing admission to hospital.

5.23 Overall the HSCP relied on existing Home 1st protocol and processes that effectively supported the teams through the pressures of the pandemic. These measures identified are on-going and are part of the contingency in Inverclyde's Unscheduled Care; Home 1st plan.

5.24 In **Glasgow City** the Community Respiratory Response Team (CRRT) was set up as an emergency interim measure to allow services to cope with the Covid Pandemic. The service was created to provide a safe alternative to hospital admission for our chronic lung disease population with the awareness of nosocomial inpatient spread and potential poor outcomes for those with severe lung disease. Initial evaluation suggests that the rapid amalgamation of several teams across community and acute has been a success in responding to the crisis. ED attendance with respiratory diagnosis was down by approximately four fold compared to 2018/19 – significantly more so than the rest of Scotland.

5.25 Also in Glasgow a Crisis Outreach Service was established to meet the needs of people who experience non-fatal overdose, in order to prevent further fatal overdose. This new service was designed to provide assertive follow up of patients who had attended hospital having experienced a non-fatal overdose. Non-fatal overdose is a strong predictor of future fatal overdose, so an immediate response and assertive outreach to individuals was considered essential in an attempt to reduce drug related deaths, including out of hours. The team provides assertive outreach to referrals from Police Scotland and SAS and works closely with third sector organisations to provide follow up and support. There is close liaison with Emergency Departments to develop pathways and ensure follow up with locality teams.

5.26 **Development of the HSCP Unscheduled Care Delivery Group, HSCP Anchors and local HSCP UC Groups** – throughout 2020 a key objective was to strengthen the interface between HSCPs, the acute sectors and primary care. To support this our Unscheduled Care Delivery Group Terms of Reference and membership was reviewed to ensure appropriate representation. Key to enhancing the collaboration across HSCPs has been the introduction of HSCP Unscheduled Care Anchors, these individuals have the ability to influence, direct and initiate change within their respective HSCPs and play pivotal roles in their local HSCP Unscheduled Care Groups. The anchors liaise with the Unscheduled Care Joint Improvement Team providing and receiving key intelligence and contributing to the overall delivery plan.

Phase 2 - 2021 -2023

5.27 During 2021 and onward we will aim to design a programme to deliver on a number of the actions continuing to align and be guided by the National Redesign of Urgent Care five national strategic priorities. The visual in figure 4 below encompasses the key actions to be delivered in the next phase.

Figure 4 - Phase 2 Unscheduled Care Improvement Programme Core Projects

Patient Flow & Flow Navigation Centre Processes	Optimising Discharge and Reducing Delays	Prof to Prof	MSK	Falls & Frailty
• ED Processes • 4 hour standard • Demand Prediction & Capacity Mgmt • FNC Process Optimisation (workflow)	• 'Home First' application of Discharge to Assess • Development of 'Hospital in Reach' processes • AWI Peer Review	• Scheduling urgent care to Medical and Surgical AU's • Community Pharmacy integration with GP in/out of hours and the FNC • SAS – access to FNC and Community Services prof to prof (falls, care homes, COPD) • Whole System Redirection (mutual aid FNC/GPOOH's/ OOHUCRH etc.)	• Develop MSK local FNH/onward community referral pathways and outflow services to reduce hospital and primary care based services • Development of NHS24 Physio resource to deliver National 111 MSK service	• Frailty Screening Tools • Anticipatory Care Planning • Falls Prevention & Management • Frailty at the Front door • Coordination & Integration of Community Models • *Hospital at Home - Glasgow City Test of Change*

5.28 NHSGGC's response to Phase 2 of the National Redesign of Urgent Care will be to further develop the Flow Navigation Centre and work will continue to develop and redesign urgent care pathways across the whole system over the next 18 months to include:

- **Primary Care/Acute Interface** – we will continue to develop pathways to convert unplanned to planned care with particular focus on scheduling urgent care within Assessment Units. Pathways under review/Development include: Care Homes (Falls), Head Injury, Acute and Surgical (Nat No 2)

- **MSK** – development of NHS24 Physio resource and local Flow Navigation Centre (FNC)/onward community referral pathways to reduce hospital and primary care based services (Nat No.5)

- **Community Pharmacy** – integration with GP in/out of hours and the FNC and to include signposting and direction from MIU/ED for minor illness (Nat No.1)

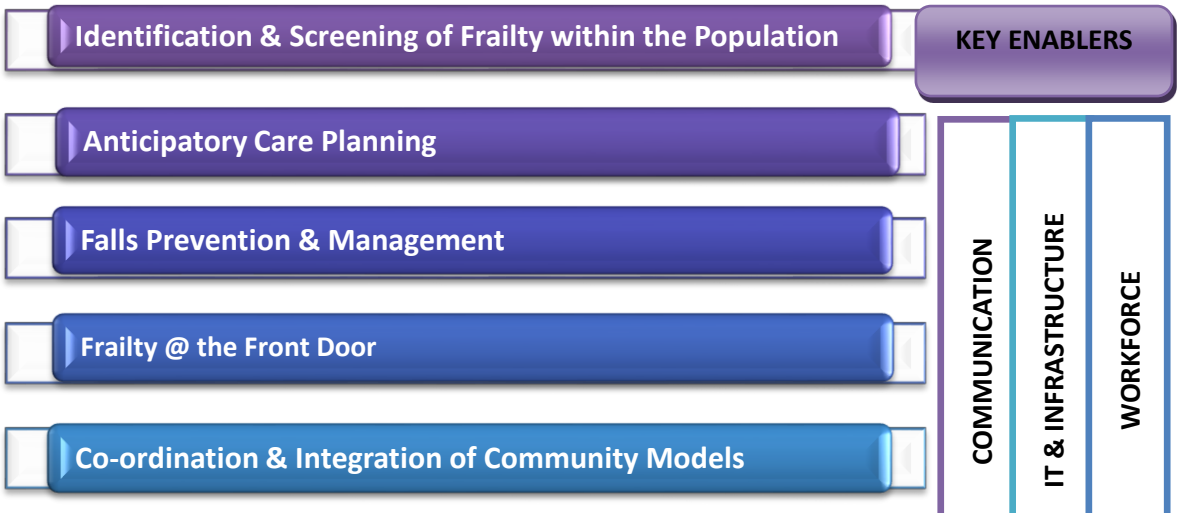
- **SAS** – development of Community Services and FNC prof to prof to access out of hospital/GP referral pathways e.g. COPD, Falls, Care Homes (Nat No.4)

- **Mental Health** - pathway development to include referrals from GP in/out of hours and the Flow Navigation Centre through prof to prof and scheduled virtual assessments (Nat No.3). This will build on the MHAU pathway fully embedded during 2020.

- **Waiting times** - additional non-recurring support to improve access and waiting times for scheduled care at QEUH and GRI to reduce times patients waiting for procedures delayed due to Covid and avoid the likelihood of them attending A&E.

5.29 Our Falls & Frailty Delivery Programme has six key priority areas of focus within Phase 2. The figure below illustrates the work streams and the key enablers to support the design and delivery of the programme.

Figure 5 - Falls & Frailty Programme Phase 2 Delivery Work streams



5.30 The approach agreed to drive and manage delivery has a strong focus on joint planning and active collaboration. Work streams have been implemented for each of the priority actions with HSCP and Acute leads appointed to each:

- Identification and screening of frailty within the population – to identify those over 65 living in the community with frailty using a frailty assessment tool, measuring deterioration over time and considering pathways to support triggered by frailty score;
- Anticipatory Care Planning – to increase anticipatory care planning conversations and ACPs available via Clinical Portal and the Key Information System (KIS) to support people living with frailty to plan for their future care needs, and when appropriate death. A baseline of 512 ACPs available on Clinical Portal was recorded in March 2021 by May this had increased to over 800;
- Falls Prevention & Management – to develop and implement a falls prevention and management strategy and policy with a view to preventing falls in the community and reducing unscheduled admissions for falls related injury, including care homes;
- Frailty @ the Front Door - enhanced presence by Frailty Team at the acute front door with direct access to a range of community services supporting joint patient centred planning to ensure the right care is given in the right setting, whether that is hospital, at home or in a homely setting;
- Co-ordination and integration of community models - review of current models/pathways and developing refreshed pathways to plan, support and coordinate the patients' journey from pre-frail through to end of life, supporting them to remain at home or a homely environment, ensuring when an intervention is required it is delivered in the right place, delivered by the right person and at the right time; and,
- Hospital @ Home - testing the concept of the Hospital @ Home model and principles. Initial Test of Change in South Glasgow over 12 months with a view to a system wide redesign, subject to evaluation and learning.

5.31 Key enablers have been identified to support delivery including Communication, IT and infrastructure and workforce:

- **Communication & Engagement Plan -** we fully intend to build on the positive GGC OOH Communication and Engagement programme. An overarching Communication Plan will be developed for 2021/22 for all stakeholders. The plan should seek to develop key principles, common language and key messages and where appropriate join up the learning, and recommendations from activity across GGC from programmes including East Renfrewshire Talking Points, Compassionate Inverclyde and the Glasgow City Maximising Independence programme. Learning

from service users and their family/carers input and involvement will be key to helping us develop the plan. A Corporate Communications plan will be considered with quarterly updates generated and shared.

- **IT & Infrastructure eHealth Digital Solutions** – on-going challenges exist regarding interfaces between core systems and shared access to electronic patient information to deliver care closer to home. In the absence of shared systems across community teams, acute, primary care etc. we continue to develop processes with numerous work arounds that are not 'lean' and create barriers to sharing key patient information.

- **Workforce** – we face a significant challenge around workforce, in particular access to clinicians with advanced clinical assessment and management skills, whether this is ANPs or Advanced Allied Health Professionals. This has been evident across the Primary Care Improvement Plan and the Memorandum of Understanding resulting in 'in=post' training and mentoring taking place to develop the skills required.

5.32 Annex D shows the Design & Delivery plan priorities phased and where actions sit within the three priority areas of early intervention and prevention, primary & secondary care interface, and hospital discharge.

Phase 3 - 2022/23 and onwards

5.33 While a number of actions within the original Joint Commissioning Plan remain outstanding this does not mean they will not be designed for delivery within this timeline. As dependences become apparent and opportunities develop, and as appropriate resource and funding support are available, proposals will be developed and approval sought.

6 ENGAGEMENT

Patient Engagement

6.1 We are conscious we need to do more to engage with patients, carers and the general public and their representatives about what we are trying to achieve through this programme. It is our aim that all aspects of the programme (e.g. falls and frailty) will involve patients directly. Further information on how this will be achieved will be communicated through our HSCP engagement channels and networks.

6.2 We are also conscious that we need to communicate better with the general public about what services to access when and for what. That's why the first key action in our programme is on communications, and developing a public

awareness campaign. This will be an ongoing action over the course of the programme.

Staff Engagement

6.3 This programme has significant changes for staff too in the way we delivery services, and develop new pathways. We will consult with and engage with staff in taking these changes forward, and regularly report to Staff Partnership Forums as we go forward.

Clinical Engagement

6.4 During 2020/21 we have continued to review our stakeholders, as part of this process we have reviewed representation across all three acute sectors. This has resulted in increased engagement with Clinical Service Managers, Consultant Physicians in Medicine for the Elderly, Chief Nurses, ED consultants and AHPs.

Primary Care

6.5 In 2020 we held a number of engagement sessions with GPs across NHSGGC. The engagement and involvement of GPs in shaping and developing this programme is crucial. We need to recognise that unscheduled care is a key issue within primary care too as most patient contact is by its nature unscheduled. The key messages from the GP engagement sessions held last year are summarised in annex E.

6.6 We will continue to engage with GPs across NHSGGC both in the development of this programme and its implementation as GP feedback on progress is also important. We will do this at various levels by:

- engaging with GPs and their representatives on specific aspects of the programme e.g. ACPs, falls & frailty etc.;
- engaging with GPs through established structures such as GP committees, primary care strategy groups, QCLs etc.; and,
- engaging at HSCP and NHSGGC levels including arranging specific set piece events / sessions at appropriate times.

6.7 A key take away message from the engagement with GPs was that the unscheduled care programme needed to specifically recognise and include the contribution of PCIP to this agenda. The PCIP and unscheduled care programme direction of travel are closely aligned and are essentially about patients being seen by the right person at the right time. To recognise and acknowledge the contribution of PCIP more clearly within the re-freshed unscheduled care programme we have broadened this aspect of the plan include an action to support GPs to operate as expert medical generalists by expanding primary care teams so GPs can focus on managing complex care for vulnerable

patients within community settings, and as part of our prevention and early intervention strategies (see actions 4, 7 and 8 in annex D)

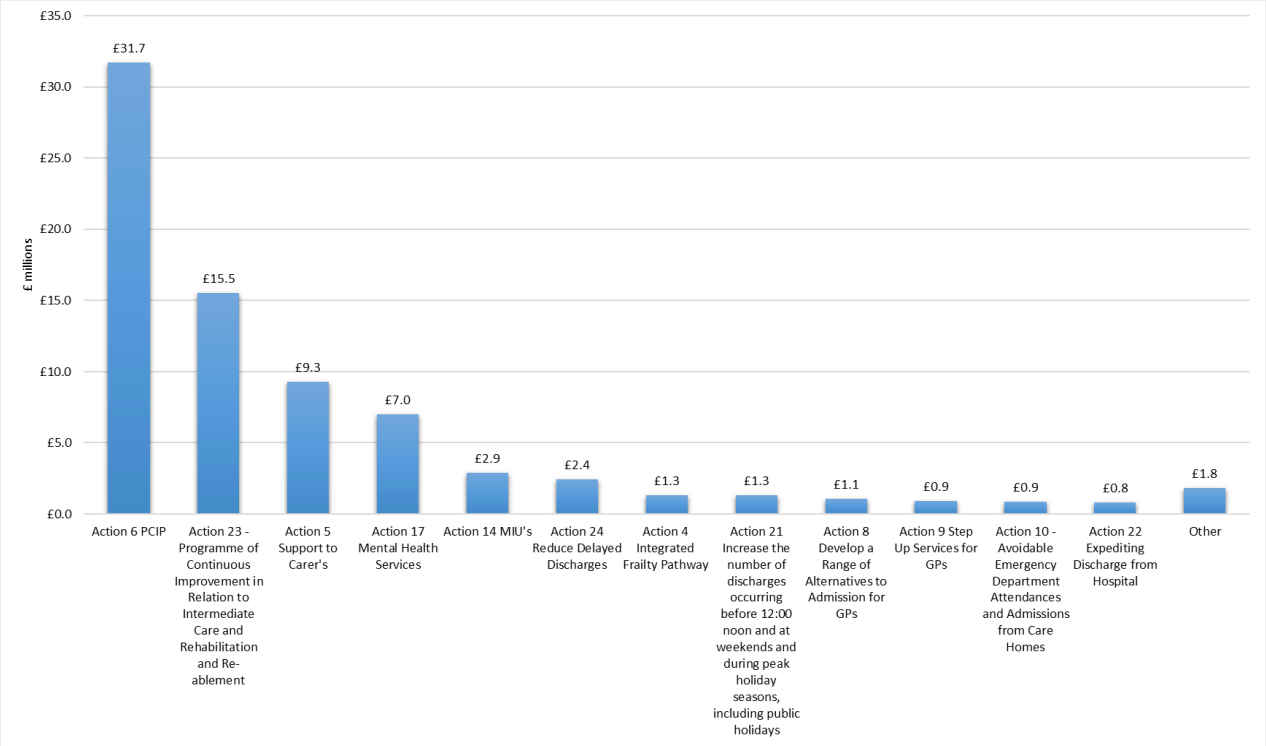
7. FINANCIAL FRAMEWORK

7.1 In this section we outline the financial framework to support delivery of the plan. A number of the proposals in this plan are already funded in HSCPs or the Acute Services Division. Others will need additional or a shift in resources to support implementation.

7.2 This Joint Commissioning Plan represents the first step in moving towards delegated hospital budgets and set aside arrangements within GG&C. In 2019/20 unscheduled care was estimated to cost GG&C £444.3m. With a budget of £415.1m identified by GG&C Health Board. This is a shortfall in funding of £29.2m and represents a significant financial risk to GG&C Health Board and the six IJBs with strategic responsibility for this area.

7.3 This budget shortfall impacts on the IJBs' ability to strategically plan for unscheduled care. Nationally there is an expectation that IJBs, through commissioning plans, can improve outcomes and performance in relation to unscheduled care, which in turn will support the release of resources to support investment in primary care and community services. This was reiterated in the Scottish Government's Medium Term Financial Plan which assumes that 50% of savings released from the hospital sector will be redirected to investment in primary, community and social care service provision.

7.4 The ability to achieve this in GG&C is hindered by the existing financial position outlined at 7.2. above, and effectively means that there are no funds which can be released to support the investment required, which mean that each partner will be responsible for funding their own investment. There is already significant investment in community care settings to support unscheduled care, with existing investment totalling £77m.



7.5 Section 5 outlined a number of step change projects that were grounded in the ambitions of the JCP which have been implemented as part of Phase 1 and has resulted in investment of circa £14m in unscheduled care within IJBs and the Health Board during 2020-21, some of which has been funded non-recurrently.

7.6 The Joint Commissioning Plan identifies a number of key actions which require financial investment to deliver on Phase 2 and Phase 3 priorities. The financial framework developed has highlighted a significant gap between current available financial resources and the funding required to deliver the programme in full. This will require the adoption of a phased implementation programme, where delivery is contingent on funding becoming available.

7.7 The recurring funding gap for Phase 1 and the investment required to deliver Phase 2 has been fully costed and the investment required is attached in annex F. It should be noted that this has been completed on a 2021/22 cost base. This highlights the need for £28.862m of investment, of which £7.337m is required on a recurring basis and £21.525m is required non-recurrently. Full funding for the non-recurring investment has been found with partner bodies utilising reserve balances or managing within existing budgets to deliver the funding required. This includes a one-off investment of £20m which has been

identified by the Health Board to support this programme. This will be used to kick-start this programme by delivering waiting times activity which was delayed due to COVID. A significant proportion of this activity will be delivered from hospitals and clinics within the boundary of Glasgow City, particularly the GRI and QUEH. This will also have a positive impact on unscheduled care levels and support delivery of the Unscheduled Care Design and Delivery Plan reducing the time patients are waiting for procedures and thereby the likelihood of them attending A&E.

7.8 Of the recurring funding of £7.337m required, only £2.704m of funding has been able to be identified on a recurring basis. This funding gap recognises the challenge which all IJBs and the Health Board have had in securing full funding for Phase 2. This has implications for the delivery of the plan, even for Phase 2, with actions not able to be fully implemented in all geographic areas until funding is secured. The table below highlights the Actions where partial implementation is proposed at this stage due to the funding gap which exists.

Table 1 - actions partially deferred for implementation or at risk – no funding in place (for detail on actions see annex D)

Action	Glasgow City	Inverclyde	East Ren	West Dun	East Dun	Renfrew	Health Board
Action 1 Comms	√	√	X	√	√	√	n/a
Action 2 ACP	√	X	X	√	√	√	n/a
Action 4 Frailty	√	√	√	√	X	√	n/a
Action 9 Step Up	√	√	X	√	X	X	n/a
Action 10 Care Homes	√	√	X	√	√	√	n/a
Action 13 Service in ED	n/a	n/a	n/a	n/a	n/a	n/a	X
Action 14 MIUs	n/a	n/a	n/a	n/a	n/a	n/a	X
Action 23 Improvement	√	√	√	√	X	√	n/a

7.9 Phase 3 will be costed fully as tests of change and work streams further develop their proposals. Some actions in Phase 3 have funding which has already been secured in some geographic areas. As a result, this investment is planned to proceed now as part of an early adoption of Phase 3. These have been highlighted in annex F.

8 PERFORMANCE FRAMEWORK

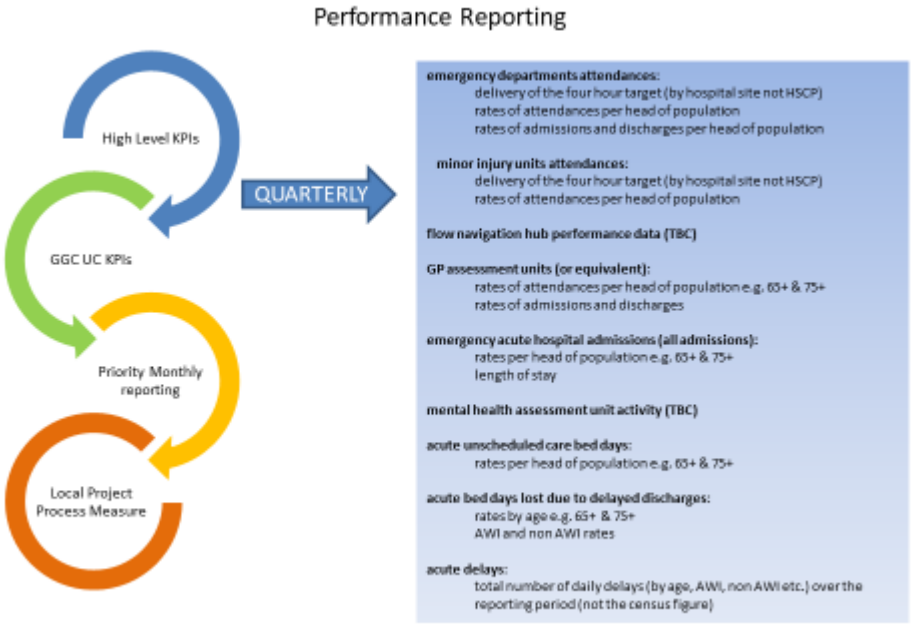
8.1 In this section we look at the performance framework to support delivery of the programme and the key measures we will use to monitor and assess progress. We also include an estimate of the potential impact on emergency admissions.

8.2 It is essential that we develop a performance framework to support all levels of data and information required including high level management reporting at both GGC and HSCP levels; operational management data to support local planning and monitoring and wider data to support targeted review and improvement activity at HSCP and locality/community levels.

8.3 It is the aspiration of the HSCP UC Delivery Group to have a single repository hosting the key data sets to support the framework. This will build on the HSCP dashboards currently developed. This will be similar to the Command Centre used by the acute sector.

8.4 A Data, Information & Knowledge work stream has been developed with key stakeholders to develop the framework and build the requirements for the single repository to be used across HSCPs. The work stream has developed the key indicators we propose to use to measure the impact of our programme as outlined in annex G. Figure 6 provides a pictorial example of the levels of data within the performance framework, with the high level data required to evidence impact example presented

Figure 6 – Performance Management Framework



8.5 In a large and complex system such as NHSGGC with many moving parts estimating and forecasting the impact of specific interventions is never an exact science. As we have seen in 2020 there are many factors that can influence the impact of any given intervention – many of which are not in our direct control e.g. changes in the economy. Forecasting or estimating the potential impact of such a wide ranging programme as described in this plan on Scotland's largest health and social care system is even more difficult when looking into future years, and beyond Covid.

8.6 The numbers presented below should therefore be viewed with extreme caution and should not be considered as a firm guarantee of the impact of this programme; the projections are a guide and our best estimate based on what we know of the health and social care system in NHSGGC. These numbers will need regular review and updating as we go forward to take account of progress in implementing the programme.

8.7 In providing an indication of the potential impact of the programme we have looked at emergency admissions as this is a key indicator of unscheduled care demand, and can also lead to delayed discharges (another key indicator). Reducing emergency admissions can alleviate pressure in other parts of the system such as A&E, GP assessment units and in primary care. We specifically look at emergency admissions for the 65+ population as they account for approximately 40% of all emergency admissions in GG&C.

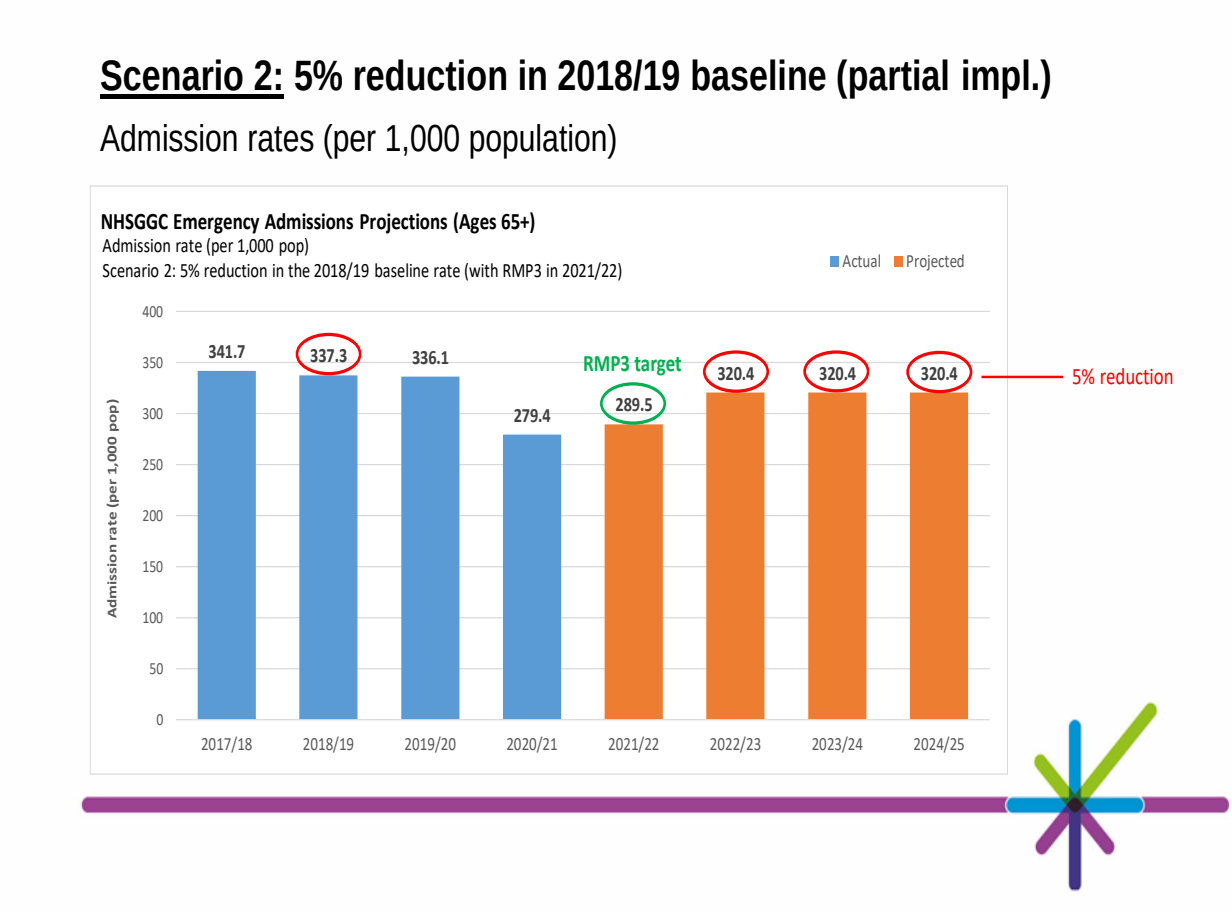
8.8 To reach our estimate we have looked at current rates of admission by head of population for different age groups and taken into account the population projections for future years (see annex H). We present three scenarios in annex H recognising that the programme as a whole is not currently fully funded (see section 7 above):

- a do nothing scenario with no implementation of the programme showing the impact demographic changes might have on current rates;
- a partial implementation of the programme taking into account that significant parts of the programme are funded non-recurrently; and,
- full implementation showing what might be the case should the programme in its entirety be fully funded on a recurrent basis.

8.9 Below we show the partial implementation scenario (see annex H for the detail) that illustrates the impact of the programme could (with all the caveats outlined above) result in a reduction in the rate of emergency admissions for over 65s from 337.3 in 2018/19 (the last pre-Covid year) to 320.4 in 2022/23 – a reduction

of 5%. This estimate takes into account the demographic changes forecast in NHSGGC over this period (see also annex H), and also current projections for 2021/22 included in RMP3.

Figure 7 – projected change in rate of emergency admissions for over 65s in NHSGGC (based on 2018/19 baseline)



8.10 The development of our work streams to deliver step change will require key outcome and process measures to be developed to measure impact with a view to informing decisions regarding scale up or change of approach. These will be reported at HSCP and GGC level using locality team data in most cases.

Benefits Realisation

8.11 It is extremely challenging to draw a direct line in relation to the impact of activities currently underway and planned as part of Phase 2 delivery of this improvement programme. In many cases it is a sum of parts that result in a cumulative and measurable improvement. At the time of writing, work is progressing to develop outcome and process measures for each work stream.

Below is a summary of the expected benefits of some of the actions that have been outlined:

Flow Navigation Centre (FNC)

8.12 The implementation of our Flow Navigation Centre during phase 1 realised significant benefits. The initial aim was to redirect up to 15% of the 2019 levels of self referrals the equivalent of 96 consultations over 24 hours and 74 over 12 hours. The FNC has carried out 7,000 virtual assessments in the first six months with 36.7% of patients seen treated and discharged without the need for an ED or MIU attendance. Phase 1 has resulted in 2,569 patients avoiding attendance at ED/MIU, Phase 2 will work to increase this by 2,405 to 4974 patients in 6 months and therefore an estimated attendance avoidance of 9,948 per annum.

Increasing ACP & KIS availability

8.13 There is strong evidence from studies demonstrating that an ACP and a coordinated team-based approach with a clearly identified population that is at high risk of hospitalisation can reduce ED attendance, admission rates and occupied bed days. This approach to care also leads to an increased likelihood of being allowed to die at home. Our GGC activity is targeting those at high risk of hospitalisation including our care home residents and those with long term conditions.

8.14 Palliative Care - a recent retrospective Scottish study reviewing 1304 medical records of peoples who died in 2017 from 18 practices across 4 Scottish health boards, concluded that people with KIS were more likely to die in the community (home, care home or hospice) compared to those without one (61% versus 30%). NHSGGC reported n12, 612 deaths in 2019/20, 53.6% of these were within a community setting and the remaining 46.4% of deaths occurred in Acute Care. During 2019/20 there were 6045 admissions to hospitals across GGC resulting in death with an average LOS of 19 days. Our aim is to target ACP's for long term conditions and palliative care to achieve a 1% increase in the number who are supported with palliative care to die comfortably at home this could result in a saving over 1100 bed days and would reduce admissions by 60.

8.15 Pilot work by the Edinburgh city HSCP supporting the adoption of ACP in care homes and their aligned GP practices, saw a 56% reduction in avoidable hospital admissions and 20% reduction in A&E admission from care homes. A similar pilot in Lanarkshire in 2009 reported a reduction in the number of Accident and Emergency attendances, number of patients with an emergency inpatient admission, and a reduced total length of hospital stay following the introduction of anticipatory care planning in 8 care homes

8.16 In 2019/20 ED/AU attendances for over 65 years were n113, 283 with n65, 857 converting to an emergency admission. The majority of these admissions were to orthopedics, medical, surgical and care of the elderly. Non elective bed days in this period was n191, 212 therefore we can estimate 2.9 days average length of stay with 46% of these within care of the elderly wards. ACP conversations and sharing of the key information could reduce the number of ED attendances and admissions for a number of these patients as evidence above.

8.17 ACPs available on Clinical Portal across GG&C i.e. those added by Community teams has seen a marked increase from January to June 2021 with 386 ACPs created in this period compared with 192 in January to June 2020. This improvement can be accredited to the activity being undertaken as part of the ACP Work Stream newly invigorating the activity and also as a consequence of Covid19. In total 851 ACPs are available on Clinical Portal as of June 2021, compared with only 9 available in 2019. Through the activity of the ACP improvement project we aim to significantly increase the number of ACPs available, the number has increased by over 100% in the first 6 months of 2021. We will aim to achieve a further 100% increase in the following 6 months till end of March 2022 and an estimated 20% reduction in admissions for those who have an ACP resulting in 340 avoided admissions and an estimated bed reduction of 986 (at 2.9 days LoS).

Falls Prevention & Management

8.18 About a third of people over 65 years old living in the community fall each year and the rate of falls related injuries increases with age. The Care Inspectorate recently reported that Falls are recorded as a contributing factor in 40% of care home admissions.

8.19 Falls incidence in care homes is reported to be about three times that in the community. This equates to rates of 1.5 falls per care home bed per year. Falls can have serious consequences, e.g. fractures and head injuries. Around 10% of falls result in a fracture. Most fall-related injuries are minor: bruising, abrasions, lacerations, strains, and sprains. However falls can also have a psychological impact, even in the absence of injury. Fear of falling is extremely common, can curtail physical activity and activities of daily living and lead to social isolation – even within the care home environment.

8.20 During 2019/20 across GGC there were n6,618 ED attendances for falls related incidents in our over 65 years population with n2,478 (37%) resulting in a hospital admission. Out of the 2,478 admission, 575 (23%) had a stay of 3 days or less utilising around 900 bed days. Through a number of actions within

the falls work stream we will aim to reduce the number of individuals with short stays of 3 days or less by 10% saving at least 90 bed days per year.

8.21 January – June 2021 Scottish Ambulance Service (SAS) attended to n6051 fallers over 65 years in the community, including Care Homes. Conveyance to ED followed for n4652, 77% of calls. Work with SAS to reduce conveyance by a further 10% (465). A number of actions within the Falls Prevention & Management plan will contribute to a reduction in ED attendance and unplanned admissions such as:

1) using the Care Home Falls Pathway incorporating the Flow Navigation Centre for clinical triage assessing the need for urgent response and opportunities to plan any required diagnostics and or referral to community teams for support; and,
2) working more closely with SAS to reduce conveyance to hospital using FNC and the general falls prevention training and local HSCP action plans.

Frailty@ the Front Door

8.22 During the test of change week there were on average of 25 patients with frailty attending per day. On average eight were discharged each day following a length of stay of two days. The average LoS for patients over 75 years is ten days therefore we can estimate that we saved eight bed days per patient through new processes and ways of working. Over seven days this equates to 3228 bed days; the equivalent of nine hospital beds.

8.23 Bearing in mind this is on one hospital site. If scaled up across three sites given QEUH accounts for 30% of activity, this could result in saving of up to 27 beds every day over a 12 month period.

Discharge to Assess Policy impact on 11B & 27A

8.24 During financial year 2019/20 there were 10,654 bed days lost to 11B (awaiting community assessment) this has improved by 45% in 2020/21 with 5,826 bed days lost recorded. Bed days lost to 27A (wait for intermediate care) reduced by 29% n4652 in 2021 compared with n6579 in 2019/20. We will continue to embed the D2A Policy and Home First ethos encouraging strong communication and MDT working to discharge individual's home at the earliest opportunity to reduce the risk of deconditioning within the hospital setting.

8.25 In doing so we will aim to reduce the bed days lost to 11B codes by a further 10% aiming to save a further 580 bed days by end of March 2022. Bed days lost to 27A hasn't evidenced as big an improvement; this could be attributed to the challenges of COVID reducing the ability to discharge patients to another

setting. We will seek to improve the bed days lost while waiting on an intermediate care placement by a further 2% aiming to save 93 bed days.

Mental Health Assessment Units

8.26 Total referrals to MHAUs in May 2020 totalled 442 compared to 1443 referrals in May 2020. This illustrates the significant growth in direct referrals to the MHAU's facilitating access for ED's SAS and the Police service and we anticipate this is having a positive overall effect on both ED attendances and admission rates. The average number of MHAU attendances referred by EDs was on average 314 per month over the three months to May 2021. We can therefore estimate that there will be 3,768 ED attendances avoided through this service over a 12 months period.

8.27 The development of our work streams to deliver step change will require key outcome and process measures to be developed to measure impact with a view to informing decisions regarding scale up or change of approach. These will be reported at HSCP and GGC level using locality team data in most cases.

8.28 It is the intention to develop mid-year and end year performance reports to allow the full impact to monitored going forward.

8.29 Projection modelling and what if scenario planning tools are being explored in collaboration with Public Health Scotland Local Intelligence Support Team (LIST). A work plan is being developed at the time of writing this paper.

9 GOVERNANCE ARRANGEMENTS

9.1 Governance arrangements have been updated to reflect the complexity of the Unscheduled Care programme. The approved structure is shown in figure 7 below. This structure will:

- facilitate strategic direction and operational leadership of UC;
- provide accountability for developing strategy and design via the Steering Group;
- demonstrate responsibility for implementation via Delivery Groups;
- embed the Programme Management approach to provide assurance that the programme is appropriately managed; and,
- to ensure alignment to system wide UC service profile.

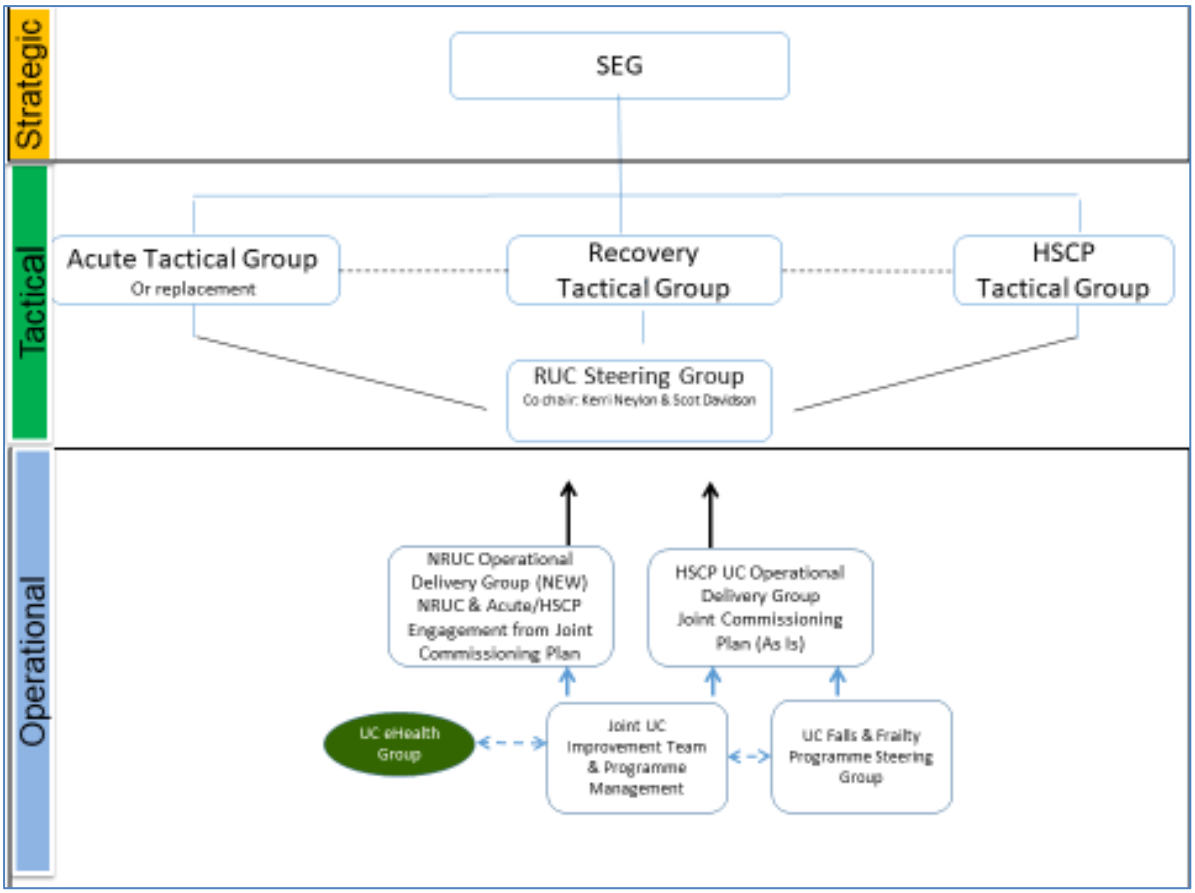
9.2 At a strategic level the overall programme will report to the Strategic Executive Group (SEG) to provide oversight and overall governance assurance. As

deemed appropriate there will be escalation to Corporate Management Team (CMT).

9.3 At tactical level reporting will continue to HSCP Tactical and Acute Tactical Group to steer, approve and sponsor the on-going unscheduled care programme activity including JCP and National Redesign of Urgent Care. The Recovery Tactical Group will approve and jointly agree project plans, assess proposals for cross system redesign and prepare update papers for SEG in conjunction with RUC Steering Group.

- **Redesign of Urgent Care (RUC) Group** - the role of this group is to develop a cross system approach to redesign, delivery of project plans for Redesign of Urgent Care including CACs, FNC, MHAUs. This will be a key group to link and engage with both Acute & HSCP Tactical groups. This group will also ensure links with Acute Clinical Governance, Acute Partnership Forum, GP Sub and Area Partnership Forum;
- **NRUC Operational Delivery Group** – this is new group within the governance structure. This group will bring together the operation delivery of the NRUC and both Acute and HSCP engagement from the Joint Commissioning Plan;
- **HSCP Unscheduled Care Delivery Group** – this group is responsible for designing and delivering a programme to achieve the ambition set out in the Joint Commissioning Plan;
- **Joint UC Improvement Team & Programme Management** - this team support the development, design and delivery of the JCP & NRUC using a project management approach to provide assurance.

Figure 8 – Unscheduled Care Governance Arrangements



10 PROGRESS REPORTING

10.1 Progress on implementation of each action in the phases outlined above will be reported routinely firstly to the HSCP Delivery Group and then quarterly to the RUC Steering Group, Tactical Groups and onto SEG. Annual updates will also be provided to IJBs and the Health Board.

10.2 Where appropriate escalation of issues or areas of concern will be reported timeously.

10.3 Performance reports on the KPIs in annex G will be submitted monthly in line with existing performance reporting for delays, the four hour target, A&E attendances and other key measures.

10.4 The Data, Information & Knowledge work stream will develop a Standard Operating Procedure providing guidance to support reporting across all levels via appropriate governance routes.

11 NEXT STEPS

11.1 This Design and Delivery Plan provides an update on the 2020 Joint Commissioning Plan for unscheduled care services agreed by IJBs and refreshes our approach in line with the new baseline adjusted for the impact of COVID-19.

11.2 This revised plan has:

- reported on progress against the actions in the original 2020 programme agreed by IJBs;
- reflected on the impact of the pandemic on unscheduled care activity;
- reported on what was delivered in 2020 including the national redesign of urgent care;
- outlined a re-freshed and updated programme, and the content of the different delivery phases;
- explained our proposals for ongoing engagement with clinicians, staff, patients and carers;
- outlined the supporting performance and financial framework; and,
- the organisational governance arrangements to ensure appropriate oversight of implementation of the plan.

11.3 The plan will be considered by IJBs, the Health Board and be the subject of engagement as outlined in section 4 above. A final version will be made available later in the year and progress reports issued at regular intervals.

NHS GREATER GLASGOW & CLYDE

UNSCHEDULED CARE
JOINT COMISSIONING PLAN

DRAFT DESIGN & DELIVERY PLAN
2021/22-2023/24

ANNEXES

August 2021

CONTENTS

ANNEX A

2020 Unscheduled Care Programme

Progress overview of activity against key actions 2020

Redesign of Urgent Care – Flow Navigation Hub and Mental Health NHS111 Service

The national definition and objective of the Health Board **Flow Navigation Hub** is to offer rapid access to a senior clinical decision maker, **optimising digital health** when possible in the clinical consultation and has the ability to advise self-care, signpost to available local services such as: Ambulatory Care / Same Day Emergency Care, Mental Health hubs, Minor Injury Units, primary care (in and out of hours) and the Emergency Department if required.

NHSGGC has implemented virtual clinical conversations across a number of service areas. Virtual telephone or Near Me consultations take place in our Community Assessment Centres (CAC), Primary Care (in and out of hours), and Acute Planned Care Services and in addition as part of the national Redesign of Urgent Care Programme have been introduced through the Flow Navigation Centre (FNC) and the Mental Health Assessment Units (MHAU).

The direct public facing access to the FNC and MHAU pathways are delivered through the new national NHS111 service. In the same way as the GPOOHs and CAC services the outcome of an initial clinical triage of patients who choose to use the service provided by NHS24 may result in an onward electronic referral for further assessment. The redesign is intended to offer an alternative route for patients to access acute and mental health advice and is largely aimed at those patients who would have self presented to an urgent care service with the objective of converting unplanned demand to urgent planned care. NHSGGC has established multi-disciplinary clinical teams to respond to the NHS111 referral by delivering a further 'virtual' clinical assessment to establish the most appropriate treatment plan for the patient and where appropriate to meet the patient's needs without a face to face attendance.

The FNC has implemented Phase 1 of the model with the 2021/22 Phase 2 plan under development and will see service access expand to connect with other urgent care specialty pathways across the health care system.

The NHS111 service has been communicated to the public through a national leaflet drop and we anticipate a national communications campaign including TV and Radio to be launched in the spring of 2021.

Signposting and Redirection Policy

Signposting and redirection aims to ensure Emergency Department (ED) attendees are appropriately reviewed in line with their reason for presentation. These processes also reduce the potential for crowding in the ED by maximising use of safe alternatives for attendees to access the right care if the reason for presentation is not an accident or an emergency.

The Acute Hospitals across NHSGGC currently provide four main access routes for urgent and emergency care patients, through designated Minor Injury Units, Assessment Units, Emergency Departments and Specialist Assessment and Treatment Areas (SATA). During the pandemic SATAs were established to provide a direct access route for patients with COVID-1919 symptoms including those referred through the CACs and GPs both in and out of hours. It has been essential during this time that the hospital sites maintain separate pathways for COVID-1919 and non COVID-1919 patients to reduce the risk of infection and to protect patients and staff, signposting and redirection has been an essential part of this process.

Signposting and redirection enables hospitals to maintain designated pathways and is delivered by senior clinical decision makers proactively streaming patients to the most appropriate area on arrival at the hospital. The majority of patients are registered for treatment within the relevant acute service and will be seen, treated and discharged as required. There are a proportion of ED attendances for conditions which could be better managed by patients themselves, NSH24, pharmacists, community optometrists, GPs or other members of the community care team. If the nature of the presenting complaint confirms that they do not require ED treatment the patient is advised that alternative options are available. The purpose of Signposting and Redirection is not to turn attendees away from the ED, but to direct them to another area/service where their healthcare need can be met and minimising the risk to them and others in overcrowded EDs.

Discharge to Assess Policy

The Greater Glasgow & Clyde Discharge to Assess (D2A) Policy went live at the end of February 2021. The Policy has been implemented across all adult services within Acute, Mental Health and Learning Disabilities and across all 6 Health & Social Care Partnerships.

The implementation of this policy will aim to ensure that once a patient is medically fit they do not remain in hospital because they are waiting for an assessment, further embedding our Home First ethos. This reduces the patient's length of stay in hospital supporting assessment within the patient's familiar environment and most appropriate place. Evidence suggests this should reduce de- conditioning and improve outcomes

significantly since 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.

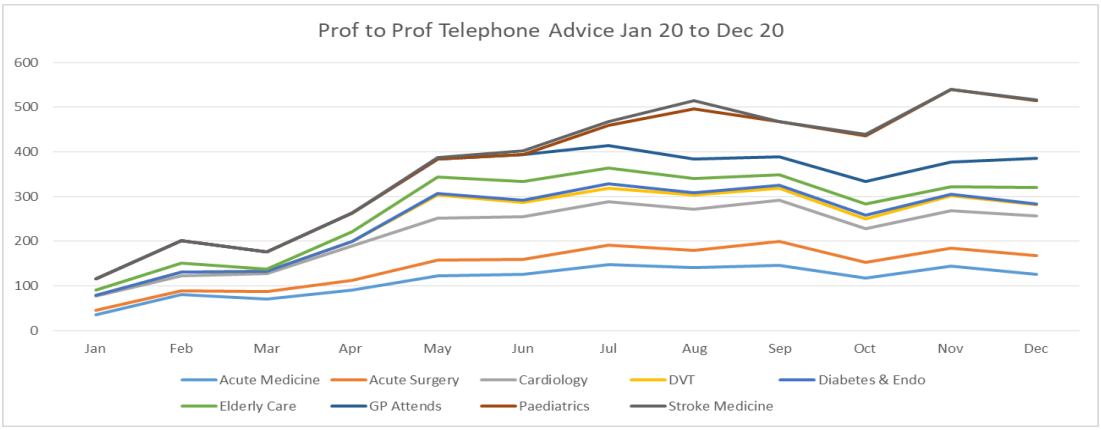
Key to successful implementation is Person Centred Care and Multi-Disciplinary Team working. The aim of all members of the MDT should be to commence planning for discharge as early as possible within the patient journey. Individual's, their family/carers will be central to decision making and engaged with at all stages. The information collated prior to and throughout the patient's journey is critical in providing a focus to determine the required support for discharge Quarterly reviews will be carried out to identify what's working well and areas requiring improvement. Regular feedback is encouraged from both Acute and HSCPs.

Digital Professional to Professional Advice Solutions

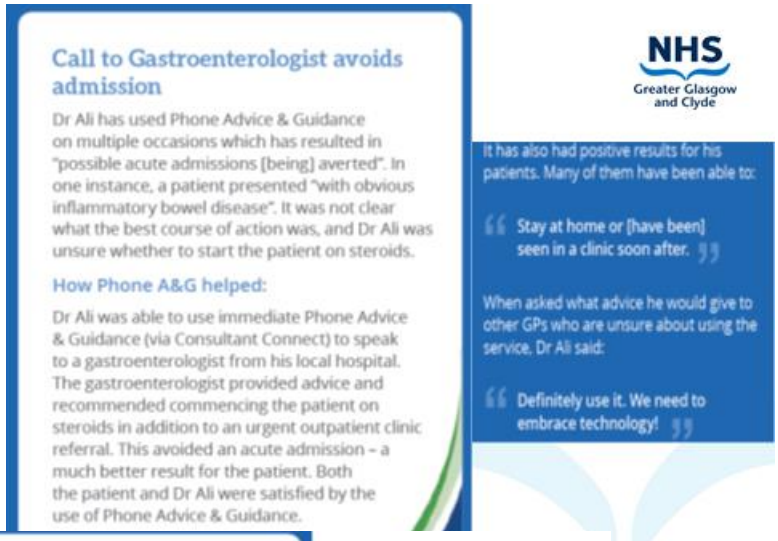
The aim of the professional to professional advice service is to provide GPs and other health care professionals with access to Specialty Advice, to ensure we are able to direct patients to the right care at the right time and in the right place. NHSGGC has introduced a telephone and app based service that provides an automated process for GP's to obtain professional specialty advice from the acute hospital team to support decision making within Primary Care. Over recent months we have expanded GP access to a range of specialties including acute medicine, medicine for the elderly, cardiology, DVT, paediatrics and medical admission from teams at Glasgow Royal Infirmary, Queen Elizabeth University Hospital and the Royal Alexandra Hospital. The service enables advice and guidance to be readily available and ranges from starting treatment within the community setting or arranging for the patient to be reviewed within an outpatient clinic, at the hospital assessment unit or where appropriate to be directed straight to the emergency department.

Whilst activity through this route has increased as a result of the expansion, call volumes remain relatively low in comparison to the number of direct referrals to the hospital assessment units. There are a number of GP's who have optimised the prof to prof advice route during the pandemic and where appropriate this has provided an effective alternative to attendance which has been very valuable during the pandemic. There remains a number of GP's who have not made use of this service and we are keen to further promote this service.

The chart below shows the number Prof to Prof telephone advice calls by GPs to Acute during January 2020 – December 2020



Two examples shared by local GPs highlighting benefits of the Prof to Prof service



OOHs Urgent Care Resource Hub and Local Response Hub Model

The review of Health and Social Care Out of Hours (OOHs) services across the Greater Glasgow and Clyde area is now complete. The review has been led by Glasgow City Health and Social Care Partnership (HSCP) on behalf of the six HSCPs and Acute Services.

Colleagues from across the Health and Social Care System, along with members of the public and other partner agencies worked together to develop a more integrated and co-ordinated OOHs Health and Social Care System.

Through this process of engagement and consultation it was agreed that an Urgent Care Resource Hub (UCRH) and Local Response Hub approach would be developed to facilitate integrated, person-centred, sustainable, efficient and co-ordinated health and social care OOHs Services across the Greater Glasgow and Clyde area. The new model will develop and enhance the way we work across the health and social care OOHs system.

The creation of the UCRH and Local Response Hubs model will:

- Allow the co-location of some of the OOHs services e.g. Home Care and District Nursing to enhance integrated working across the system
- provide direct professional to professional access across the Health and Social Care OOHs System through enhanced communication by co-locating staff and developing virtual links across the Greater Glasgow and Clyde area
- provide OOHs staff with a single point of access across the Health and Social Care OOHs system, along with the facility for professional to professional advice to support management decisions for patients and service users with increasing complexities
- enable a whole system approach to the provision of changes to scheduled care and unscheduled and/or emergency care across the OOHs Health and Social Care System.
- support the increase of the number of multi-agency and multi-disciplinary responses which would match patient, service user and carers' needs through a wide range of health and social care based resources.

The UCRH provides a single point of access for staff working across Health and Social Care OOHs services to co-ordinate a multi-service response during times of crisis and escalation. The following services are co-located in the UCRH: Emergency Social Work, Home Care, Community Alarms, Responder Services and OOHs North District Nursing are all located within Borron Street. The UCRH is virtually connected with the teams working in the Mental Health Assessment Units and OOHS South District Nursing Service.

Staff will still be able to contact other services through their existing numbers, however if a response to a complex issue of crisis or escalation is required the UCRH can be contacted. The hours of operation are 5pm to 9am Monday to Friday and 24 hours Saturday, Sundays and Public Holidays.

Importantly there is no change for patients, service users and cares in how they access services in the OOHs period as they will continue to use existing numbers/existing

pathways to access services. This is a change in where some staff are located and how all services will work together.

As Glasgow City hosts a number of the OOHs board wide services e.g. Emergency Social Work and Mental Health Services the UCRH will be implemented in Glasgow City (Borron Street) first with the other HSCPs implementing their Local Response Hubs in a phased approach thereafter. Glasgow City will implement the UCRH on 29 March 2021 and the Local Response Hubs across the five other HSCPs will be implemented by end April 2021.

Following a period of review and evaluation a second phase of implementation (May – June 2021) will take place where the UCRH will also co-ordinate referrals from GP OOHs and the FNC and Acute Services.

Other professional groups to be considered in a future phase (timescales to be determined) includes SAS, Police Scotland, Third and Voluntary Sectors.

ANNEX B

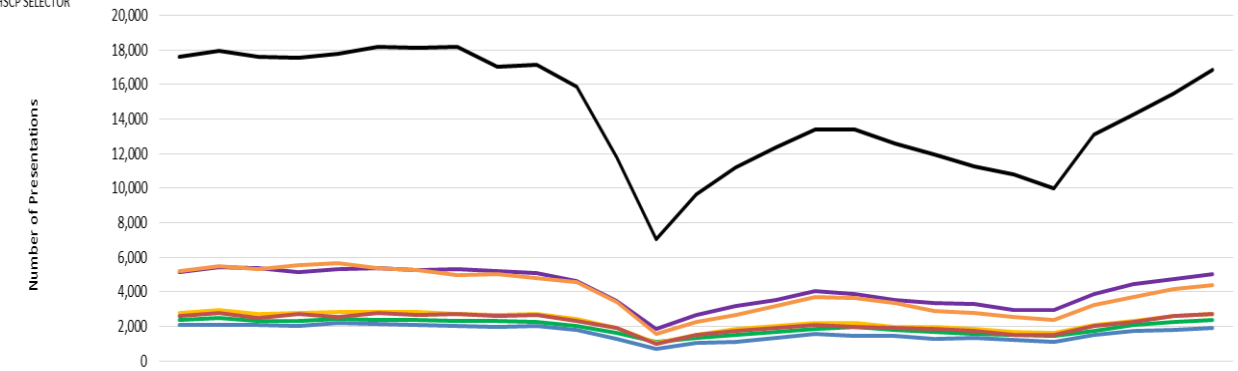
Rear View Mirror Slides

Unscheduled Care activity

2019-2021

by HSCP and GG&C

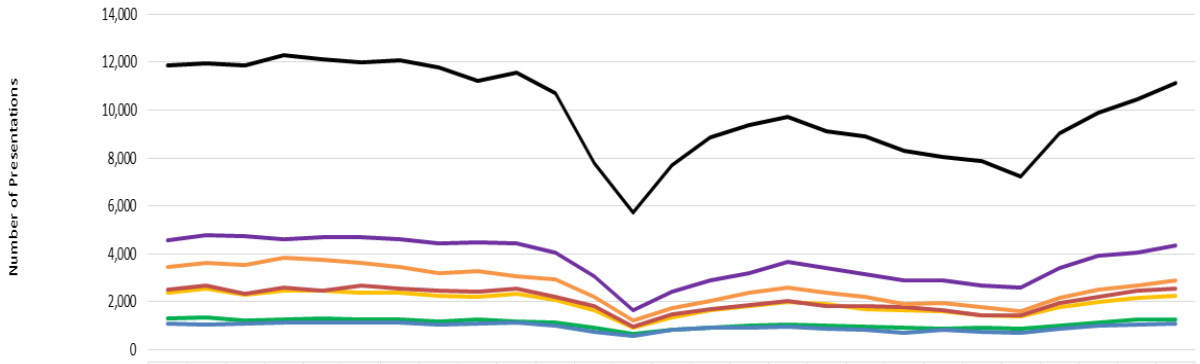
DATASOURCE: MONTHLY UNSCHEDULED CARE HSCP - APR-Jun 21/22
WITH HSCP SELECTOR



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
GLASGOW TOTAL	17,592	17,957	17,613	17,561	17,758	18,204	18,134	18,200	17,014	17,161	15,891	11,790	7,053	9,653	11,186	12,324	13,384	13,382	12,557	11,950	11,276	10,822	10,005	13,108	14,253	15,494	16,877
East Dunbartonshire	2,356	2,489	2,298	2,318	2,415	2,383	2,360	2,293	2,335	2,264	2,047	1,635	1,084	1,342	1,532	1,699	1,854	1,950	1,778	1,666	1,572	1,522	1,465	1,767	2,101	2,252	2,379
West Dunbartonshire	2,771	2,940	2,704	2,788	2,850	2,812	2,839	2,745	2,674	2,746	2,452	1,922	1,043	1,512	1,857	2,032	2,215	2,220	1,998	1,953	1,838	1,675	1,620	2,103	2,314	2,583	2,717
East Renfrewshire	2,068	2,078	2,117	2,022	2,211	2,160	2,080	2,048	1,983	2,037	1,824	1,306	689	1,027	1,129	1,337	1,568	1,480	1,452	1,256	1,336	1,213	1,121	1,485	1,738	1,799	1,921
Renfrewshire	5,161	5,406	5,388	5,148	5,296	5,391	5,253	5,319	5,184	5,069	4,614	3,485	1,851	2,681	3,196	3,523	4,025	3,885	3,541	3,338	3,325	2,979	2,929	3,879	4,461	4,762	5,055
Inverclyde	2,604	2,763	2,481	2,714	2,561	2,802	2,690	2,741	2,613	2,694	2,321	1,943	993	1,529	1,760	1,934	2,095	1,946	1,910	1,850	1,742	1,532	1,486	2,034	2,286	2,602	2,752
Other	5,210	5,481	5,298	5,571	5,636	5,389	5,254	4,985	5,055	4,774	4,585	3,393	1,596	2,283	2,661	3,200	3,711	3,619	3,356	2,920	2,805	2,548	2,370	3,256	3,698	4,150	4,420

DATASOURCE: MONTHLY UNSCHEDULED CARE HSCP - APR-Jun 21/22
WITH HSCP SELECTOR

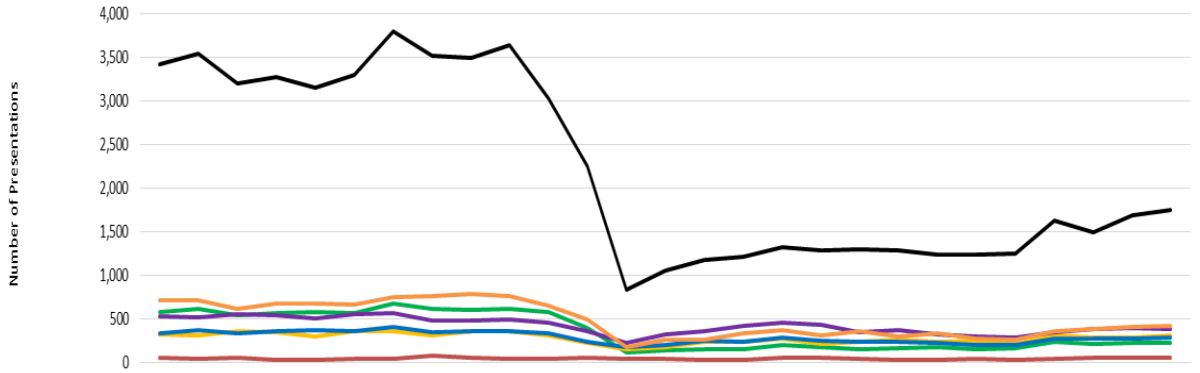
ED Presentations (Excluding MIU & RHC) April 2019 - June 2021



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
GLASGOW TOTAL	11,869	11,940	11,864	12,278	12,131	11,999	12,103	11,768	11,222	11,548	10,721	7,795	5,713	7,695	8,862	9,389	9,701	9,142	8,924	8,285	8,064	7,888	7,225	9,019	9,877	10,448	11,149
East Dunbartonshire	1,316	1,351	1,229	1,273	1,293	1,249	1,247	1,170	1,285	1,195	1,141	907	671	820	912	997	1,034	1,026	959	929	873	941	879	1,007	1,131	1,269	1,249
West Dunbartonshire	2,399	2,537	2,292	2,465	2,475	2,372	2,382	2,237	2,220	2,336	2,087	1,660	933	1,368	1,669	1,810	1,979	1,892	1,711	1,661	1,602	1,434	1,403	1,786	1,983	2,162	2,266
East Renfrewshire	1,109	1,064	1,099	1,124	1,142	1,125	1,116	1,051	1,103	1,125	993	757	571	836	936	907	975	884	856	699	819	757	717	900	1,014	1,060	1,106
Renfrewshire	4,574	4,775	4,743	4,635	4,705	4,702	4,629	4,439	4,480	4,457	4,037	3,064	1,645	2,437	2,902	3,212	3,660	3,420	3,143	2,916	2,893	2,668	2,607	3,404	3,942	4,077	4,361
Inverclyde	2,490	2,661	2,355	2,599	2,458	2,686	2,559	2,479	2,440	2,573	2,199	1,845	957	1,476	1,709	1,879	2,017	1,832	1,832	1,765	1,663	1,458	1,427	1,950	2,194	2,449	2,563
Other	3,443	3,631	3,561	3,852	3,754	3,610	3,437	3,215	3,271	3,081	2,936	2,214	1,219	1,741	2,020	2,363	2,587	2,384	2,203	1,921	1,960	1,774	1,603	2,188	2,514	2,682	2,892

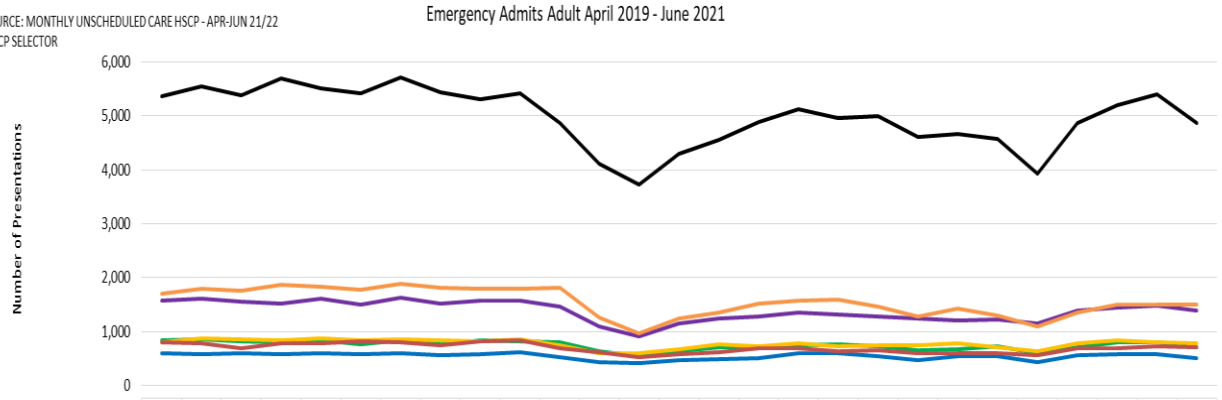
DATASOURCE: MONTHLY UNSCHEDULED CARE HSCP - APR-JUN 21/22
WITH HSCP SELECTOR

Assessment Unit Attends (inc RHC CDU) April 2019 - June 2021



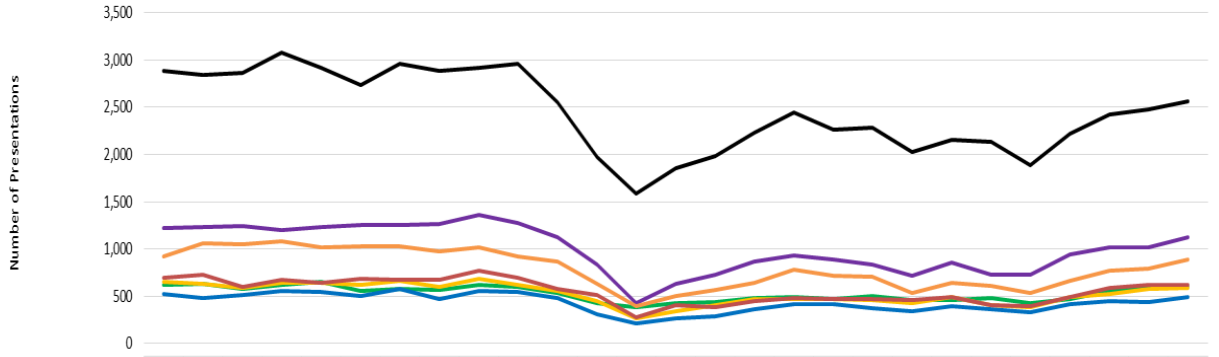
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
GLASGOW TOTAL	3,412	3,537	3,204	3,270	3,154	3,302	3,790	3,515	3,490	3,633	3,032	2,243	835	1,058	1,180	1,212	1,317	1,288	1,294	1,281	1,241	1,235	1,246	1,627	1,487	1,686	1,747
East Dunbartonshire	581	611	545	565	575	562	675	610	601	611	580	395	118	135	153	146	200	173	157	166	175	153	163	238	218	225	227
West Dunbartonshire	318	307	354	342	303	360	360	305	355	358	312	226	157	181	233	235	276	214	236	259	243	254	211	307	290	290	314
East Renfrewshire	337	374	337	355	372	360	407	342	357	355	331	239	173	196	246	242	281	249	232	240	225	197	205	270	276	278	281
Renfrewshire	529	523	551	547	508	557	569	480	481	493	459	360	227	323	362	420	454	431	351	373	324	296	287	350	380	396	381
Inverclyde	55	43	50	29	30	47	48	81	55	47	47	51	36	43	34	33	52	59	41	35	35	36	29	41	49	54	56
Other	713	716	618	676	674	662	747	758	786	755	656	490	182	257	266	332	365	304	354	294	336	278	262	361	378	406	415

DATASOURCE: MONTHLY UNSCHEDULED CARE HSCP - APR-JUN 21/22
WITH HSCP SELECTOR



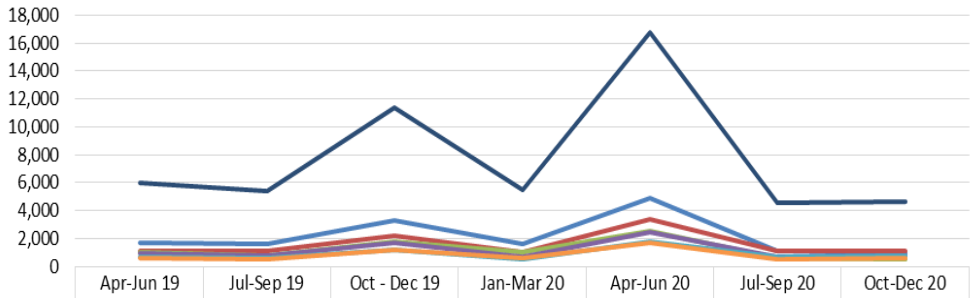
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
GLASGOW TOTAL	5,358	5,553	5,381	5,686	5,517	5,411	5,704	5,430	5,311	5,427	4,869	4,112	3,732	4,301	4,553	4,879	5,126	4,961	4,998	4,606	4,656	4,569	3,920	4,874	5,206	5,404	4,868
East Dunbartonshire	838	854	811	798	835	765	830	763	832	824	795	639	542	641	712	716	754	765	736	651	679	732	599	715	794	809	704
West Dunbartonshire	798	879	847	846	870	835	858	841	812	854	750	600	603	673	757	724	787	729	744	745	779	714	627	785	839	809	775
East Renfrewshire	599	586	591	584	604	577	607	563	571	621	530	426	419	468	483	513	604	599	544	478	540	538	435	561	574	584	506
Renfrewshire	1,568	1,603	1,552	1,524	1,616	1,509	1,628	1,510	1,580	1,568	1,471	1,103	905	1,147	1,246	1,276	1,352	1,323	1,285	1,248	1,199	1,219	1,146	1393	1,450	1,477	1,382
Inverclyde	794	778	697	787	780	823	806	752	816	833	694	625	520	572	621	685	695	633	658	604	590	604	558	687	691	729	702
Other	1,711	1,785	1,759	1,876	1,829	1,784	1,889	1,814	1,789	1,801	1,808	1,254	966	1,234	1,344	1,511	1,568	1,593	1,468	1,282	1,418	1,293	1,100	1359	1,499	1,509	1,509

DATASOURCE: MONTHLY UNSCHEDULED CARE HSCP - APR-JUN 21/22
WITH HSCP SELECTOR



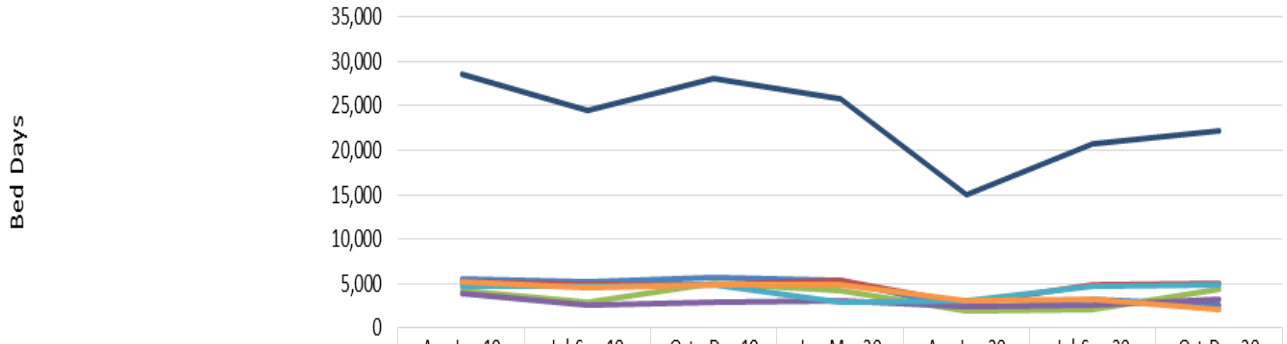
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
GLASGOW TOTAL	2,887	2,839	2,868	3,080	2,916	2,735	2,957	2,884	2,921	2,963	2,553	1,971	1,590	1,853	1,985	2,233	2,441	2,260	2,284	2,021	2,152	2,132	1,885	2,214	2,428	2,480	2,566
East Dunbartonshire	618	630	582	615	654	560	573	566	622	595	533	424	383	422	439	484	496	475	506	462	459	479	424	466	556	591	594
West Dunbartonshire	649	634	592	640	639	620	658	595	688	623	560	447	262	337	404	466	470	470	456	422	488	402	387	486	519	581	587
East Renfrewshire	519	477	510	557	548	505	577	465	560	542	479	309	207	270	284	365	421	411	376	336	396	359	325	417	447	440	491
Renfrewshire	1,219	1,231	1,245	1,195	1,229	1,252	1,255	1,267	1,361	1,279	1,122	840	424	635	722	865	935	893	836	721	856	732	730	937	1,018	1,018	1,127
Inverclyde	700	725	602	670	639	683	677	672	770	697	581	516	278	405	381	452	480	466	473	459	492	408	392	495	588	624	615
Other	924	1,060	1,045	1,077	1,021	1,024	1,023	976	1,018	923	867	635	399	499	568	640	778	714	706	530	641	605	535	668	767	794	885

Glasgow City top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



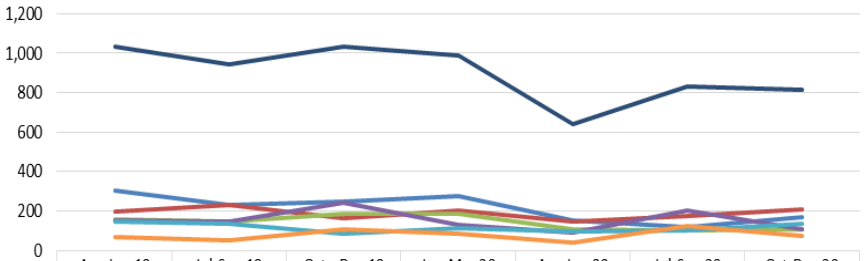
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	1,694	1,611	3,305	1,588	4,916	1,082	963
Other disorders of urinary system	1,087	1,132	2,219	1,024	3,351	1,086	1,072
Unspecified acute lower respiratory infection	1,003	769	1,772	1,015	2,541	568	531
Heart failure	925	772	1,697	707	2,469	722	779
Cerebral infarction	654	567	1,221	499	1,788	656	770
Fracture of femur	609	554	1,163	611	1,717	478	566
All diagnosis Total	5,972	5,405	11,377	5,444	16,782	4,592	4,681

Glasgow City top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



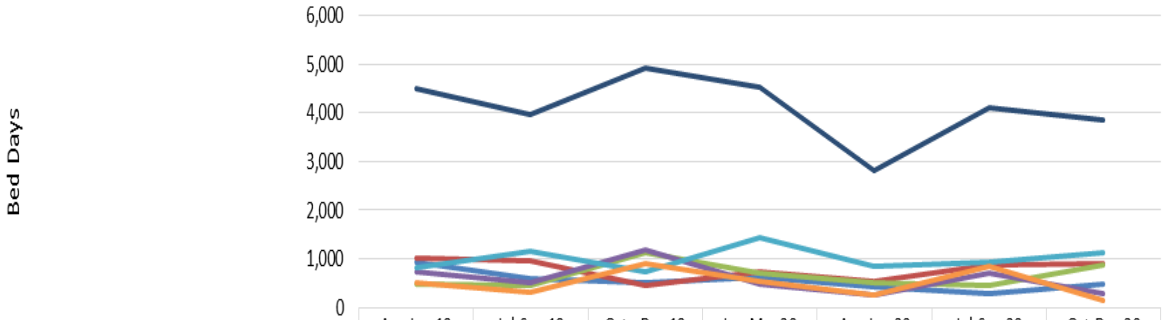
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	5,544	5,136	5,618	5,409	2,041	3,294	2,641
Other disorders of urinary system	5,177	4,806	4,795	5,329	2,657	4,863	5,060
Unspecified acute lower respiratory infection	4,148	2,856	5,051	4,259	1,829	2,130	4,308
Heart failure	3,943	2,564	2,884	3,038	2,432	2,509	3,172
Cerebral infarction	4,665	4,642	4,916	2,938	2,993	4,753	4,915
Fracture of femur	5,161	4,460	4,887	4,828	3,117	3,235	2,084
All diagnosis Total	28,638	24,464	28,151	25,801	15,069	20,784	22,180

West Dunbartonshire top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



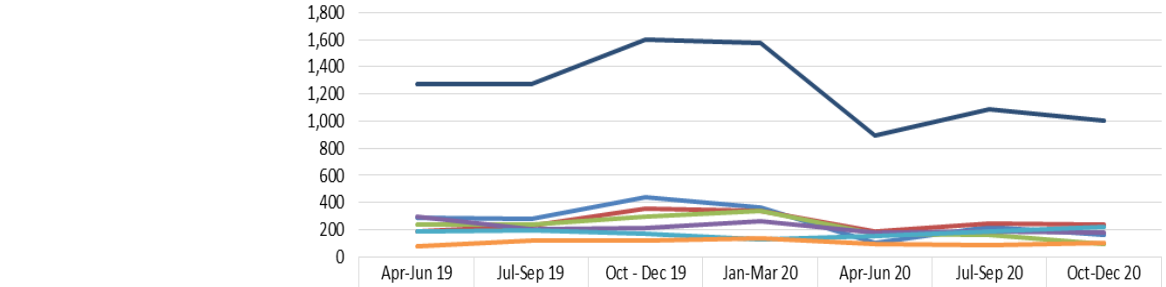
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	307	232	247	275	155	119	169
Other disorders of urinary system	200	229	164	203	149	177	211
Unspecified acute lower respiratory infection	157	147	189	184	108	101	110
Heart failure	155	147	240	129	91	203	108
Cerebral infarction	147	138	86	115	95	103	138
Fracture of femur	67	51	110	84	42	127	76
All diagnosis Total	1,033	944	1,036	990	640	830	812

West Dunbartonshire top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



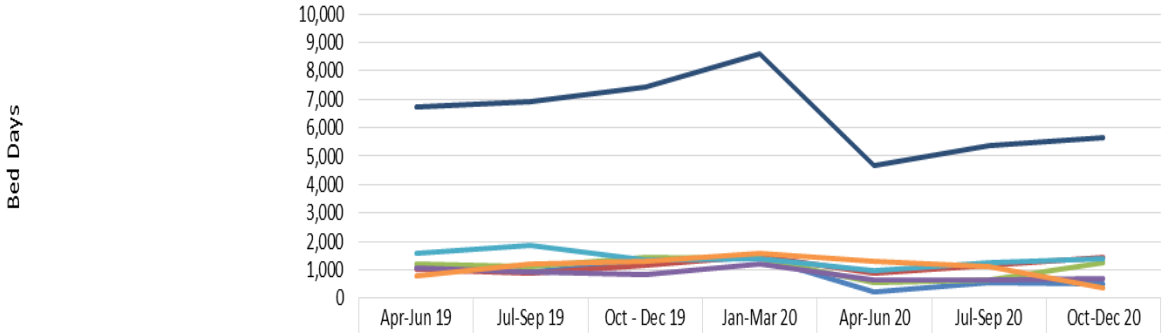
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	925	595	516	638	424	294	486
Other disorders of urinary system	1,015	950	471	725	532	879	908
Unspecified acute lower respiratory infection	490	455	1,131	697	501	452	882
Heart failure	726	507	1,173	487	254	714	284
Cerebral infarction	813	1,145	739	1,447	842	922	1,139
Fracture of femur	524	311	898	529	273	837	149
All diagnosis Total	4,493	3,963	4,928	4,523	2,826	4,098	3,848

Renfrewshire top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



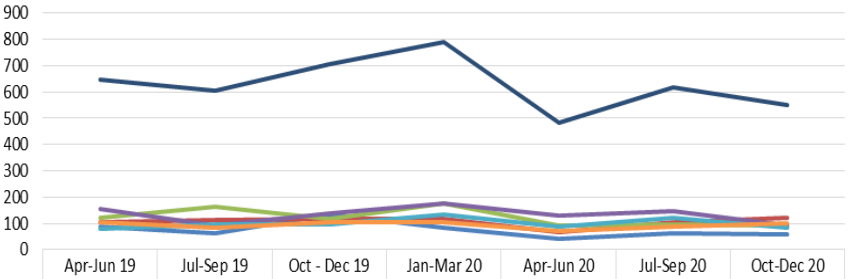
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	285	279	441	368	102	224	162
Other disorders of urinary system	185	226	357	341	189	248	242
Unspecified acute lower respiratory infection	241	238	296	336	170	161	99
Heart failure	296	208	215	263	178	191	181
Cerebral infarction	186	200	175	125	156	184	220
Fracture of femur	77	122	118	139	96	84	101
All diagnosis Total	1,270	1,273	1,602	1,572	891	1,092	1,005

Renfrewshire top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



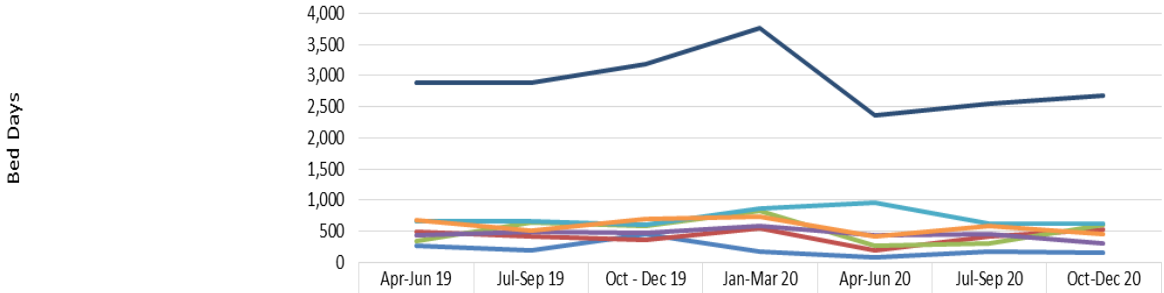
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	1,055	910	1,319	1,466	230	556	505
Other disorders of urinary system	1,003	901	1,147	1,474	907	1,155	1,423
Unspecified acute lower respiratory infection	1,196	1,106	1,452	1,421	564	661	1,250
Heart failure	1,084	917	846	1,234	661	650	699
Cerebral infarction	1,572	1,848	1,364	1,414	964	1,236	1,398
Fracture of femur	808	1,213	1,289	1,580	1,328	1,096	369
All diagnosis Total	6,718	6,895	7,417	8,589	4,654	5,354	5,644

East Renfrewshire top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



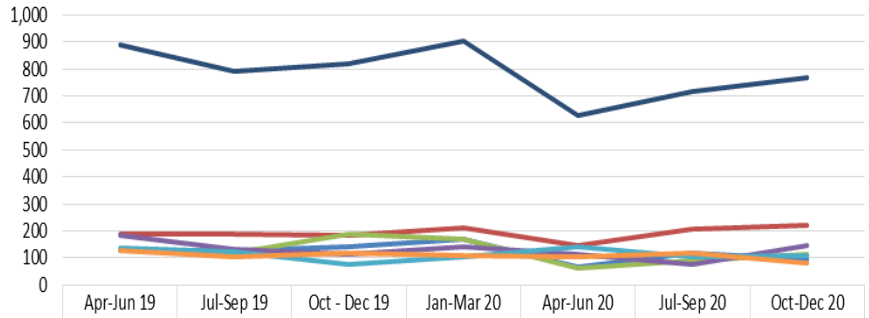
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	86	61	132	84	43	64	58
Other disorders of urinary system	105	111	119	119	65	103	123
Unspecified acute lower respiratory infection	121	163	115	176	91	95	90
Heart failure	154	91	139	177	128	148	92
Cerebral infarction	77	98	98	132	86	121	84
Fracture of femur	106	83	103	103	70	86	102
All diagnosis Total	649	607	706	791	483	617	549

East Renfrewshire top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



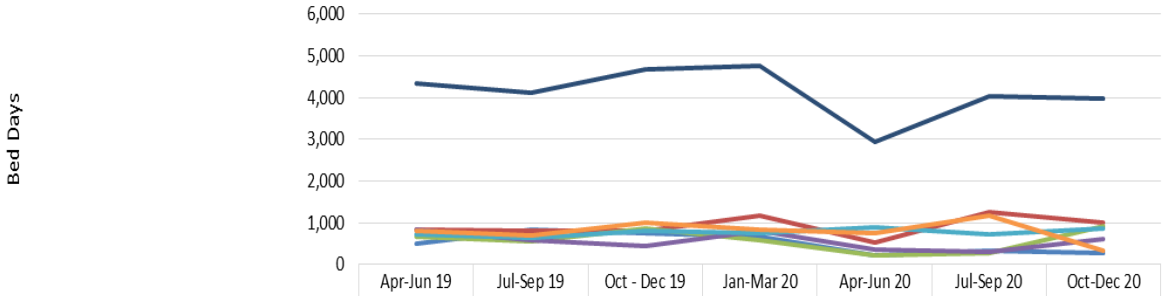
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	259	186	461	179	81	167	155
Other disorders of urinary system	496	411	365	554	188	422	537
Unspecified acute lower respiratory infection	351	640	581	824	264	309	606
Heart failure	445	484	477	594	436	454	310
Cerebral infarction	664	658	607	869	962	620	625
Fracture of femur	674	502	700	744	422	576	456
All diagnosis Total	2,889	2,881	3,191	3,764	2,353	2,548	2,689

East Dunbartonshire top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



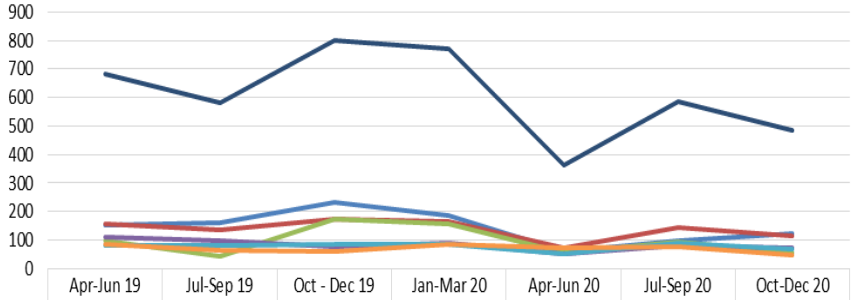
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	129	127	143	170	68	120	96
Other disorders of urinary system	187	186	181	210	147	205	220
Unspecified acute lower respiratory infection	130	118	186	169	60	88	114
Heart failure	182	132	113	141	113	76	146
Cerebral infarction	137	123	76	103	139	106	109
Fracture of femur	126	103	118	110	102	120	81
All diagnosis Total	891	789	817	903	629	715	766

East Dunbartonshire top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



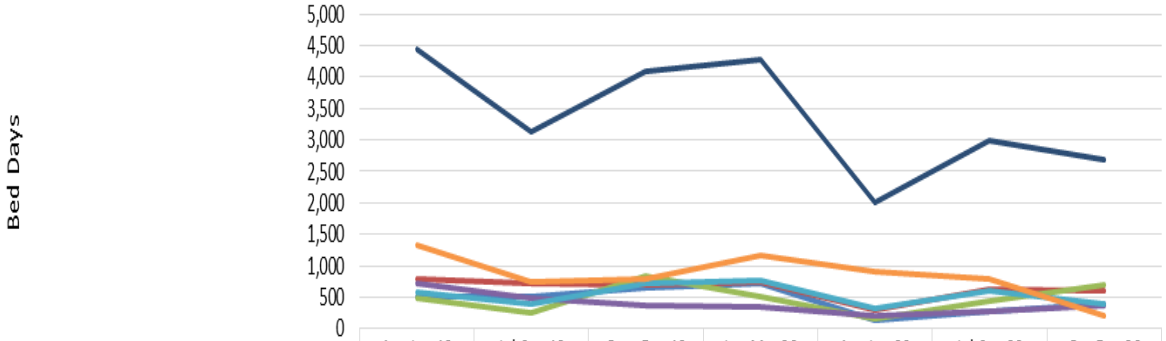
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	494	842	752	661	205	338	273
Other disorders of urinary system	843	806	797	1,170	514	1,242	1,008
Unspecified acute lower respiratory infection	655	564	855	571	206	283	910
Heart failure	827	581	450	798	365	294	605
Cerebral infarction	724	636	806	743	891	718	860
Fracture of femur	807	679	1,014	828	753	1,163	323
All diagnosis Total	4,350	4,108	4,674	4,771	2,934	4,038	3,979

Inverclyde top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



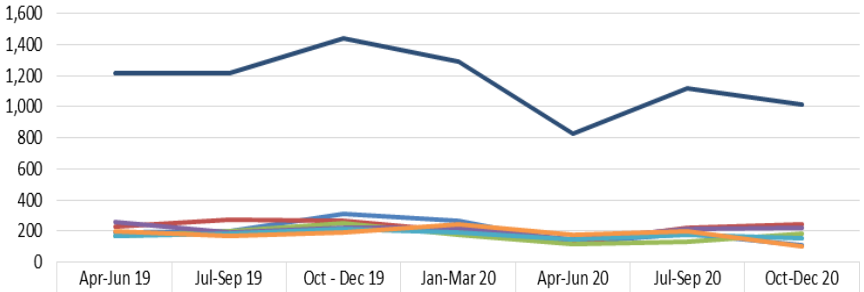
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	151	160	233	185	62	99	125
Other disorders of urinary system	158	134	174	167	73	145	113
Unspecified acute lower respiratory infection	96	42	174	157	55	93	56
Heart failure	110	99	76	89	50	80	74
Cerebral infarction	82	80	84	87	53	91	70
Fracture of femur	87	65	60	85	71	79	46
All diagnosis Total	684	580	801	770	364	587	484

Inverclyde top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



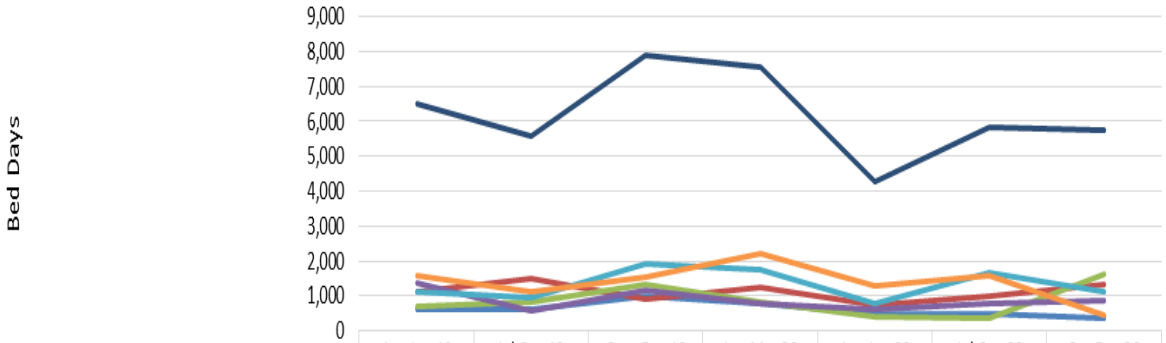
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	515	515	661	717	130	270	401
Other disorders of urinary system	789	723	692	752	312	629	614
Unspecified acute lower respiratory infection	493	248	851	513	156	437	705
Heart failure	713	496	378	353	201	273	373
Cerebral infarction	588	406	712	775	320	607	386
Fracture of femur	1,336	747	792	1,161	901	784	218
All diagnosis Total	4,434	3,135	4,086	4,271	2,020	3,000	2,697

Other top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20

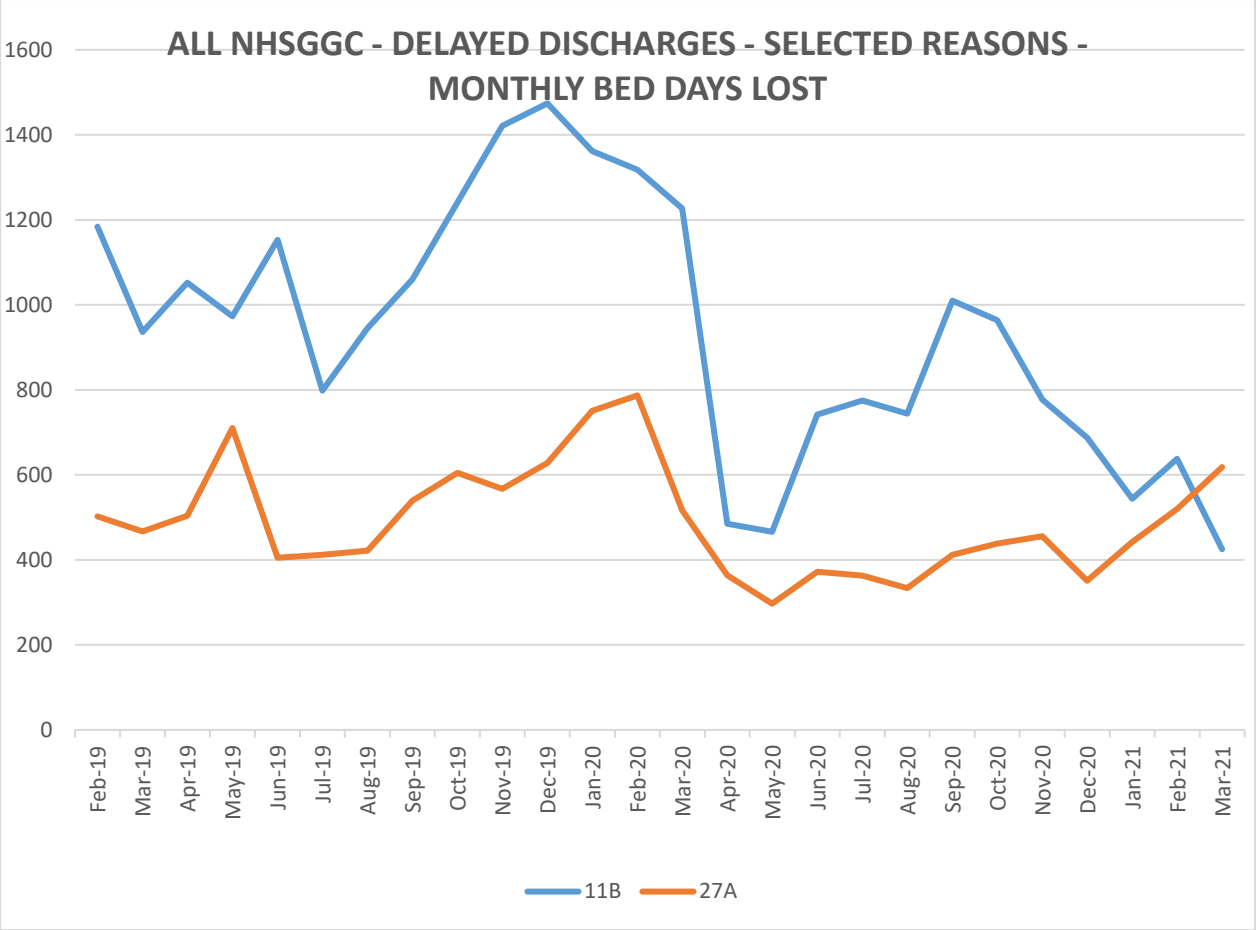


	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	192	201	310	266	125	181	106
Other disorders of urinary system	230	270	262	197	122	219	246
Unspecified acute lower respiratory infection	169	197	250	175	115	131	185
Heart failure	259	193	217	217	145	214	219
Cerebral infarction	171	184	214	194	147	179	156
Fracture of femur	195	170	190	243	175	196	103
All diagnosis Total	1,216	1,215	1,443	1,292	829	1,120	1,015

Other top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20

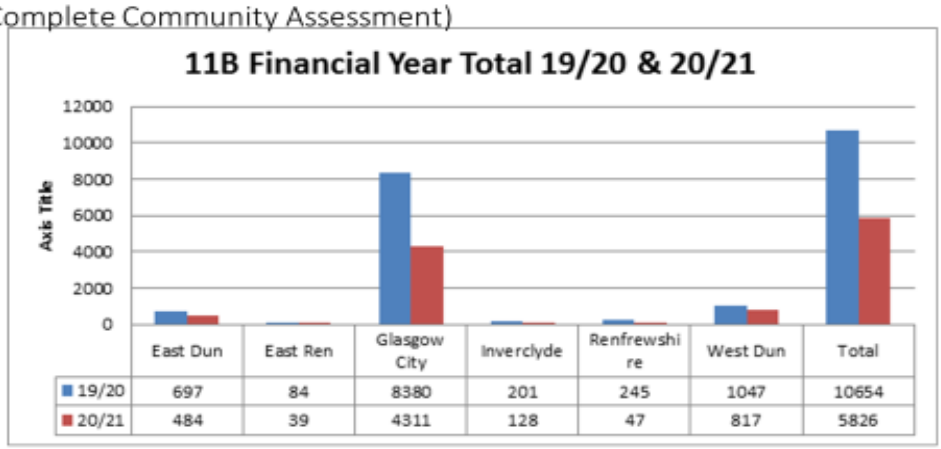


	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	593	608	1,005	773	482	481	360
Other disorders of urinary system	1,099	1,492	922	1,260	719	977	1,319
Unspecified acute lower respiratory infection	712	818	1,330	808	421	356	1,643
Heart failure	1,387	572	1,171	768	624	777	851
Cerebral infarction	1,117	942	1,922	1,739	772	1,679	1,127
Fracture of femur	1,574	1,127	1,544	2,197	1,272	1,567	450
All diagnosis Total	6,482	5,559	7,894	7,545	4,290	5,837	5,750



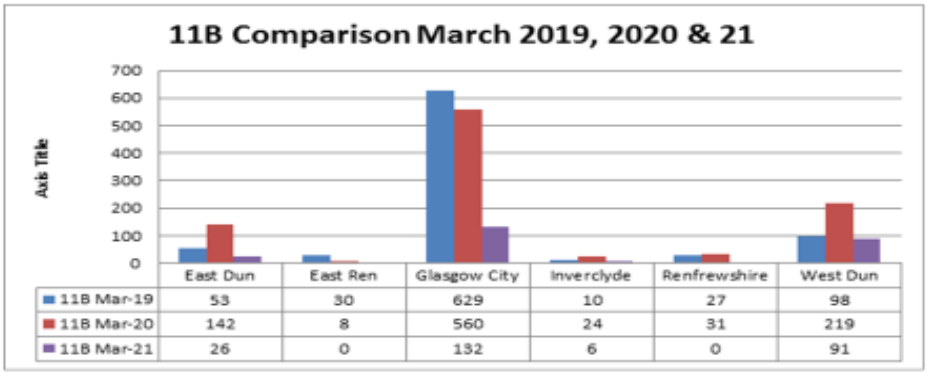
Bed Days Lost to 11B & 27A

11B (Complete Community Assessment)



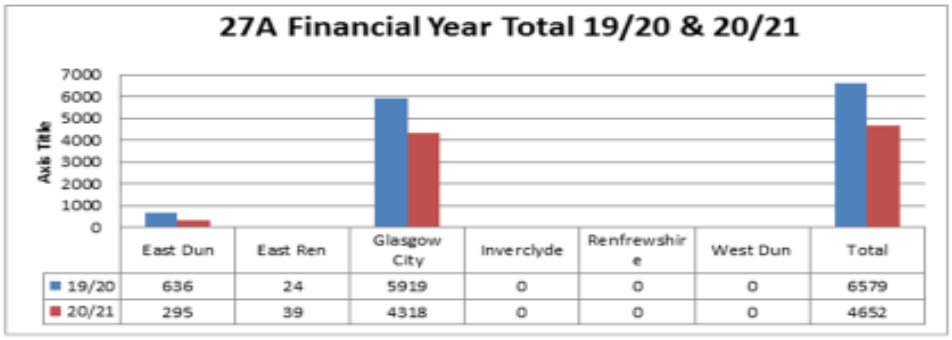
During financial year 2019/20 there were 10,654 bed days lost to 11B this has improved by 45% in 2020/21 with 5,826 bed days lost recorded

11B Comparison March 2019/20 & 21

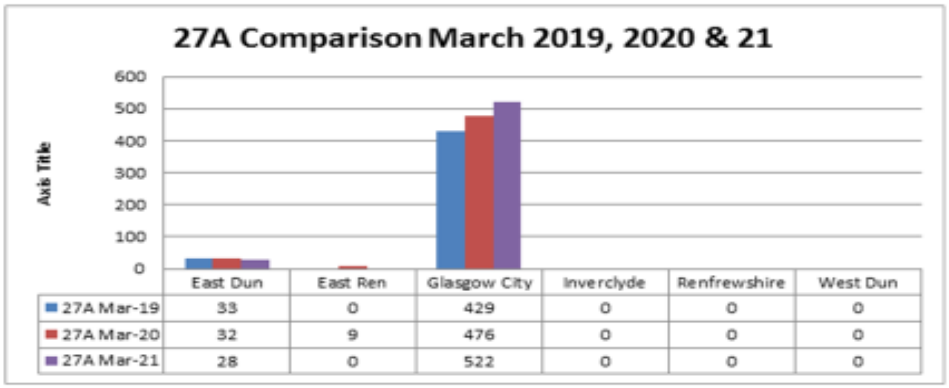


In March 2020 4/6 HSCPs evidenced an increase in bed days lost to 11B.
In March 2021 there is a marked reduction across all Partnerships.

Bed days lost to 27A (wait for intermediate care)



	East Dun	East Ren	Glasgow City	Inverclyde	Renfrewshire	West Dun	Total
19/20	636	24	5919	0	0	0	6579
20/21	295	39	4318	0	0	0	4652



	East Dun	East Ren	Glasgow City	Inverclyde	Renfrewshire	West Dun
27A Mar-19	33	0	429	0	0	0
27A Mar-20	32	9	476	0	0	0
27A Mar-21	28	0	522	0	0	0

ANNEX C

Urgent Care Service 11 Weeks Activity Review

01/04/2021 to 13/06/2021

The 2020/2021 Covid19 pandemic and the impact of the public lockdown resulted in an overall reduction in emergency attendance rates across NHSGGC. This summary paper focuses on the changes in activity across a number of our urgent care activity as lockdown began to ease during March 2021.

Acute Hospitals Emergency Attendances: Table 1.1 below represents the ED and AU (including SATA) emergency attendances for the core hospital sites in the first 11 weeks of 2021/2022 and table 1.2 reports the same period of 2019/2020 pre the Covid19 pandemic year of 2020/2021. It is clear from the data that the early part of the year routinely includes a number of weeks of variability usually associated with Easter and May public holidays (increases noted in red). During the 2021/2022 period there is clear evidence of cumulative step changes in emergency attendances and this is illustrated in the graph labelled 1.3 below.

TABLE: 1.1 - April 2021 to 13th June 2021

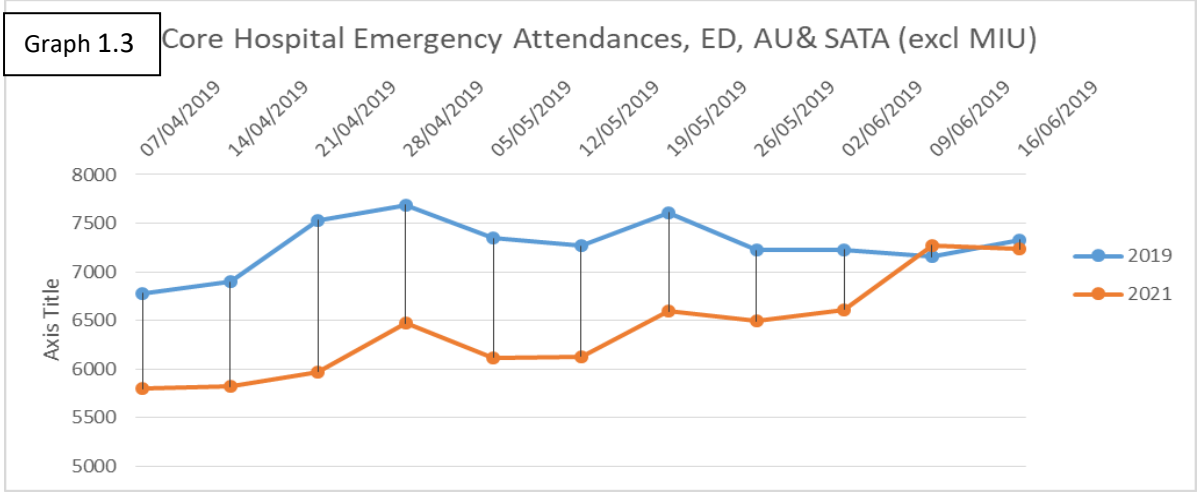
Week Ending - Core Sites	13/06/2021	06/06/2021	30/05/2021	23/05/2021	16/05/2021	09/05/2021	02/05/2021	25/04/2021	18/04/2021	11/04/2021	04/04/2021
Royal Alexandra Hospital	1346	1385	1269	1218	1169	1093	1210	1201	1215	1157	1102
Glasgow Royal Infirmary	1796	1690	1542	1558	1595	1524	1513	1654	1468	1436	1456
Queen Elizabeth University Hospital	1898	2035	1824	1739	1827	1759	1683	1777	1729	1730	1657
Inverclyde Royal Hospital	691	666	627	633	641	584	562	613	548	537	520
Royal Children's Hospital	1500	1497	1346	1342	1363	1165	1148	1225	1011	957	1061
Total	**7231**	**7273**	**6608**	**6490**	**6595**	**6125**	**6116**	**6470**	**5971**	**5817**	**5796**
% increase on prev week	**-0.6%**	**10.1%**	**1.8%**	**-1.6%**	**7.7%**	**0.1%**	**-5.5%**	**8.4%**	**2.6%**	**0.4%**	
		665	**118**		**470**			**499**	**154**		

TABLE: 1.2 - April 2019 to 16th June 2019

Week Ending - Core Sites	16/06/2019	09/06/2019	02/06/2019	26/05/2019	19/05/2019	12/05/2019	05/05/2019	28/04/2019	21/04/2019	14/04/2019	07/04/2019
Royal Alexandra Hospital	1387	1337	1386	1443	1439	1332	1305	1439	1413	1225	1309
Glasgow Royal Infirmary	1878	1875	1913	1814	1939	1877	1930	2034	2004	1841	1774
Queen Elizabeth University Hospital	2016	2015	2054	1977	2046	2016	2006	2085	2084	2055	1913
Inverclyde Royal Hospital	636	636	662	685	729	654	644	717	638	607	623
Royal Children's Hospital	1411	1290	1214	1303	1455	1386	1460	1412	1389	1169	1162
Total	**7328**	**7153**	**7229**	**7222**	**7608**	**7265**	**7345**	**7687**	**7528**	**6897**	**6781**
% increase on prev week	**2.4%**	**-1.1%**	**0.1%**	**-5.1%**	**4.7%**	**-1.1%**	**-4.4%**	**2.1%**	**9.1%**	**1.7%**	
	175				**343**			**159**	**631**	**116**	

Graph 1.3 – The cumulative step change in attendances can be seen over the 11 week period bringing the 11 weeks of 2021/2022 emergency attendances up to the same level as pre-pandemic in 2019/2020. This change in attendance rates has not been seen at any point previously and represents a statistically significant shift in activity across the core sites and reflects changes in demand.

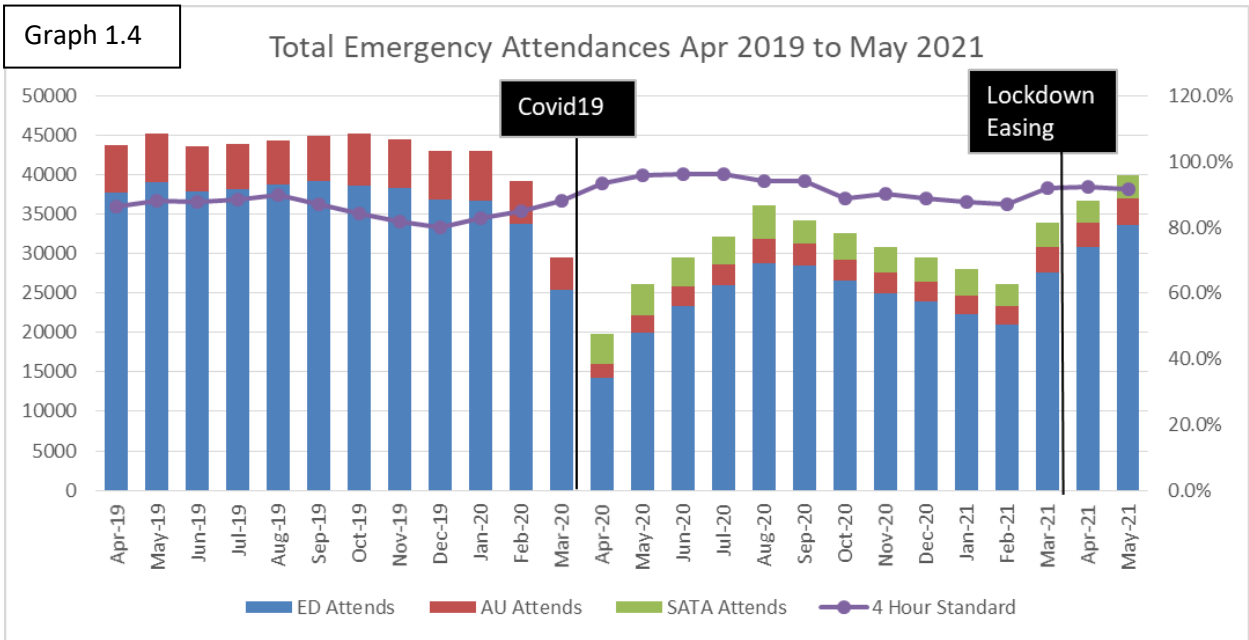
Graph 1.3



In summary UC attendances have reached pre pandemic levels whilst maintaining Covid19 pathways.

Graph 1.4 - The trend in cumulative emergency attendances from April 2019 through to May 2021 is provided below. This clearly illustrates the impact of Covid19 however there is increasing evidence of a step change in overall front door attendances to the end of May, June figures are not yet fully available. The 11 week review detailed above however confirms that in the first two weeks of June attendances were in line with 2019 figures at 14,504 for 2021/2022 compared to 14,481 for 2019/20. We anticipate that the full total by the end of June will show a similar step change trend of month on month increases.

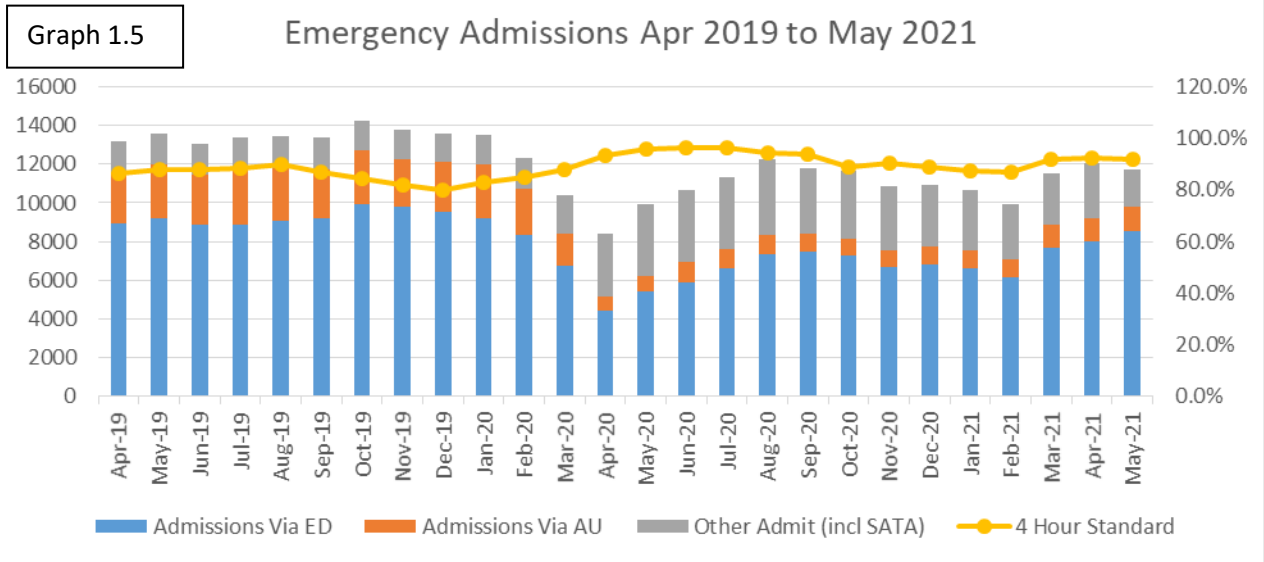
Graph 1.4



Acute Admissions: During the Covid19 pandemic the acute hospitals experienced an overall increase in the acuity of presentation with many patients requiring intensive care treatment in general new ways of working had to be quickly developed to deal

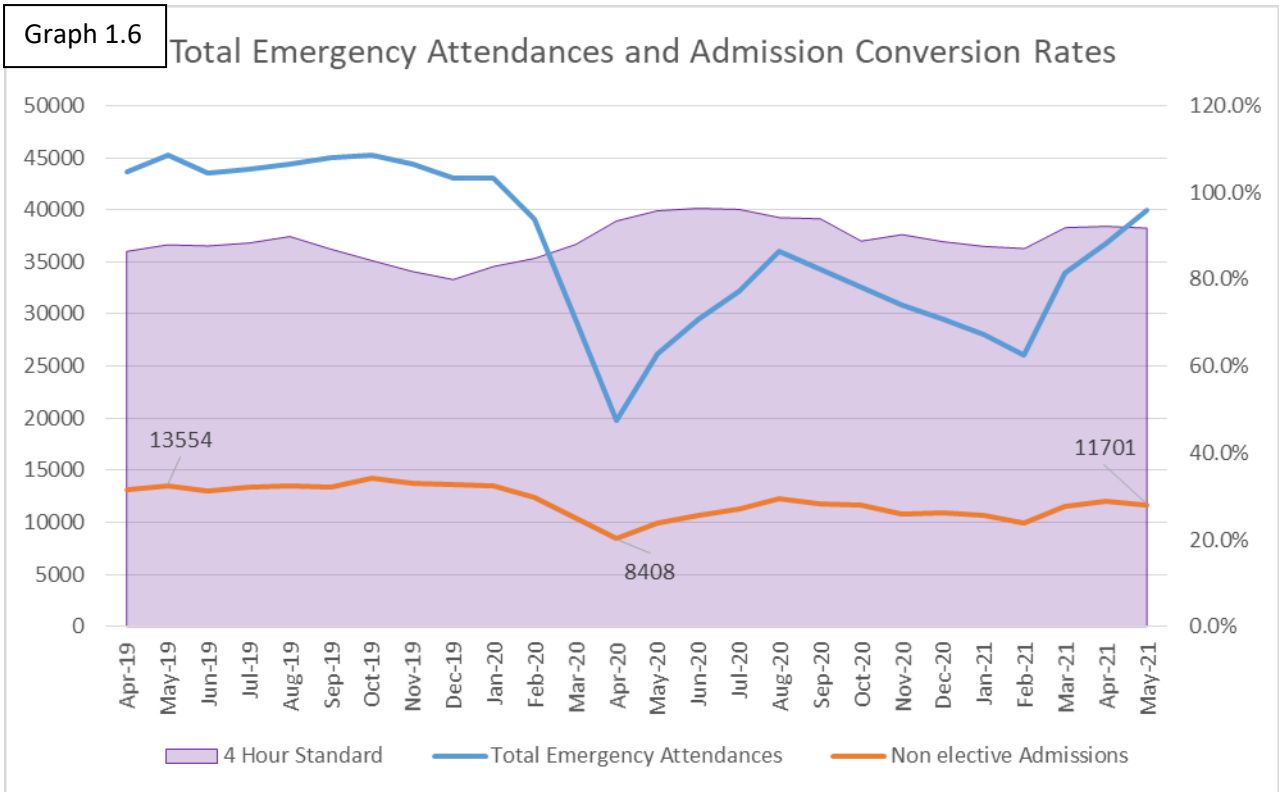
with these challenges. In line with the reduced attendance profile during the pandemic the acute sites also experienced a reduction in the number of emergency admissions as the public adopted stay at home restrictions. Graph 1.5 below shows the total Emergency admissions and illustrates the correlation between admissions and 4 hour performance.

Graph 1.5



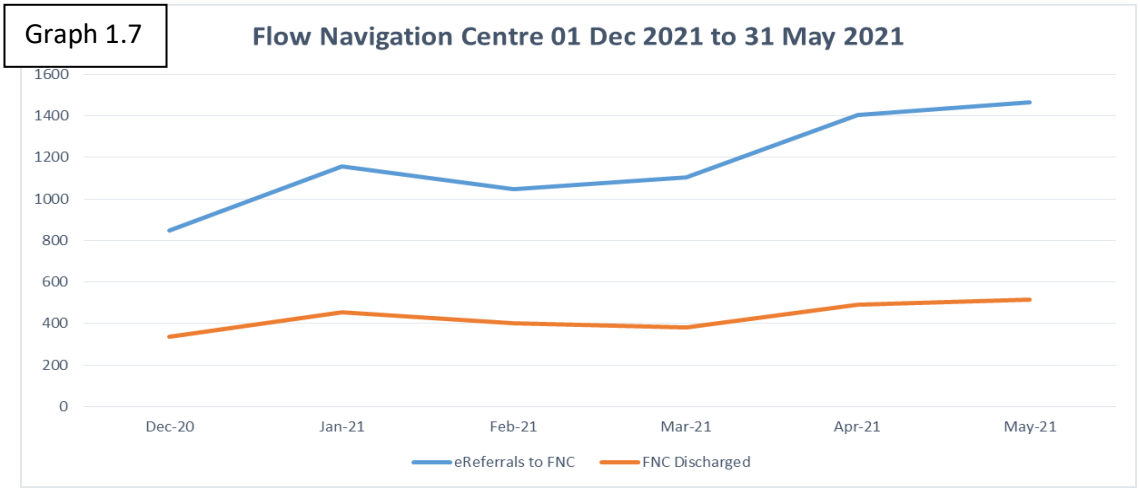
Emergency Admission Conversion Rates are detailed in Graph 1.6., whilst there is clearly a trend towards increasing admissions we have not yet reached pre Covid19 levels. Our significant efforts through the redesign of urgent care including the Covid19 Community Assessment Centres, the introduction of the Flow Navigation Centre and the Mental Health Assessment Unit and the increased provision of prof to prof advice may cumulatively be making a difference however difficult this may be to attribute cause and effect.

Graph 1.6



Flow Navigation Centre (FNC): The NHS111 service was launched on 1st December 2021 with eReferrals sent to the FNC for Near Me and telephone consultations. Graph 1.7 below shows the increasing number of referrals from NHS24 and a slower growth rate in the number of direct discharges from FNC. This is a result of two operational limitations that Phase 2 of the programme is trying to address, firstly the availability of alternative outflow options needs to increase to provide access to specialists including physio for MSK conditions and secondly as the FNC operates currently over 12 hours it is only able to deliver for 60% of the daily referrals.

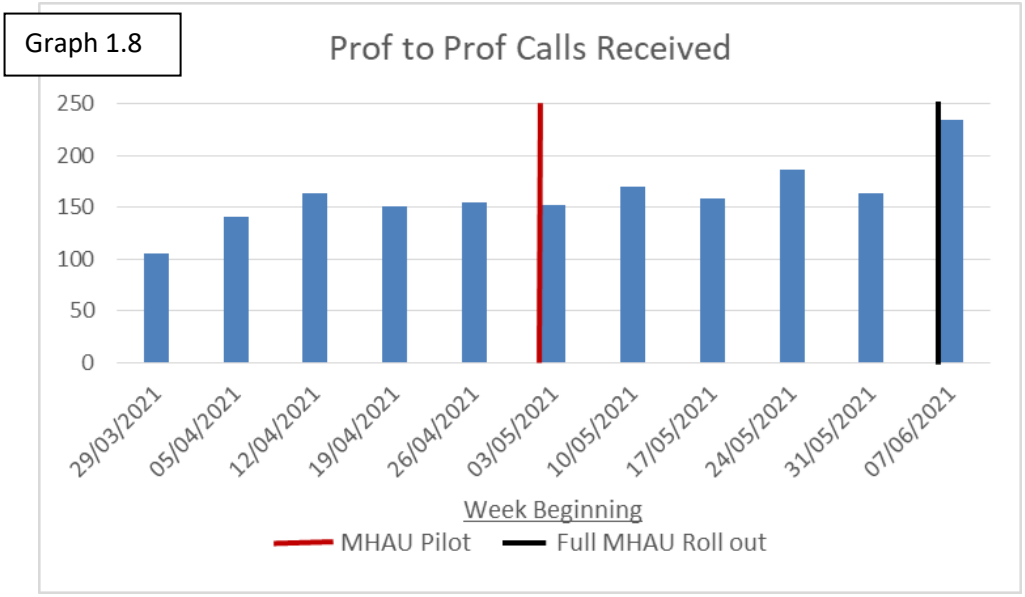
Graph 1.7



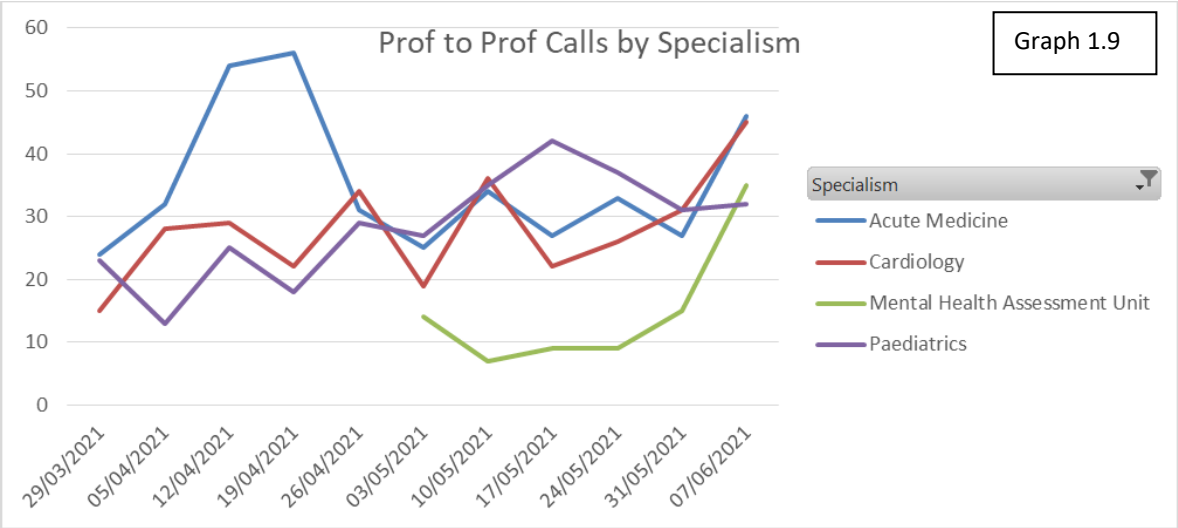
Professional to Professional Advice: The Acute hospital teams provide prof to prof specialty advice through a designated telephone system and a mobile device App. In

March 20 the Mental Health Assessment Unit (MHAU) piloted a new prof to prof advice service for GP practices. This initially was for South GP's only to test the process and functionality however was fully rolled out to all GP's at the beginning of June.

Graph 1.8 - The increase in advice referrals illustrated in the 11 week graph below to 13/06/2021 shows a step change increase of 45% in week 11 and reflects the impact of the new MHAU service and a rise in activity across a number of other specialties as detailed in Graph 1.5.



Graph 1.9: Professional to Professional Advice demonstrating significant increase in MHAU calls and also a corresponding increase in medicine, cardiology and paediatrics.



Mental Health Assessment Units (MHAU): Referrals to MHAUs in May 2020 totalled 442 compared to the referrals reported for May 2021 of 1443 and reflects a 3 fold increase in MHAUs activity over the 12 month period as detailed below in Graph 1.10 (data collated from EMIS dashboard for comparison). This illustrates the significant growth in direct referrals to the MHAU's facilitating access for ED's SAS and the Police service and we anticipate this is having a positive overall effect on both ED attendances and admission rates. To provide a snapshot of the new service Table 1.11 shows the range of services that have direct access to the MHAU including NHS24.

Graph 1.10

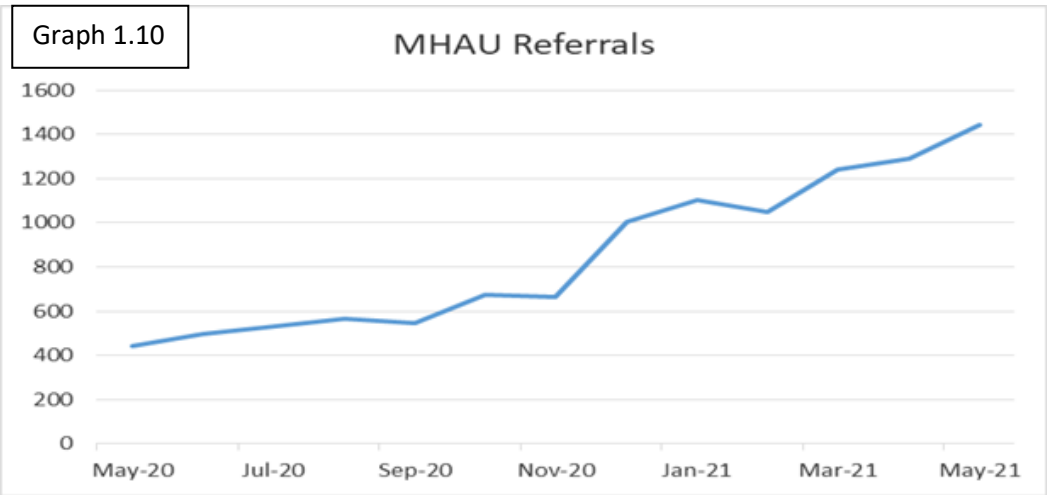


Table 1.8: MHAU Source of referral with a marked increase in referrals from NHS24.

As detailed in the table referrals to the MHAU are reporting month on month increases and the service has clearly evidenced the value delivered through this route by providing direct access to the specialty.

Referrals by source - Leverndale & Stobhill	Mar-21	Apr-21	May-21
Accident and Emergency Department	327	322	293
Ambulance Service	77	99	111
Community Health Service	10	12	10
General Medical Practitioner	50	50	109
Hospital Inpatient/Outpatient	5	1	0
Not known	1	2	4
Police	409	383	435
Self-Referral	2	12	6
Allied Health Professional	1	1	4
NHS24	356	407	462
Other (includes Armed Forces)	2	1	8
Not specified	2	1	1
TOTAL	**1,242**	**1,291**	**1,443**

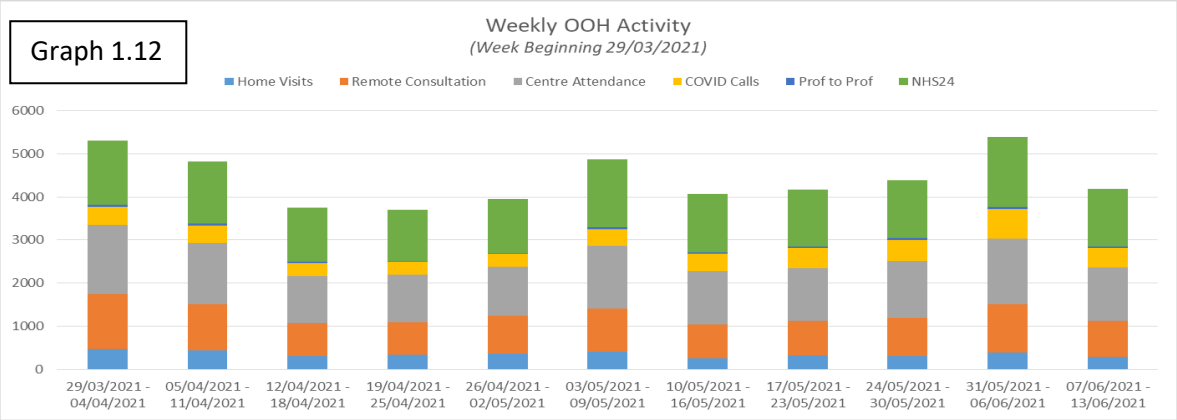
Table 1.11

As a new service establsihed during Covid19 this represents a cumulative increased in overall urgent care demand

GP OOH's Service: similar to the hospital attendances there has been significant levels of variation in the number of weekly attendances to the GPOOH's service. As anticipated some of this will be a reflection of the Easter and May holiday periods.

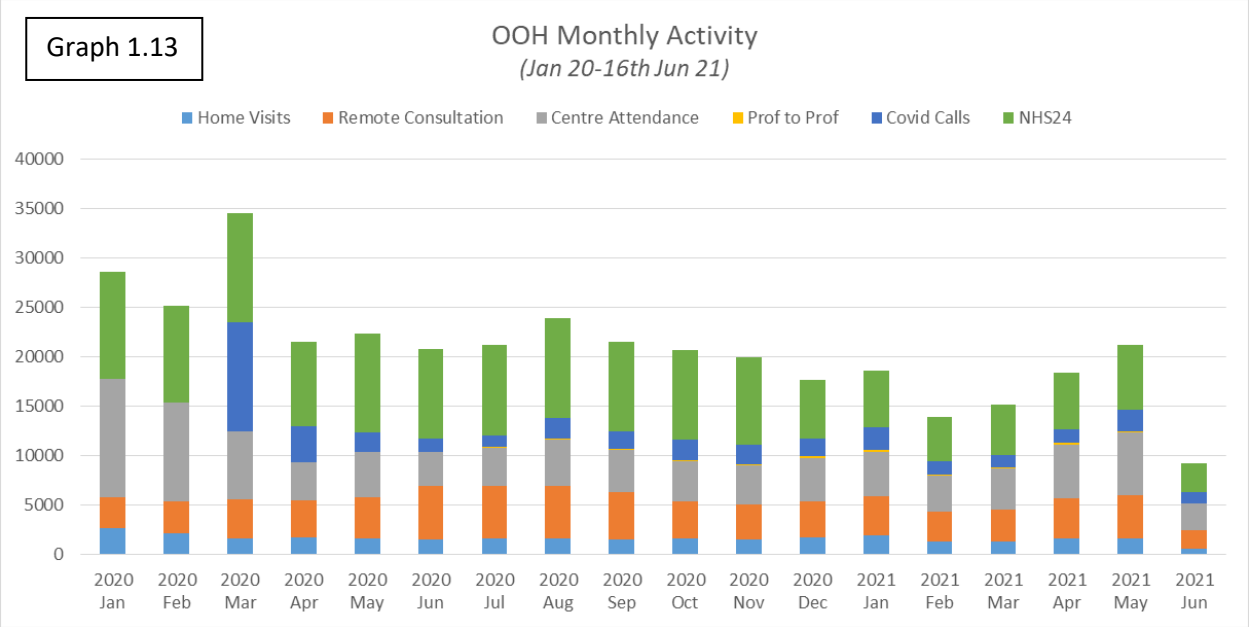
Graph 1.12 below reports the weekly GP OOH's activity week ending 04/04/2021 to 13/06/2021

Graph 1.12



The annual picture for GPOOH's from March 2020 to date is provided below in Graph 1.13 and illustrates the change in service provision to incorporate the delivery of remote consultations. The GPOOH's data cannot be considered independently of the Community Assessment Centres (CAC's) as the cumulative demand is now spread across both services therefore the section to follow provides the CAC demand over similar periods

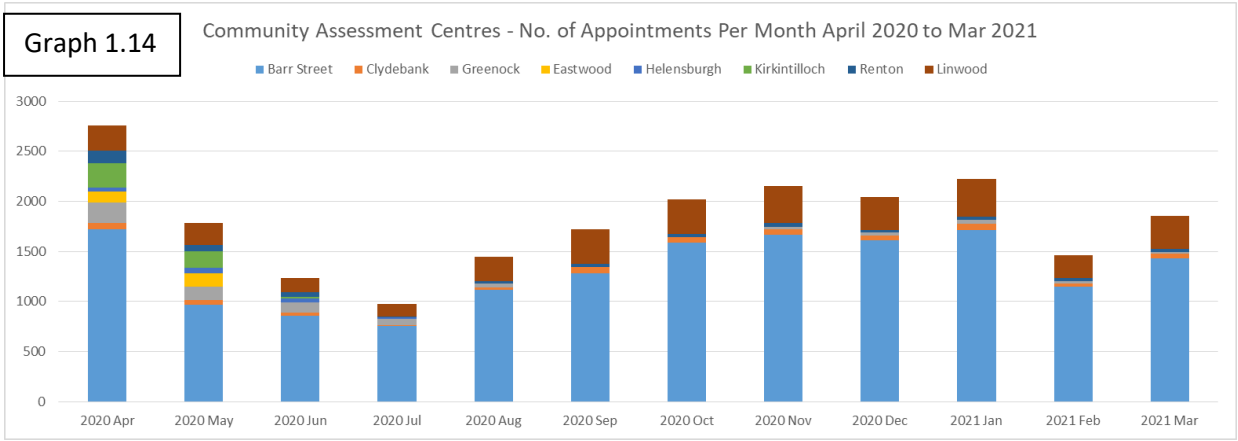
Graph 1.13



Community Assessment Centres: The CAC's were established in April to provide an alternative pathway for GP's both in and OOH's to provide assessment and treatment of patients with Covid19 symptoms.

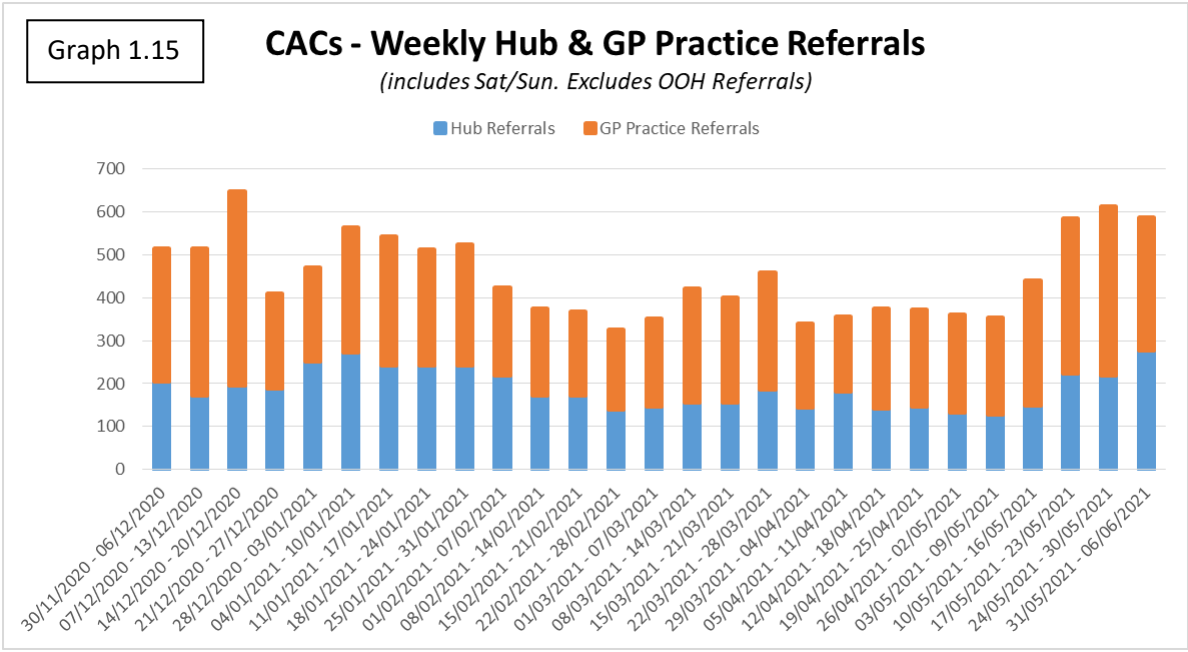
The profile of attendances in Graph 1.14 below shows peak attendance in April 2020 as the pandemic took hold and the pattern mirrors the high demand experienced during wave one, easing during the summer months when restrictions were lifted and then resumes in the autumn in line with wave two of the pandemic and plateaus in line with the prevalence of the virus during Feb and March 2021.

Graph 1.14



The weekly demand illustrated in Graph 1.15 below however reflects another step change in attendances in particular during May and June and this has been largely associated with the Delta variant and spread amongst younger age groups as lockdown eases. The position in the most recent three weeks reports weekly attendances between 550 and 600 and these numbers are similar to the wave two peak in autumn 2020.

Graph 1.15

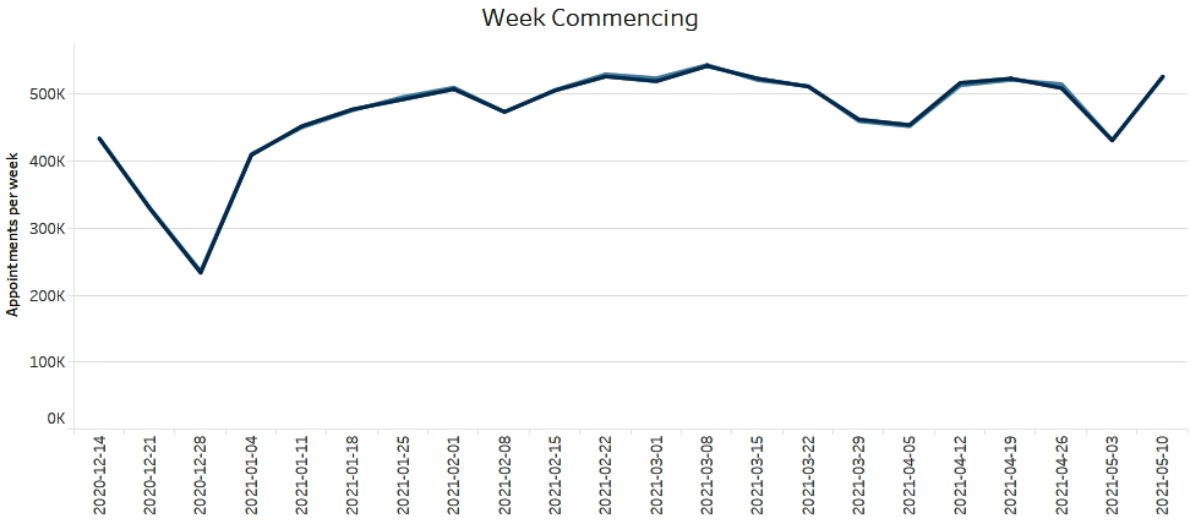


Primary Care: In the absence of available NHSGGC data we have used a combination of both the nationally published GP demand profile and an extract from two practices within NHSGGC who have shared their local data with us to support the analysis.

The latest national figures were published on 21st June 2021 using data collection from a sample of practices. Graph 1.16 below shows a continuing upward trend in overall appointment in the period between December 2020 and May 2021 and further narrative published reports an increase in the proportion of face to face appointments. The figure of around 500,000 appointments per week for Scotland is equivalent to approximately 115,000 weekly appointments for NHSGGC.

Graph 1.16

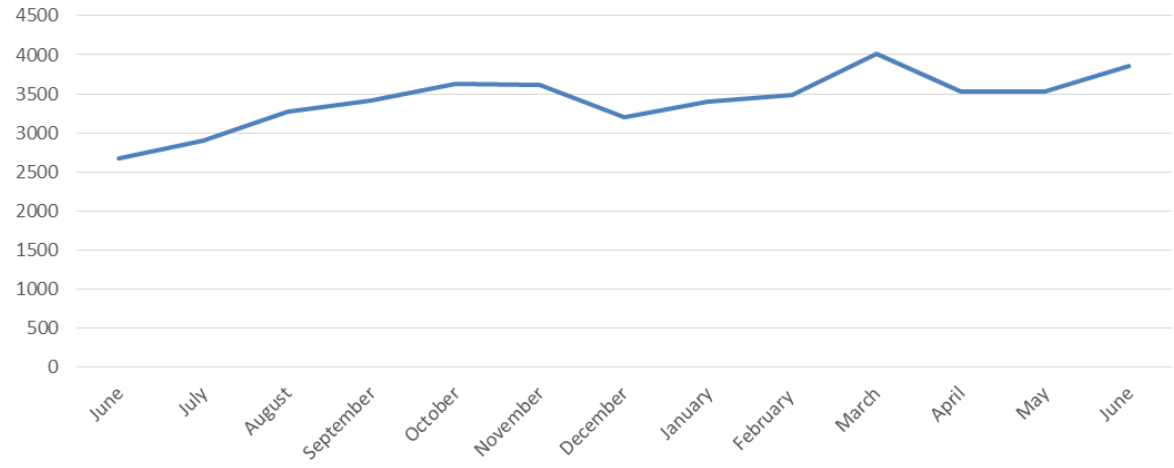
GP Activity Survey
Estimated number* of appointments in Scotland



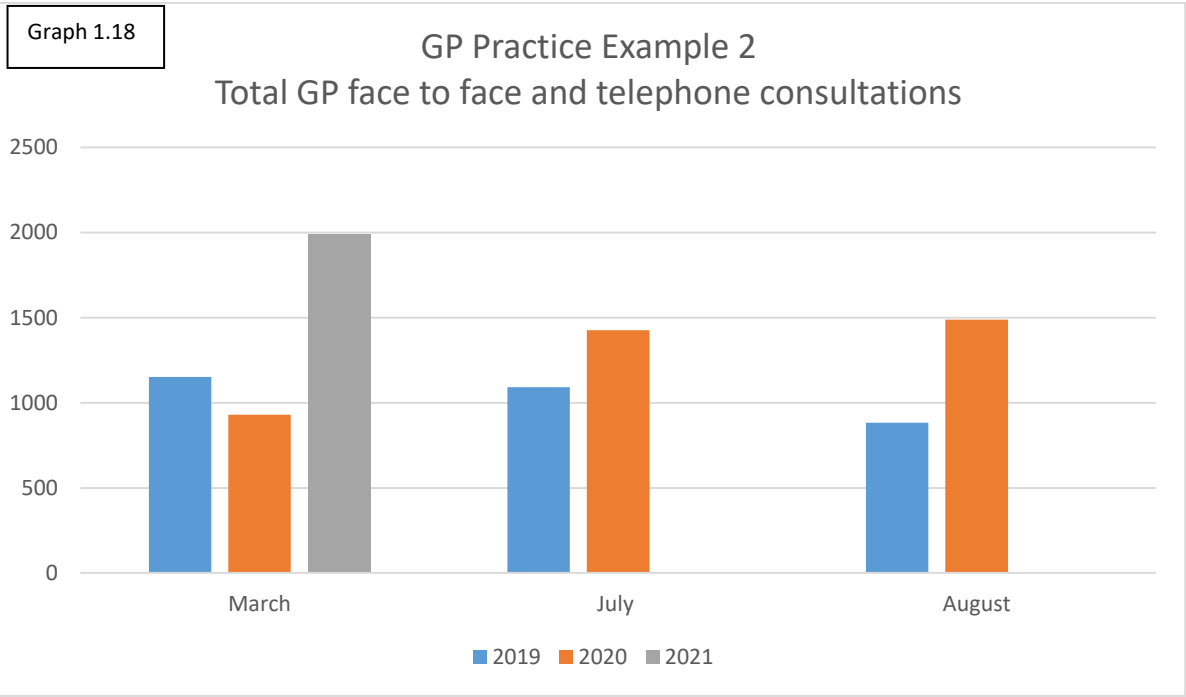
*NB data for weeks at Christmas, Easter and early May include public holidays so weekly activity is over 3-4 days

Graph 1.17 – Practice 1 trend over the past 12 months illustrating that the increase in activity last winter has been sustained into the spring and early summer. Graph 1.15 – Practice 2 showing significant growth in appointments since March 2019.

Graph 1.17



Graph 1.18



In summary there is evidence of demand reaching pre pandemic levels albeit it is too early to understand or predict the levels of variation being experienced across the full range of service. Clearly the new services such as the FNC and MHAU are designed to divert previously identified demand to alternatives however at this stage we are unable to conclude if these are new presenations or replacements for what may have been previous emergency demand.

The service configuration remains challenging as we continue to deliver Covid19 amd Non Covid pathways and adds a layer of complexity to managing patient flow in and out of all servces.

Our next steps will be to review the acute hospital occupancy levels and the length of stay to see if there have been any comparable changes to these as a measure of the level of demand on urgent care services across the system.

ANNEX D

Design & Delivery Plan Actions

Phased Delivery Matrix

Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions (Phased)		Phase 1&2 (21/23)	Work Stream or Programme to Progress	Phase 3 (22/23)	D&D Plan Section Reference
Communications					
1	We will take forward a major campaign across a range of media to better inform the public about which service to access for what and when. The campaign will also raise awareness about issues such as anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services		Communication & Engagement		**6**
Prevention & Early Intervention					
2	We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions		Anticipatory Care Planning Work Stream		**5.7**
3	We will work with the SAS and patient groups to develop a care pathway to safely manage the care of patients who have had a fall but do not need to be seen in an A&E department		Falls Prevention & Management Work Stream		**5.7**

Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions (Phased)		Phase 1&2 (21/23)	Work Stream or Programme to Progress	Phase 3 (22/23)	D&D Plan Section Reference
4	We will through the frailty collaborative develop an integrated frailty pathway with secondary care, GPs and community teams to provide alternatives to hospital or to reduce length of stay for patients admitted with frailty and that contributes to a reduction in emergency admissions		Progressed via: National Redesign Of Urgent Care Programme and GGC Falls & Frailty Programme		**5.7**
5	We will increase support to carers as part of implementation of the Carer's Act		via HSCP Carers' Strategy		
6	We will increase the number of community links workers working with Primary Care to 50 by the end of 20/21		via HSCP Primary Care Improvement Plans		
7	We will develop integrated pathways for the top six conditions most associated with admission to hospital with the aim of better supporting patients in the community		To be developed		
8	We will develop a range of alternatives to admission for GPs such as access to consultant advice, access to diagnostics and "hot clinics" e.g. community respiratory team advice for COPD and promote consultant connect - that enable unscheduled care to be converted into urgent planned care wherever possible		Redesign of Urgent Care		

Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions (Phased)		Phase 1&2 (21/23)	Work Stream or Programme to Progress	Phase 3 (22/23)	D&D Plan Section Reference
9	We will further develop access to "step up" services for GPs as an alternative to hospital admission		Co-ordination & Integration of Community Models		
10	We will continue the work with the independent sector, GPs and others to further reduce avoidable emergency department attendances and admissions from care homes		Co-ordination & Integration of Community Models Falls Prevention & Management		
11	We will explore extending the care home local enhanced service to provide more GP support to care homes		Led by Primary Care		
Primary Care & Secondary Care Interface					
12	We will develop and apply a policy of re-direction to ensure patients see the right person in the right place at the right time		Redesign of Urgent Care		
13	We will test a service in Emergency Departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service		Redesign of Urgent Care		
14	To improve the management of minor injuries and flow within Emergency Departments and access for patients, separate and distinct minor injury units (MIUs) will be established at all main acute sites		Redesign of Urgent Care		
15	We will incentivise patients to attend MIUs		Redesign of Urgent Care		

Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions (Phased)		Phase 1&2 (21/23)	Work Stream or Programme to Progress	Phase 3 (22/23)	D&D Plan Section Reference
	rather than A&E with non-emergencies through the testing of a tow hour treatment target.				
16	We will explore extending MIU hours of operation to better match demand		Redesign of Urgent Care		
17	We will improve urgent access to mental health services		Redesign of Urgent Care		
18	We will reduce the number of A&E attendances accounted for by people who have attended more than five times in the previous twelve months equivalent to 2% of total attendances.		Multiple work streams		
19	We will reduce the number of people discharged on the same day from GP assessment units through the implementation of care pathways for high volume conditions such as deep vein thrombosis and abdominal pain. To enable this we will review same day discharges and signpost GPs to non-hospital alternatives that can be accessed on a planned basis		Redesign of Urgent Care		
20	We will develop hospital at home approaches that strengthen joint working between consultant geriatricians and GPs in order to better support patients in the community at most at		Integrated Pathways for Older People 3. Hospital @ Home		

Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions (Phased)		Phase 1&2 (21/23)	Work Stream or Programme to Progress	Phase 3 (22/23)	D&D Plan Section Reference
	risk of admission to hospital. Specific populations will be prioritised, including care home residents and people with frailty. (PILOT ONLY)				
21	Improving access and waiting times for scheduled care at QEUH and GRI to reduce the time patients are waiting for procedures and thereby the likelihood of them attending A&E		Redesign of Urgent Care		
Improving Discharge					
22	We will work with acute services to increase by 10% the number of discharges occurring before 12:00 noon and at weekends and during peak holiday seasons, including public holidays		Discharge to Assess Frailty @ the Front Door Co-ordination & Integration of Community Models		
23	Working closely with acute teams, HSCP staff will proactively begin care planning as soon as possible after a patient is admitted to hospital with the aim of expediting discharge at the earliest opportunity once the person it medically fit.		Discharge to Assess Frailty @ the Front Door Co-ordination & Integration of Community Models		
24	We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement in an effort to optimise efficient and effective use of these		Co-ordination and Integration of Community Models		

Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions (Phased)		Phase 1&2 (21/23)	Work Stream or Programme to Progress	Phase 3 (22/23)	D&D Plan Section Reference
	resources which are critical to the overall acute system performance				
25	We will reduce delayed discharges so that the level of delays accounts for approximately 2.5-3.0% of total acute beds, and bed days lost to delays is maintained within the range of 37,00-40,000 per year				

ANNEX E

GP ENGAGEMENT SESSIONS 2020

SUMMARY FEEDBACK

- resounding support for the proposed campaign to support public education although there was concern that if not framed appropriately and supported by strong redirection policy with well trained staff this could result in more demand for GPs;
- undifferentiated care demand in primary care needs to be reflected although it is recognised that data to support this is lacking;
- links with the GP Contract and PCIP should be made within the JCP and opportunities to develop new pathways considered in collaboration;
- opportunity to develop links with JCP actions and the objectives within the PCIP MOU considering the benefits of resources such as link workers, ANPs, physiotherapy etc. Pharmacy First Plus to support right person, right place, right time;
- a willingness to embrace data if this can be provided e.g. variation in ED attendances by practice, MAU same day discharge. Discussions could be facilitated at cluster level;
- data on the use of Consultant Connect and professional to professional advice with GPs to allow them to understand outcomes achieved, calls answered etc. may help to improve the service provided;
- engagement with Acute Sectors varies, there is an opportunity to review the current situation with a view to understanding what works well and seeking to roll this out across all three acute sectors;
- GP input to further scoping and development of the ACP/KIS approach along with other stakeholders;
- a number of acute processes have been highlighted as problematic, these can be shared and opportunities to collaborate to improve explored; and,
- future GP engagement is welcomed.

ANNEX F

Unscheduled Care : Financial Framework		Total					
		2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Phase 2							
Communications							
1	We will take forward a major campaign across a range of media to better inform the public about which service to access for what and when. The campaign will also raise awareness about issues such as anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.	£0	£111,000	£25,000	£0	£0	£136,000
Prevention & Early Intervention							
2	We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions.	£0	£52,939	£142,333	£0	£0	£195,272
3	We will work with the SAS and patient groups to develop a care pathway to safely manage the care of patients who have had a fall but do not need to be seen in an A&E department.	£0	£33,696	£33,696	£0	£0	£67,392
4	We will through the frailty collaborative develop an integrated frailty pathway with secondary care, GPs and community teams to provide alternatives to hospital or to reduce length of stay for patients admitted with frailty and that contributes to a reduction in emergency admissions.	£0	£179,374	£357,855	£54,080	£0	£591,309
5	We will increase support to carers as part of implementation of the Carer's Act.	£0	£0	£0	£0	£0	£0
6	We will increase the number of community links workers working with Primary Care to 50 by the end of 20/21.	£0	£0	£0	£0	£0	£0
9	We will further develop access to "step up" services for GPs as an alternative to hospital admission.	£0	£37,733	£263,553	£0	£0	£301,287
10	We will continue the work with the independent sector, GPs and others to further reduce avoidable emergency department attendances and admissions from care homes.	£0	£1,270,591	£90,480	£0	£0	£1,361,071
Primary Care & Secondary Care Interface							
12	We will develop and apply a policy of re-direction to ensure patients see the right person in the right place at the right time.	£0	£702,000	£0	£0	£0	£702,000
13	We will test a service in Emergency Departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service.	£0	£2,448,289	£0	£0	£0	£2,448,289
14	To improve the management of minor injuries and flow within Emergency Departments and access for patients, separate and distinct minor injury units (MIUs) will be established at all main acute sites.	£0	£700,000	£5,000	£0	£0	£705,000
17	We will improve urgent access to mental health services.	£0	£982,848	£0	£0	£0	£982,848
20	We will develop hospital at home approaches that strengthen joint working between consultant geriatricians and GPs in order to better support patients in the community at most at risk of admission to hospital. Specific populations will be prioritised, including care home residents and people with frailty. (PILOT ONLY - SOUTH).	£0	£570,322	£291,860	£0	£0	£862,182

Unscheduled Care : Financial Framework		Total					
		2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Primary Care & Secondary Care Interface							
21	Improving access and waiting times for scheduled care at QEUH and GRI to reduce the time patients are waiting for procedures and thereby the likelihood of them attending A&E	£0	£20,000,000	£0	£0	£0	£0
Improving Discharge							
23	Working closely with acute teams, HSCP staff will proactively begin care planning as soon as possible after a patient is admitted to hospital with the aim of expediting discharge at the earliest opportunity once the person it medically fit.	£0	£0	£200,000	£200,000	£0	£400,000
24	We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.	£0	£10,000	£99,040	£0	£0	£109,040
Total		**£0**	**£7,098,793**	**£1,508,818**	**£254,080**	**£0**	**£8,861,691**

	2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Recurring	£0	£6,311,171	£971,958	£54,080	£0	£7,337,209
Non Recurring	£0	£20,787,622	£536,860	£200,000	£0	£21,524,482
Total	**£0**	**£27,098,793**	**£1,508,818**	**£254,080**	**£0**	**£28,861,691**

Funding : Recurring Expenditure	2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Mental Health Assessment Unit - LMP/Additional Scottish Government Funding (to be confirmed)	£0	£982,848	£0	£0	£0	£982,848
Scottish Government Funding : HB	£0	£2,221,252	-£2,221,252	£0	£0	£0
HB Budget	£0	£779,000	-£779,000	£0	£0	£0
IJB Budget	£0	£1,124,896	£304,219	£0	£0	£1,429,115
PCIP Funding	£0	£292,172	£0	£0	£0	£292,172
Total Funding Recurring	**£0**	**£5,400,168**	**-£2,696,033**	**£0**	**£0**	**£2,704,135**

Funding Gap	**£0**	**£911,002**	**£3,667,991**	**£54,080**	**£0**	**£4,633,073**

Funding : Non Recurring Expenditure	2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Earmarked Reserves	£0	£20,320,000	£45,000	£0	£0	£20,365,000
Manage within HSCP Budget	£0	£242,322	£491,860	£200,000	£0	£934,182
Scottish Government Funding : HB	£0	£0	£0	£0	£0	£0
Hospital at Home Pilot Funding - HIS	£0	£175,000	£0	£0	£0	£175,000
PCIP Funding	£0	£50,300	£0	£0	£0	£50,300
Total Funding Non Recurring	**£0**	**£20,787,622**	**£536,860**	**£200,000**	**£0**	**£21,524,482**

Funding Gap	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

ANNEX G

Unscheduled Care Performance Management Framework

Proposed Key Performance Indicators (using baseline year 2018/19)

- **emergency departments attendances**:
  - delivery of the four hour target (by hospital site not HSCP)
  - total attendances by age, sex and deprivation
  - rates of attendances per head of population
  - rates of admissions and discharges per head of population
  - frequent attenders as a percentage of total attendances

- **minor injury units attendances**:
  - delivery of the four hour target (by hospital site not HSCP)
  - total attendances by age, sex and deprivation
  - rates of attendances per head of population

- **flow navigation hub performance data** (TBC)

- **GP assessment units (or equivalent)**:
  - total attendances by age, sex and deprivation
  - rates of attendances per head of population e.g. 65+ & 75+
  - rates of admissions and discharges
  - GP referral rates
  - Consultant Connect activity by practice
  - Near Me / Attend Anywhere activity

- **emergency acute hospital admissions (all admissions):**
  - admissions by age, sex and deprivation
  - rates per head of population e.g. 65+ & 75+
  - length of stay
  - rates per GP practice
  - ACPs

- **mental health assessment unit activity** (TBC)

- **acute unscheduled care bed days**:
  - rates per head of population e.g. 65+ & 75+

- **acute bed days lost due to delayed discharges**:
  - rates by age e.g. 65+ & 75+
  - AWI and non AWI rates
  - bed days lost as % of total acute beds (reported annually)

- **acute delays**:
  - total number of daily delays (by age, AWI, non AWI etc.) over the reporting period (not the census figure)
  - as above for AMH, LD and OPMH

- monthly average delay duration (in days) for AWI and non AWI over 65 and under for the reporting period
- D2A indicators

ANNEX H

EMERGENCY ADMISSIONS (65+) PROJECTIONS

2022/23-2024/25

Design and Delivery Plan Projections

NHSGGC Emergency Admissions Projections (Ages 65+)

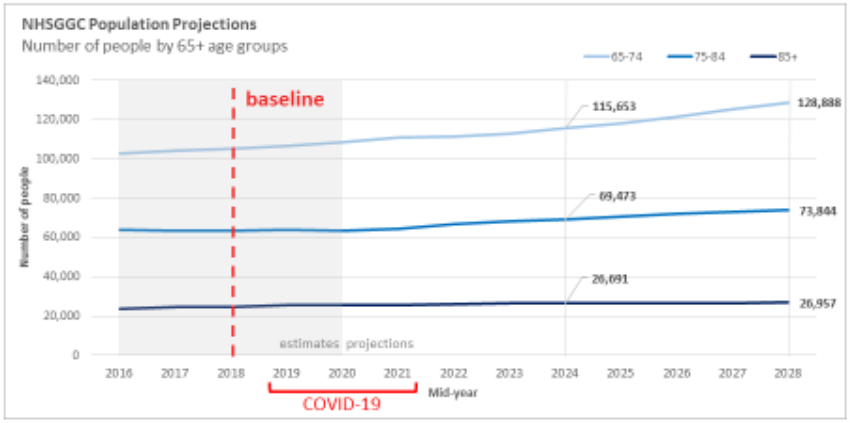
Gary King
Local Intelligence Support Team (LIST)

Public Health Scotland

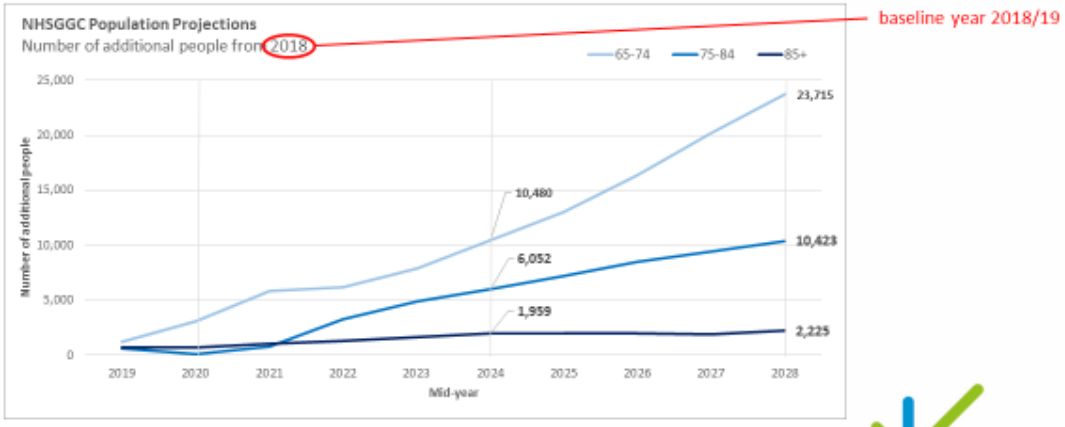
Summary

- Population Projections 2018 to 2028
  - Age groups 65-74, 75-84 & 85+
  - Age group 65+ alone
- Emergency Admissions Projections (Age 65+)
  - Actual numbers 2017/18 to 2020/21
  - Use rates per 1,000 population
  - Take into account increase in 65+ population
  - 2018/19 baseline (pre-COVID-19)
  - Use rates to propose three scenarios for 2021/22 to 2024/25
  - Taking into consideration RMP3 target for 2021/22

Population Projections
Number of people (aged 65+ groups)

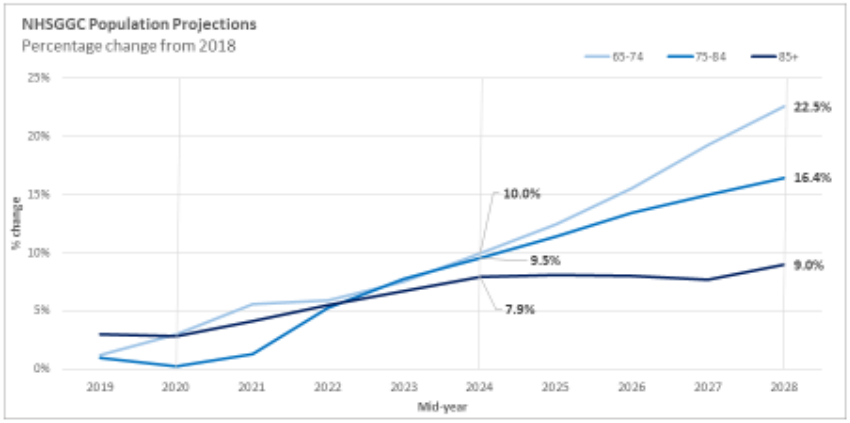


Population Projections
Number of additional people (aged 65+ groups)



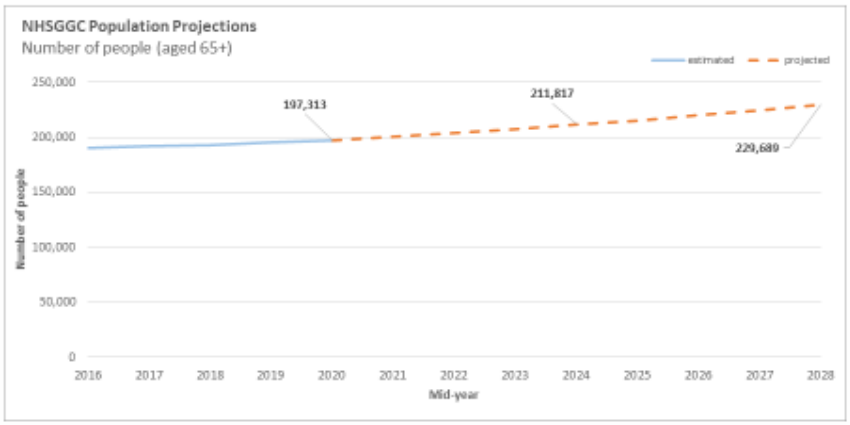
Population Projections

Percentage change from 2018 (aged 65+ groups)

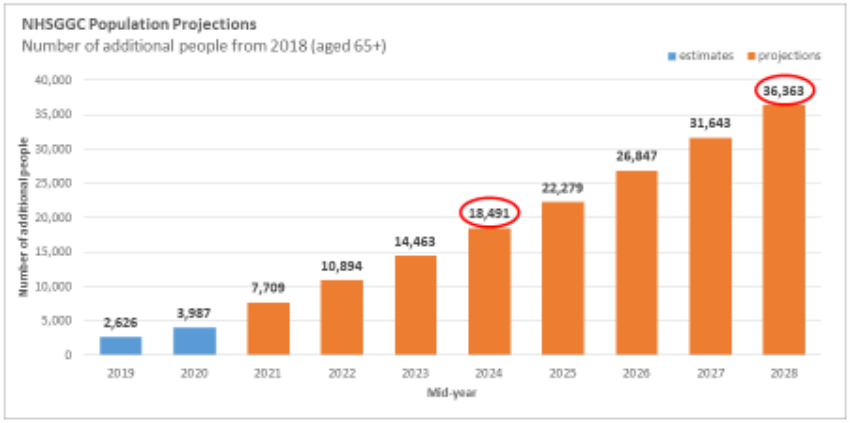


Population Projections

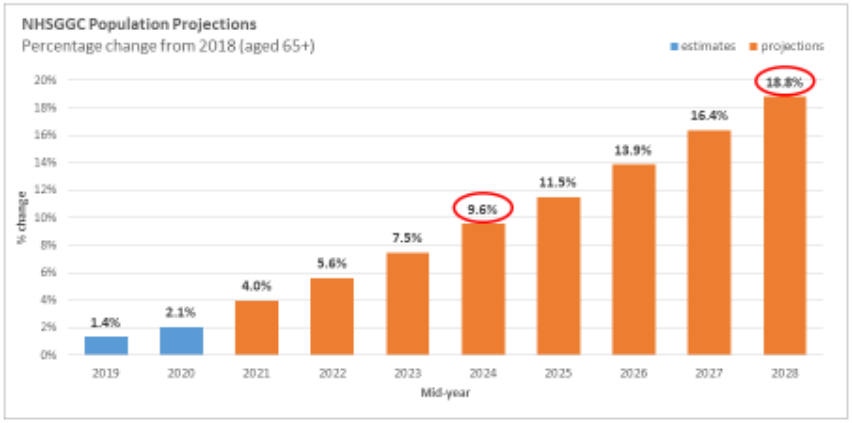
Number of people (aged 65+)



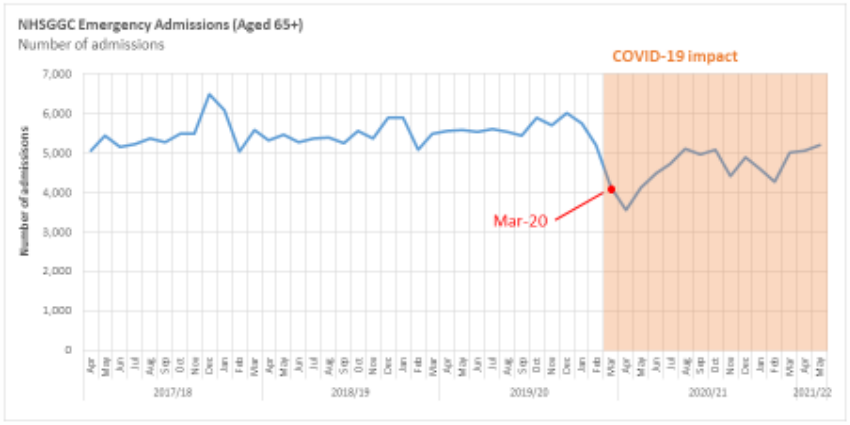
Population Projections
Additional people from 2018 (aged 65+)



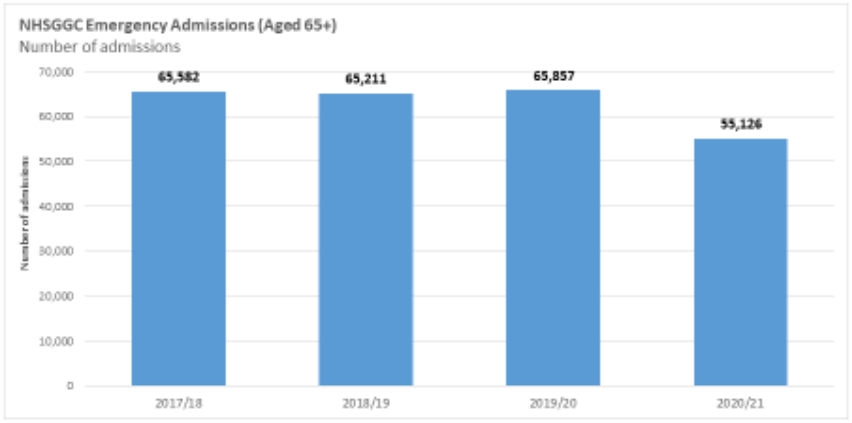
Population Projections
Change from 2018 (aged 65+)



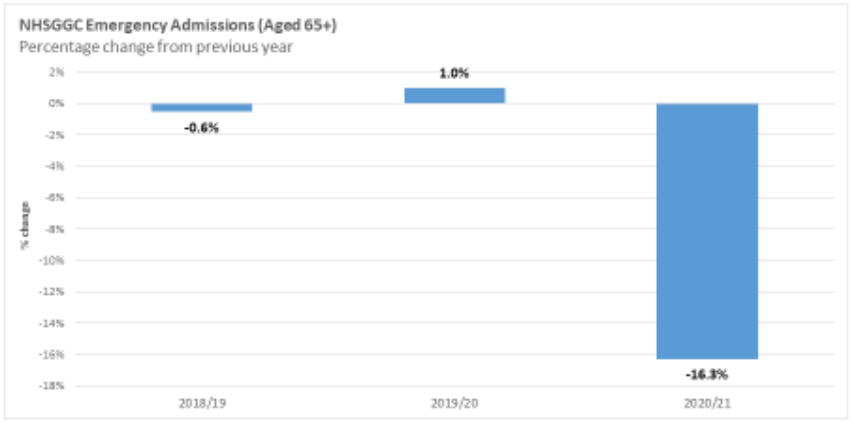
Emergency Admissions (Ages 65+)
Number of admissions



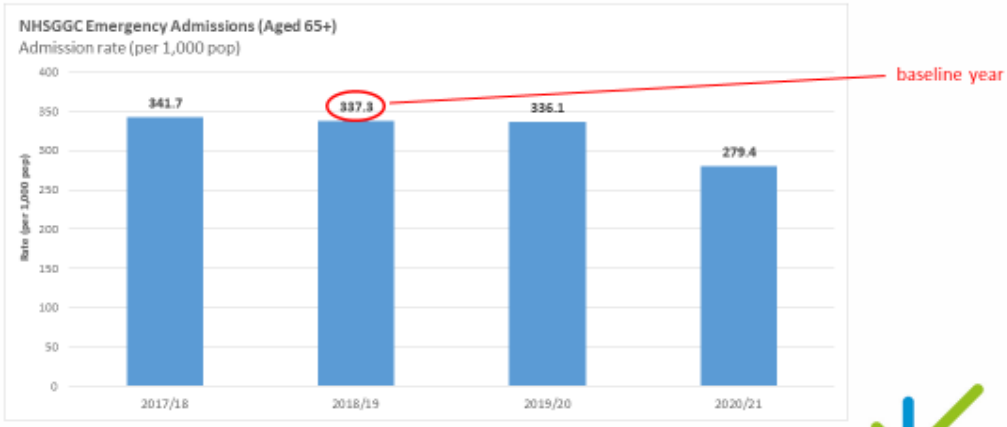
Emergency Admissions Ages 65+
Number of admissions



Emergency Admissions Ages 65+
% change from previous year



Emergency Admissions Ages 65+
Admission rates (per 1,000 population)



Emergency Admissions Ages 65+
Projection Scenarios

Scenario 1

No implementation ⇨ No reduction in 2018/19 baseline rate

Scenario 2

Partial implementation ⇨ 5% reduction

Scenario 3

Full implementation ⇨ 10% reduction

RMP3 is a 14.2% reduction

⇨ While factoring in RMP3 targets for 2021/22

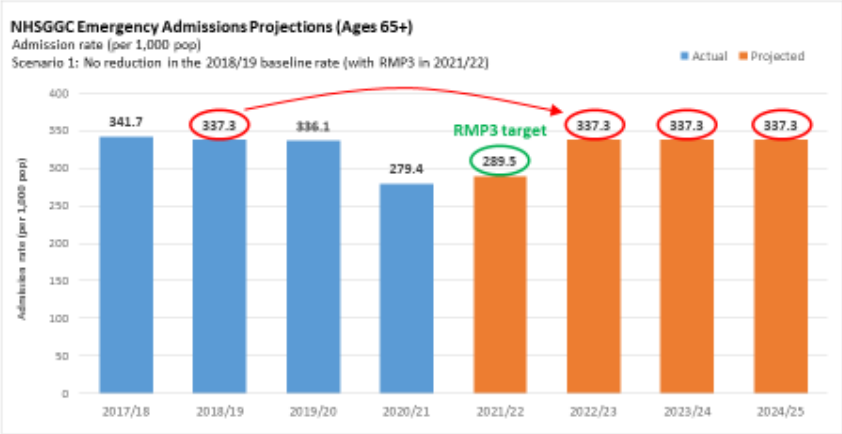
RMP3 target 2021/22:
138,594 (All ages)

Estimate for ages 65+:
138,594 x 42%
= 58,209

Ratio of EAs:
Age 65+ / All ages

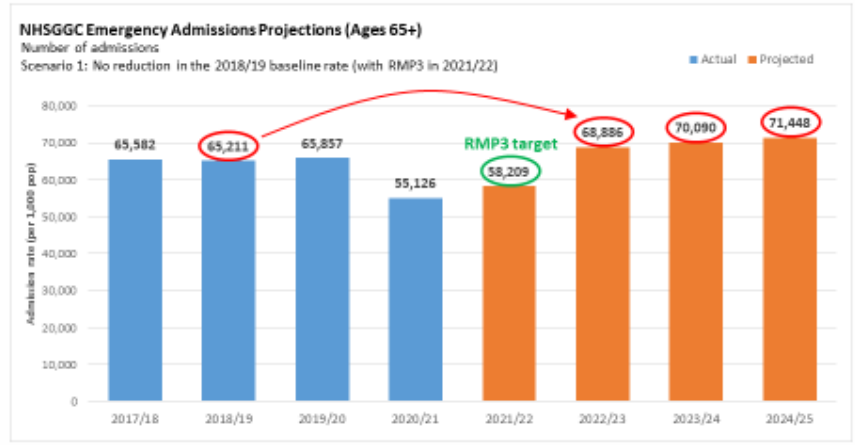
Scenario 1: No reduction in 2018/19 baseline (no implementation)

Admission rates (per 1,000 population)



Scenario 1 No reduction in 2018/19 baseline (no implementation)

Number of Admissions

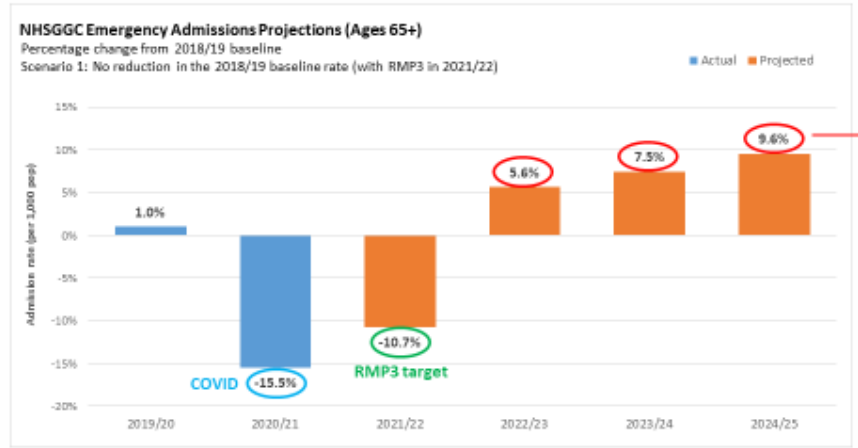


RMP3 target 2021/22:
138,594 (All ages)

Estimate for ages 65+:
138,594 x 42%
= 58,209

Scenario 1: No reduction in 2018/19 baseline (no implementation)

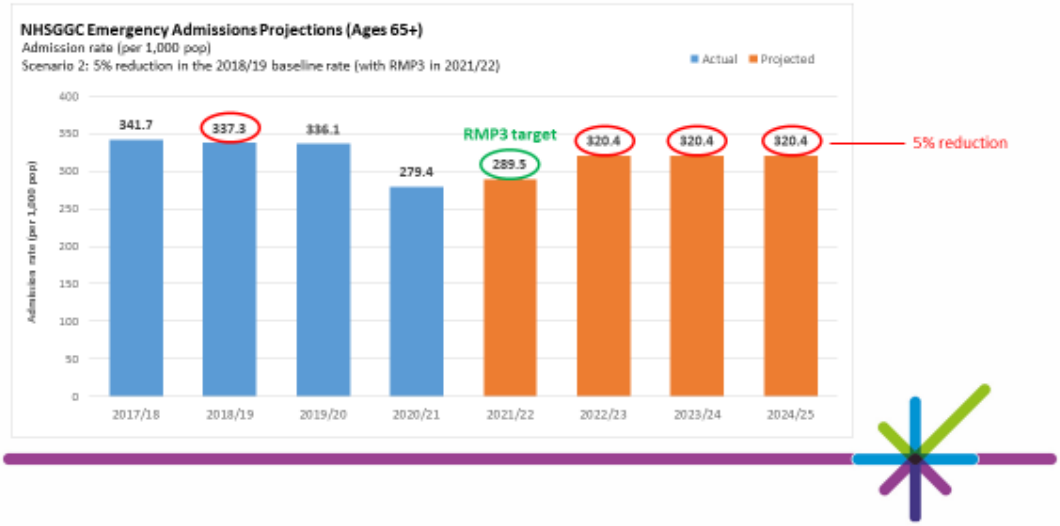
Percentage change from 2018/19 baseline



Increase solely due to the 65+ projected population increase

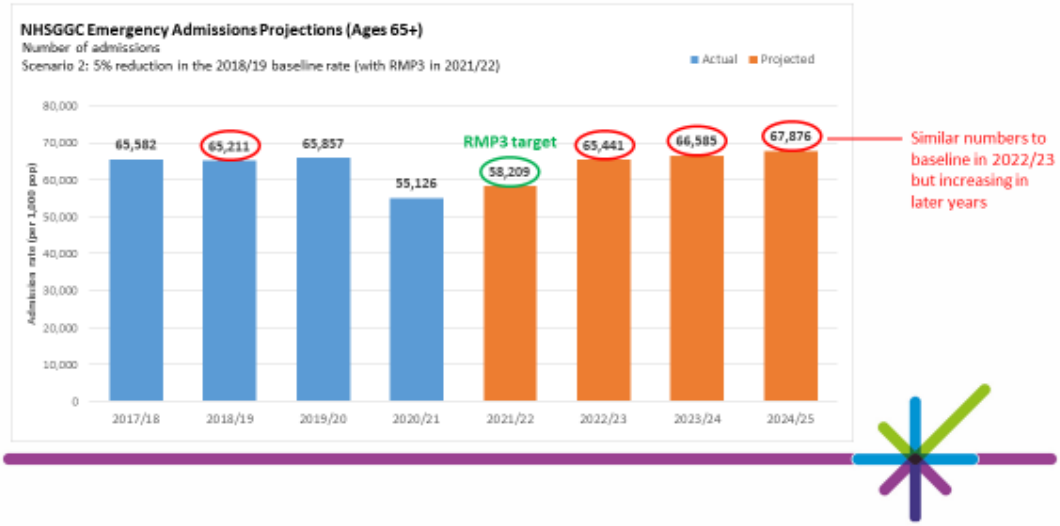
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Admission rates (per 1,000 population)



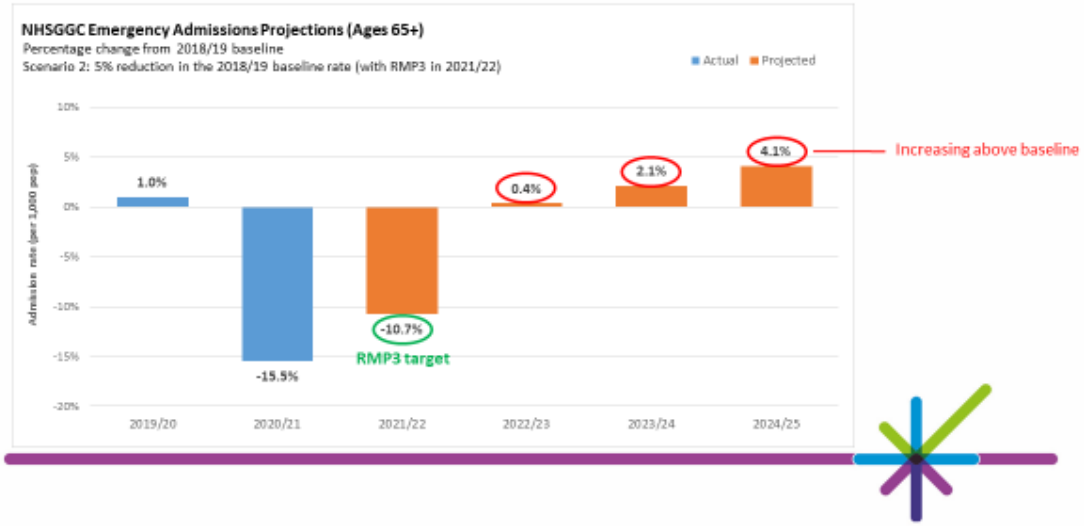
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Number of Admissions



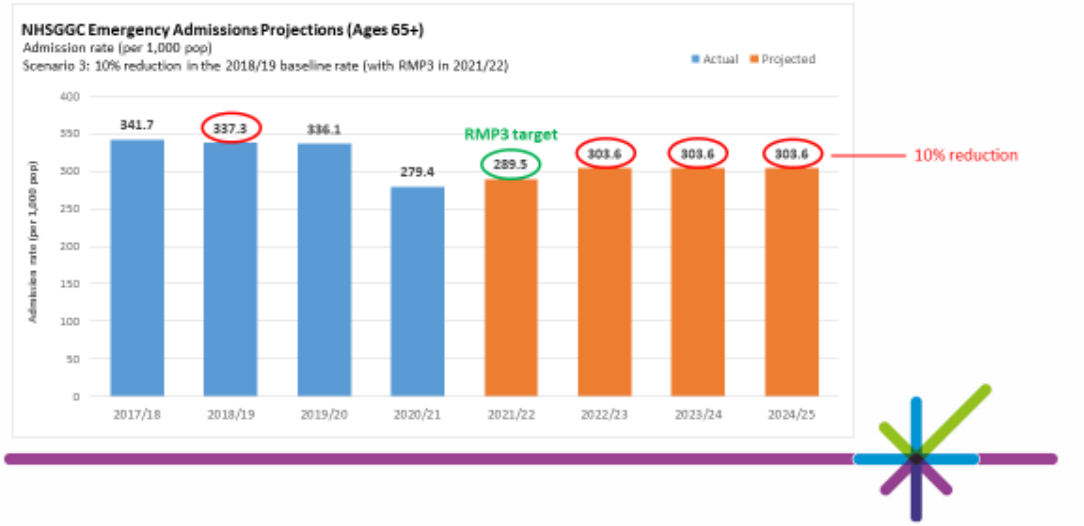
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Percentage change from 2018/19 baseline



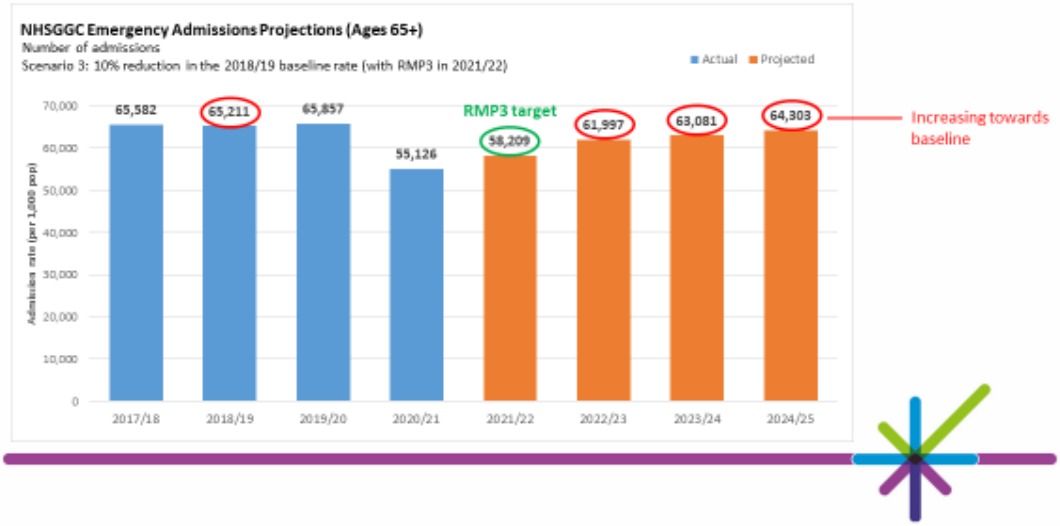
Scenario 3: 10% reduction in 2018/19 baseline (full impl.)

Admission rates (per 1,000 population)



Scenario 3: 10% reduction in 2018/19 baseline (full impl.)

Number of Admissions



Scenario 3: 10% reduction in 2018/19 baseline (full impl.)

Percentage change from 2018/19 baseline