INVERCLYDE HSCP Health and Social Care Partnership

**AGENDA ITEM NO: 7**

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|---|---|---|---|
| **Report To:** | **Inverclyde Integration Joint Board** | **Date:** | **21 March 2022** |
| **Report By:** | **Allen Stevenson Interim Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership** | **Report No:** | **IJB/15/2022/AB** |
| **Contact Officer:** | **Alan Best, Head of Health and Community Care** | **Contact No:** | **01475 715212** |
| **Subject:** | **UNSCHEDULED CARE COMMISSIONING PLAN (DESIGN & DELIVERY PLAN 2022/23 – 2024/25)** | | |

## 1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board and ask for approval of the refreshed NHS Greater Glasgow & Clyde Board Wide strategic Unscheduled Care Commissioning Design and Delivery Plan.

## 2.0 SUMMARY

2.1 The Unscheduled Care Programme contributes to all nine national outcomes, and in particular is fundamental to the delivery of outcome nine: that resources are used effectively and efficiently in the provision of health & social care services.

2.2 The Plan ensures that Inverclyde HSCP along with other GG&C HSCP's, NHS Boards, Local Authorities and other care providers make full use of their powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning service provision across acute and community services.

2.3 Section 7 of the Plan outlines the financial framework to deliver against the phased approach and highlights a funding gap between the current available financial resources and the funding required to deliver the program.

## 3.0 RECOMMENDATIONS

3.1 The Integration Board is asked to approve the Design & Delivery Plan 2022/23 – 2024/25 attached in Appendix 1 as the updated and re-freshed Board Wide Unscheduled Care Improvement Programme and note that the Programme is iterative and will evolve and further develop over time.

3.2 The Integration Board is asked to approve the financial framework outlined in section 7 of the updated plan and the IJB is asked to note the funding gap for Inverclyde HSCP is £181,720.

3.3 The Integration Board is asked to note the performance arrangements to report on and monitor progress towards delivery of the Plan and receive a further update on the delivery of the Programme towards the end of 2022/23. All six Integration Joint Boards are receiving similar updates.

## 4.0 BACKGROUND

4.1 The previous Unscheduled Care Plan was previously approved by the all GG&C HSCPs in 2021. The Plan was developed in partnership with the NHS Board and Acute Services Division and built on the Board's Programme (http://www.nhsggc.org.uk/media/245268/10-unscheduled-care-update.pdf.) which was integral to the Board-wide Moving Forward Together Program: (https://www.nhsggc.org.uk/media/251904/item-10a-paper-18_60-mft-update.pdf).

4.2 Since the original Plan was developed in early 2020 there has been considerable change in the health and social system overall as a result of the Coronavirus pandemic. While many of the actions in the draft Plan approved by IJBs remain relevant, some needed 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 is Scotland's biggest, most complex and diverse health and social care economy, with many moving and inter-related parts

4.3 The purpose of the plan is to show how we aim to respond to the pressures on health and social care services across GG&C and meet future demand. The Plan explains 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, with services that were more clearly integrated and with better public understanding. In addition further work has been undertaken on engagement and the development and performance frameworks to support delivery of the Programme overall.

4.4 The Programme outlined in the Plan is 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.

4.5 The final Design & Delivery Plan attached updates the actions in the draft unscheduled care plan reported previously to the IJB. The re-freshed 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).

4.6 An updated action Plan is included in Annex C, and revised performance trajectories included. It is projected that the overall impact of the programme on emergency admissions (65+) taking account of future population increases and current trends, as currently funded, has the potential to reduce emergency admissions for over 65s by 5% during 2022/23.

4.7 A financial framework has been developed in partnership with all six IJBs across 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 2022/23 cost base. We will develop a performance dashboard for use within the delivery plan.

4.8 The investment required to deliver on Phase 1 priorities has been fully costed and is included in the Financial Framework (see annex D of the Design and Delivery Plan). This highlights the need for £37.000m of investment across Greater Glasgow and Clyde, of which £14.998m is required on a recurring basis and £22.002m 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. Of the recurring funding of £14.822m required, only £8.864m of funding has been able to be identified on a recurring basis. £1.273m of the funding gap relates to MHAU's for which recurring funding is still to be put in place by Scottish Government. The remaining funding gap recognises the challenge which all IJBs and

the Health Board have had in securing full funding for Phase 1. This has implications for the delivery of the plan, even for Phase 1, with actions not able to be fully implemented in all IJBs until funding is secured.

4.9 Funding requirements for Phase 1 implementation in Inverclyde HSCP shows a funding shortfall of £181,720 contained within Annex D, (with the exception of the funding for the Mental Health Assessment Units). Recurring funding from the Scottish Government continues to be pursued for these. Phase 2 and 3 will be costed fully as tests of change and work streams will develop their proposals. Some actions in Phase 2 and 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 2 and 3. Details can be found in the Design and Delivery Plan and specifically Annex D.

## 5.0 IMPLICATIONS

### Finance

5.1 Financial Implications:

One off Costs

| Cost Centre | Budget Heading | Budget Years | Proposed Spend this Report | Virement From | Other Comments |
|---|---|---|---|---|---|
| | | | | | |

Annually Recurring Costs/ (Savings)

| Cost Centre | Budget Heading | With Effect from | Annual Net Impact | Virement From (If Applicable) | Other Comments |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

### Legal

5.2 None

### Human Resources

5.3 None

### Equalities

5.4 This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy, therefore, no Equality Impact Assessment is required.

(a) Has an Equality Impact Assessment been carried out?

| | |
|---|---|
| | YES (see attached appendix) |
| X | NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required |

5.5 How does this report address our Equality Outcomes?

| Equalities Outcome | Implications |
|---|---|
| People, including individuals from the above protected characteristic groups, can access HSCP services. | Protects characteristic groups |
| Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated. | Reduces discrimination |
| People with protected characteristics feel safe within their communities. | Protects communities |
| People with protected characteristics feel included in the planning and developing of services. | Promotes inclusion |
| HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do. | Promotes diversity |
| Opportunities to support Learning Disability service users experiencing gender based violence are maximised. | Protects communities |
| Positive attitudes towards the resettled refugee community in Inverclyde are promoted. | Protects communities |

**CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

5.6 There are no clinical or care governance implications arising from this report.

**NATIONAL WELLBEING OUTCOMES**

5.7 How does this report support delivery of the National Wellbeing Outcomes?

| National Wellbeing Outcome | Implications |
|---|---|
| People are able to look after and improve their own health and wellbeing and live in good health for longer. | N/A |
| People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community | N/A |
| People who use health and social care services have positive experiences of those services, and have their dignity respected. | Promotes positive experiences |
| Health and social care services are centred on helping to maintain or | Improves quality of lives |

| | |
|---|---|
| improve the quality of life of people who use those services. | |
| Health and social care services contribute to reducing health inequalities. | Contributes to reducing health inequalities |
| People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing. | Supports carers |
| People using health and social care services are safe from harm. | Protects communities |
| People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. | Promotes inclusion |
| Resources are used effectively in the provision of health and social care services. | Promotes best use of resources. |

(b) Fairer Scotland Duty

If this report affects or proposes any major strategic decision:-

Has there been active consideration of how this report's recommendations reduce inequalities of outcome?

| | |
|---|---|
| | YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed. |
| X | NO – This report does not affect or propose any major strategic decision. |

(c) Data Protection

Has a Data Protection Impact Assessment been carried out?

| | |
|---|---|
| X | YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals. A DPIA has been carried out as part of the procurement process. |
| | NO |

## 6.0 DIRECTIONS

6.1

| **Direction Required to Council, Health Board or Both** | Direction to: | |
|---|---|---|
| | 1. No Direction Required | x |
| | 2. Inverclyde Council | |
| | 3. NHS Greater Glasgow & Clyde (GG&C) | |
| | 4. Inverclyde Council and NHS GG&C | |

## 7.0 CONSULTATIONS

7.1 The Interim Head of Legal and Democratic Services and the Corporate Procurement Manager have been consulted on the terms of this report.

## 8.0 BACKGROUND PAPERS

8.1 Un-scheduled Care Commissioning Plan (Design & Delivery Plan 2022/23 -2024/25) - Version 6 -14.03.2022

8.2 Un-scheduled Care Commissioning Plan (Design & Delivery Plan 2022/23 -2024/25**) –**Annexes A-F

# NHS GREATER GLASGOW & CLYDE

# UNSCHEDULED CARE JOINT COMMISSIONING PLAN

# DESIGN & DELIVERY PLAN 2022/23-2024/25

**March 2022**

## 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.**

**The legislation requires the IJB and Health Board to put in place arrangements to support set aside arrangements for unscheduled care, and is subject to external assessment. The Unscheduled Care Commissioning Plan delivers a joint strategic commissioning approach to unscheduled care which will deliver on the intentions of the legislation. This plan 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 in 2020 and takes account of the impact of COVID-19. Our objective in refreshing 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.**

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## 1. PURPOSE

1.1 The purpose of this plan 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 2022/23-2024/25.

## 2. INTRODUCTION

2.1 This plan updates the draft Joint Strategic Commissioning Plan approved by Integration Joint Boards (IJBs) last year and (https://glasgowcity.hscp.scot/sites/default/files/publications/ITEM%20No%2012%20-%20Draft%20Unscheduled%20Care%20commissioning%20Plan.pdf. takes into account the impact of the Coronavirus pandemic, including the delivery of 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[1] 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. The combination of reduced demand as a result of COVID-19 and new or redesigned services introduced has resulted in an improvement in performance against the four hour standard reporting 92.0% for 2020/21. Section 4 and annex A and B shows performance pre, during and post pandemic and illustrates that although demand reduced during the pandemic there is evidence that demand is on a rapid trajectory towards pre pandemic levels.

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

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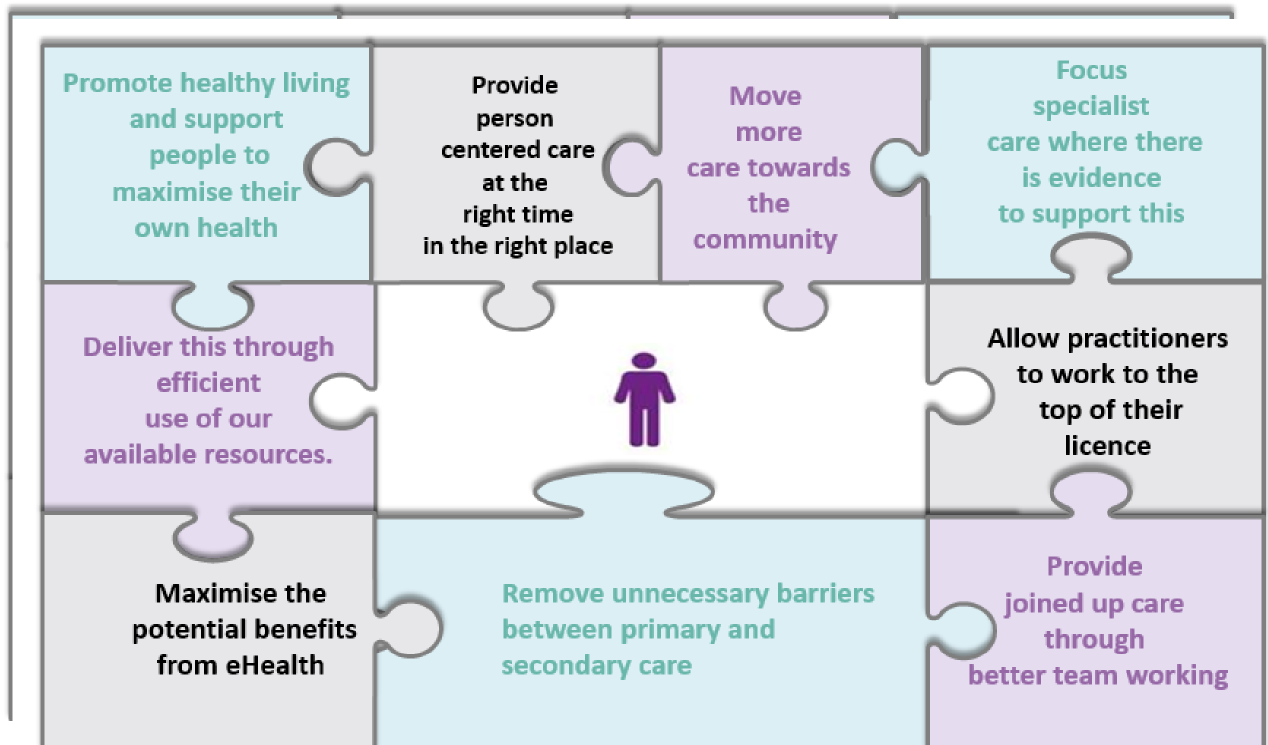
[1] 2019/20 has been used as the baseline year for this plan as it was the last full year before activity levels were affected by the pandemic

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 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.

2.8 The remainder of this Design and Delivery plan :

- updates on progress against the actions in the draft programme agreed by IJBs;
- reflects on the impact of the pandemic on unscheduled care activity;
- updates on what was delivered in 2020 including the national redesign of urgent care;
- describes the re-freshed programme to be continued, and the content of the design and delivery phases;
- explains our proposals for ongoing engagement with clinicians, staff, patients and carers;
- outlines the performance and financial framework to support the delivery; and,
- describes 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 was based on the best available evidence of what works[2]. As a result the plan 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.

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[2] *Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.*

## 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 2022 is significantly different from that in 2019 or early 2020. The data presented in annex A and 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%.

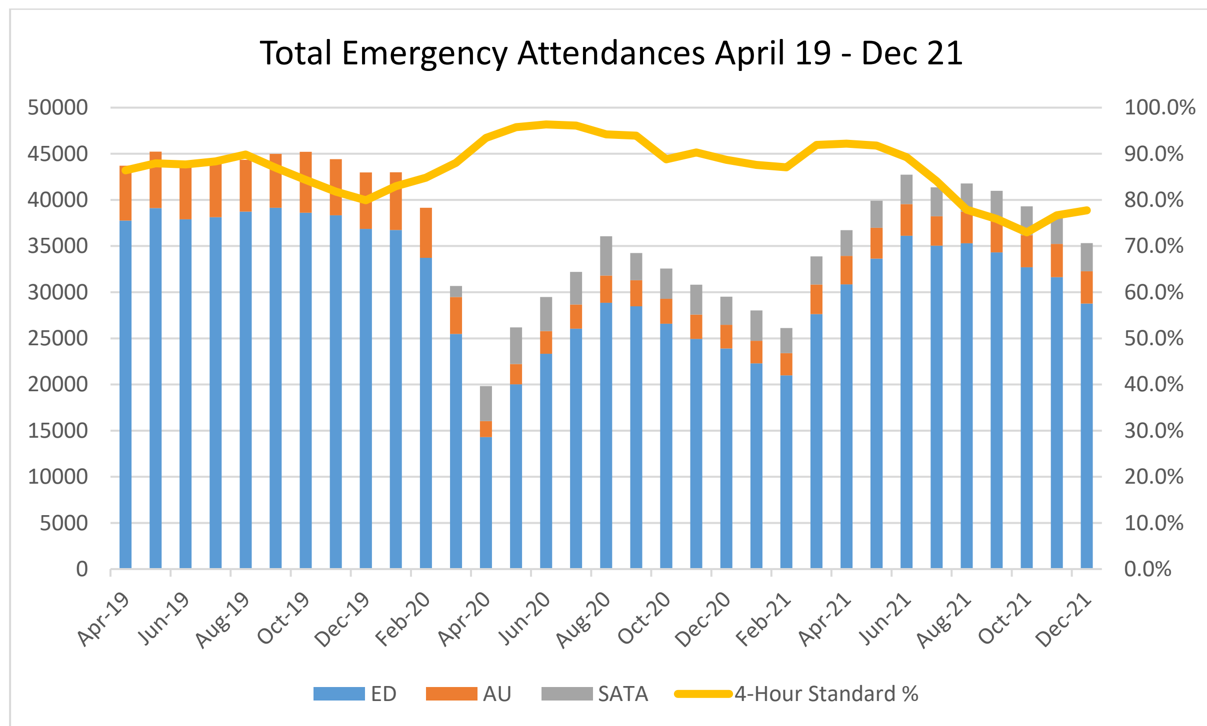
4.3 To ensure direct access for patients who required access to mental health service the Board established two new Mental Health Assessment Units (MHAUs). This provides direct access to specialty avoiding more traditional referral routes from A&E, Scottish Ambulance Service and the Police. During the 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, and the Board is experiencing a step change in demand in line with the success of the vaccination programme and easing of restrictions.

4.5 Figure 2 below shows activity over the period April 2019 to December 2021 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 demonstrates the importance of 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 - Hospital Emergence Attendances*




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 The Scottish Government has prioritised four virtual pathways as part of an on-going national response to the pandemic – work on two of these is included in this plan – further work on the others is in hand. The four priority pathways are:

- the national roll out of Covid remote health monitoring;
- optimising hospital at home services (see section 5.19 below);
- community respiratory rapid response pathway (see section 5.20 below); and,
- Out-patient parental antibiotic therapy (OPAT) including anti-viral treatment.

4.9 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.

4.10 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 – 2022/23** – implementation of the national redesign of urgent care and associated actions from the 2020 programme;
- **Phase 2 – 2023/24** – consolidation of the national programme and implementation of the remaining actions from the 2020 programme; and,
- **Phase 3 – 2024** onwards – further development of the programme including evaluation and roll out of pilots and tests of change.

### Phase 1 – 2022/23

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. National guidance was issued in November 2021. 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.

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 in 2020 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.

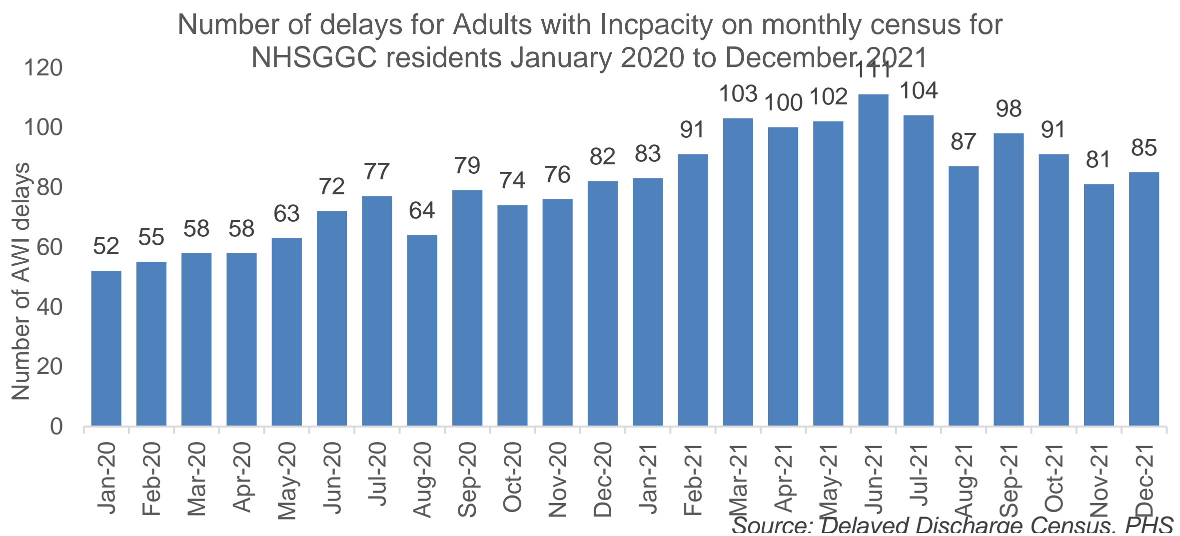
5.13 **Urgent Care Resource Hub Model -** HSCPs launched their Urgent Care Resource Hub models in January 2021. This model was established to bring together OOHs services in the community, enhancing integration and the co-ordination of care. The hub provides direct professional to professional access 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 and 2021/22 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 2020-2021*




**Phase 2 - 2023 -2024**

5.16 During 2022 we will 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<br>• 4 hour standard<br>• Demand Prediction & Capacity Mgmt<br>• FNC Process Optimisation (workflow) | • ‘Home First’ application of Discharge to Assess<br>• Developmen t of ‘Hospital in Reach’ processes<br>• AWI Peer Review | • Scheduling urgent care to Medical and Surgical AU’s<br>• Community Pharmacy integration with GP in/out of hours and the FNC<br>• SAS – access to FNC and Community Services prof to prof (falls, care homes, COPD)<br>• 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<br>• Development of NHS24 Physio resource to deliver National 111 MSK service | • Frailty Screening Tools<br>• Anticipatory Care Planning<br>• Falls Prevention & Management<br>• Frailty at the Front door<br>• Coordination & Integration of Community Models<br>• Hospital at Home - Glasgow City Test of Change |

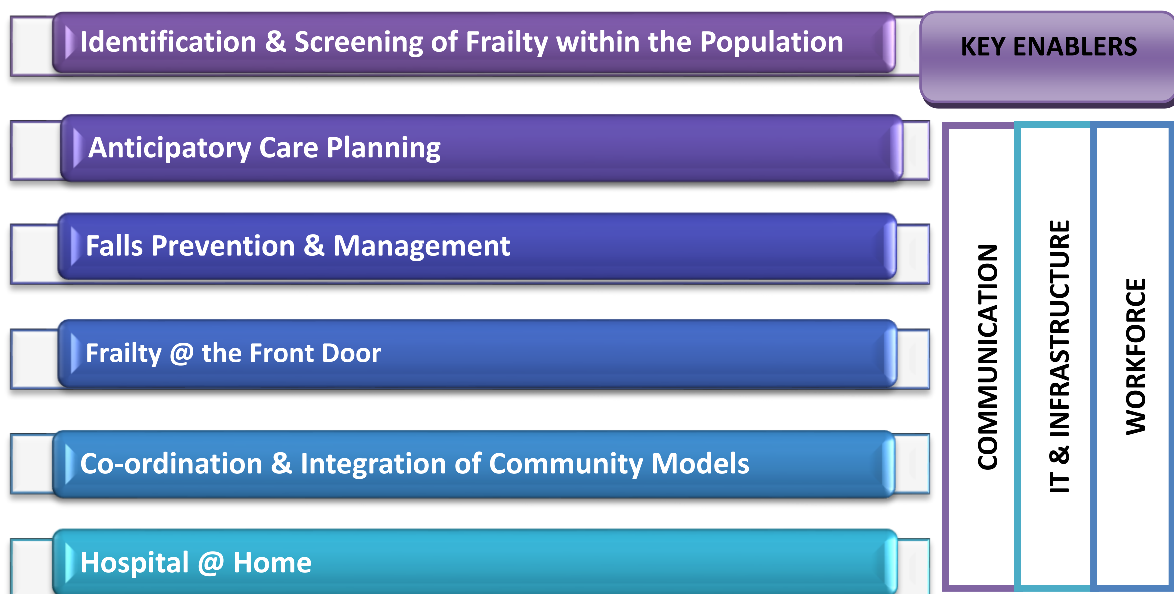
5.17 NHSGGC’s response to Phase 2 of the National Redesign of Urgent Care will be to further develop the Flow Navigation Centre and work will continue to develop and redesign urgent care pathways across the whole system over the next 18 months to include:

- **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 and development include: Care Homes (Falls), Head Injury, Heart Failure and Outpatient Parental Antibiotic Therapy (OPAT) service are being progressed as pathfinders in NHSGGC.

- **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.

5.18 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*



5.19 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.

5.20 In addition phase 2 of the programme will take forward in GG&C the national work on developing virtual capacity for resilience and recovery. The most recent programme launched in January 2022 is aimed at 'Developing Virtual Capacity' and includes:

- COVID remote health monitoring pathway;
- community respiratory rapid response pathways; and,
- expanding OPAT to include antiviral treatment.

5.21 This Scottish Government RUC programme aligns with the NHSGGC Joint Commissioning Plan. The national focus has assisted in some case to accelerate implementation plans, with additional funding but also in building

consensus and shaping public acceptance for changes. It is expected that this focus will continue and complement delivery of the Joint Commissioning Plan.

5.22 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 2022/23 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.

5.23 Annex C 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 - 2024 and onwards**

5.23 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 2021 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.

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.

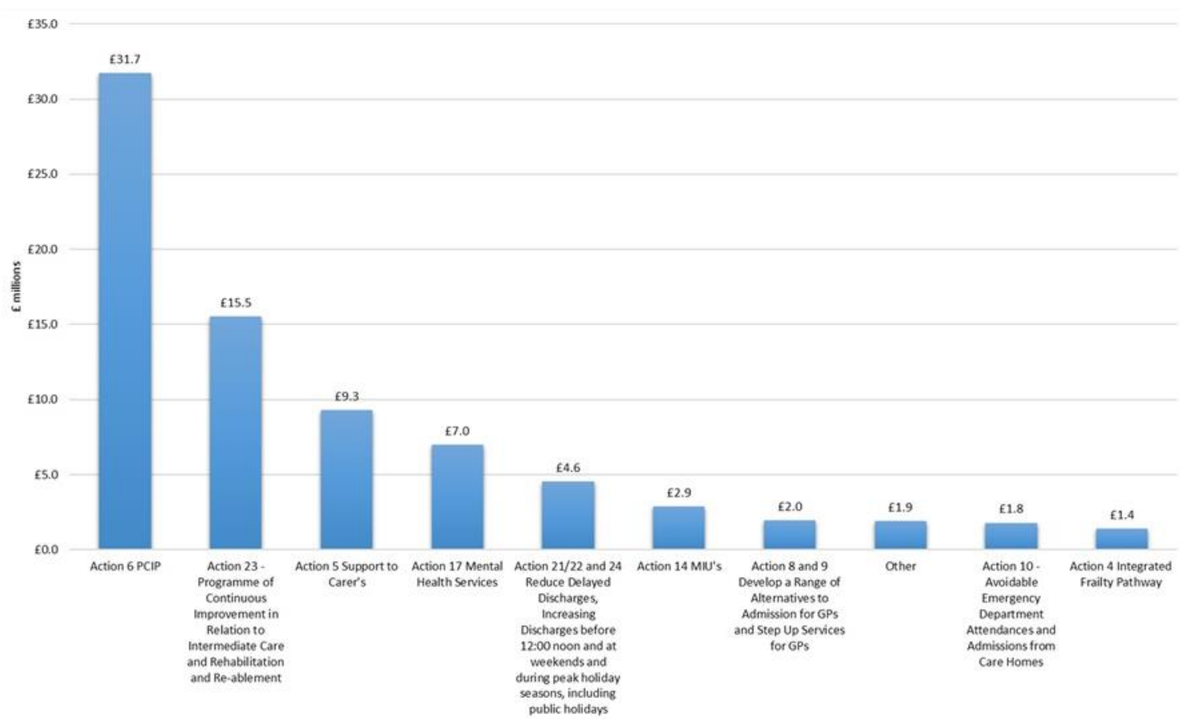
## 7. FINANCIALFRAMEWORK

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 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. The legislation requires the IJB and Health Board to put in place arrangements to support set aside arrangements for unscheduled care, and is subject to external assessment. The Unscheduled Care Commissioning Plan delivers a joint strategic commissioning approach to unscheduled care which will deliver on the intentions of the legislation.

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 £78m.




7.5 The Joint Commissioning Plan identifies a number of key actions which require financial investment to deliver on the priorities within the Plan. 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.

7.6 The investment required to deliver on Phase 1 priorities has been fully costed and the investment required is attached in annex D. It should be noted that this has been completed on a 2022/23 cost base. This highlights the need for £36.824m of investment, of which £14.822m is required on a recurring basis and £22.002m 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.

7.7 Of the recurring funding of £14.822m required, only £8.864m of funding has been able to be identified on a recurring basis. £1.273m of the funding gap relates to MHAU's for which recurring funding is still to be put in place by Scottish Government. The remaining funding gap recognises the challenge which all IJBs and the Health Board have had in securing full funding for Phase 1. This has implications for the delivery of the plan, even for Phase 1, 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** | √ | √ | √ | √ | √ | √ | n/a |
| **Action 2 ACP** | √ | X | √ | √ | √ | √ | n/a |
| **Action 4 Frailty** | √ | √ | √ | √ | √ | √ | n/a |
| **Action 9 Step Up** | √ | √ | √ | √ | √ | X | n/a |
| **Action 10 Care Homes** | √ | √ | √ | √ | √ | √ | 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 24 Improvement** | √ | √ | √ | √ | √ | √ | n/a |

7.9 Phase 2 and 3 will be costed fully as tests of change and work streams further develop their proposals. Some actions in Phase 2 and 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 2 and 3. These have been highlighted in annex D.

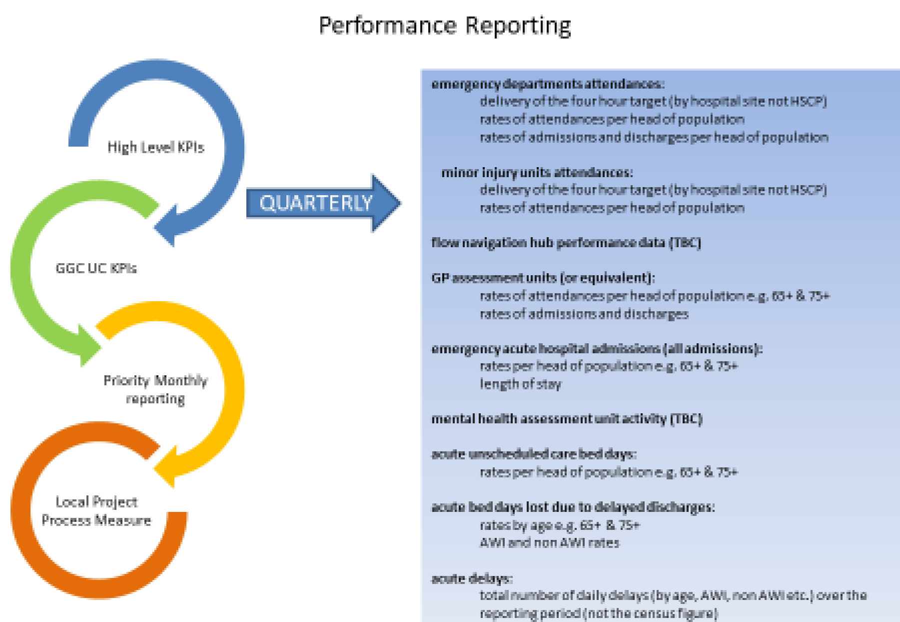
## 8 PERFORMANCE FRAMEWORK

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 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 E. 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 and in 2021 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.

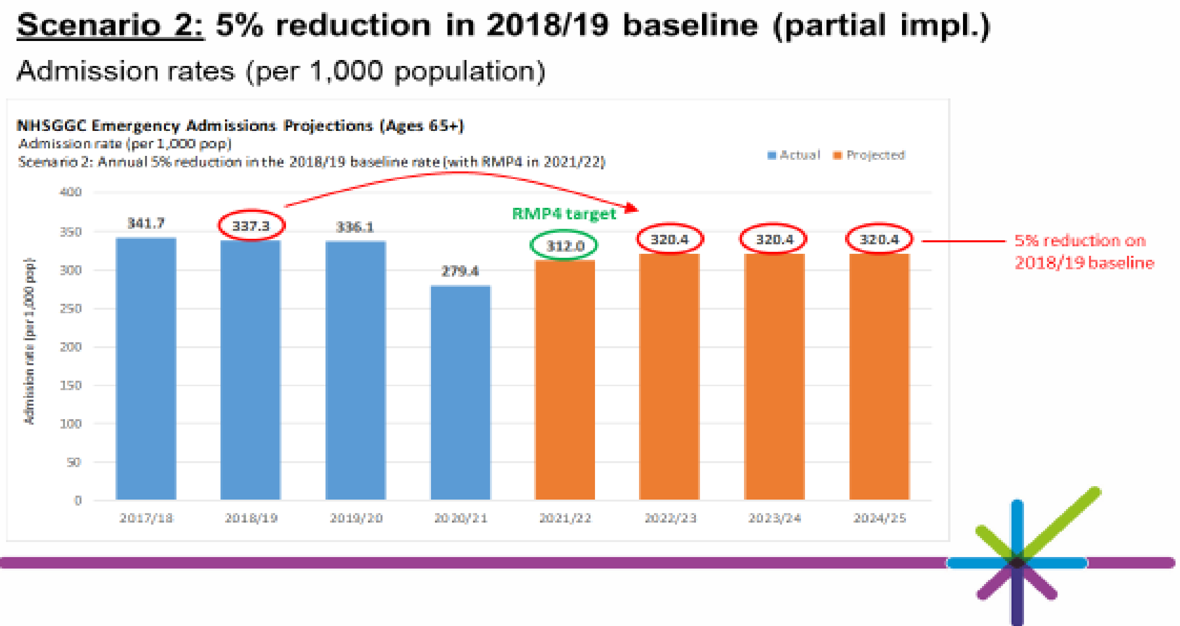
8.8 To reach our estimate we have looked at current rates of admission by head of population for different age groups and taken into account the population projections for future years (see annex F). We present three scenarios in annex F recognising that the programme as a whole is not currently fully 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 E 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 and also current projections for 2021/22 included in RMP4.

*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:

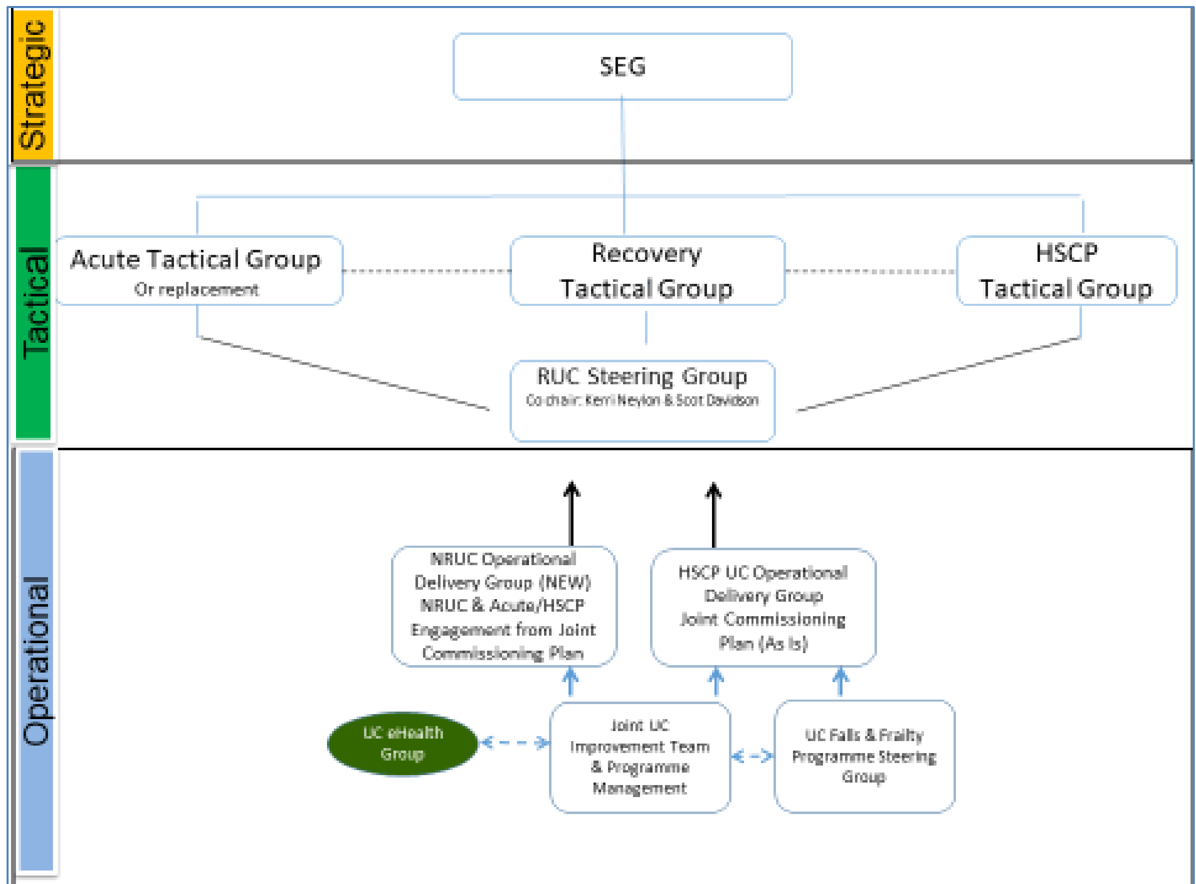
- facilitate strategic direction and operational leadership of UC;
- provide accountability for developing strategy and design via the Steering Group;
- demonstrate responsibility for implementation via Delivery Groups;
- embed the Programme Management approach to provide assurance that the programme 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 E 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 presented to IJBs, the Health Board and be the subject of ongoing engagement as outlined in section 4 above, and progress reports issued at regular intervals.

# NHS GREATER GLASGOW & CLYDE

# UNSCHEDULED CARE
# JOINT COMMISSIONING PLAN

# DESIGN & DELIVERY PLAN
# 2022/23-2024/25

# ANNEXES

**March 2022**

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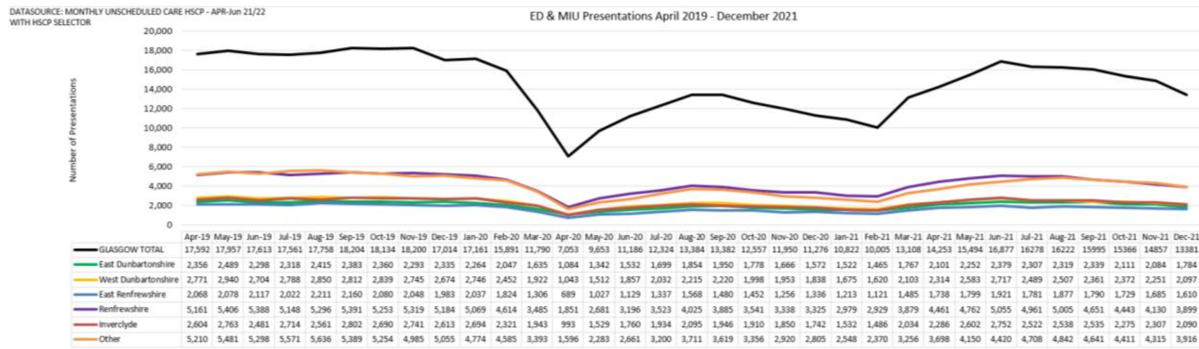
**ANNEX A**

# Rear View Mirror

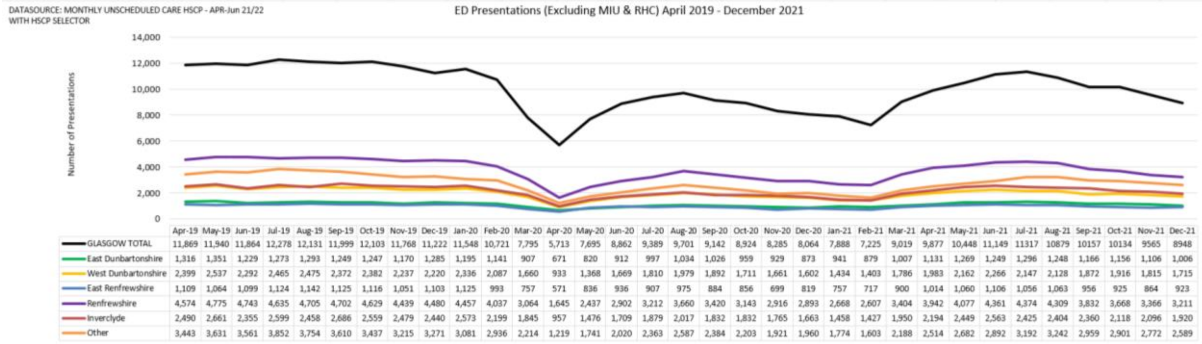
## Unscheduled Care activity

2019-2021
by HSCP and GG&C



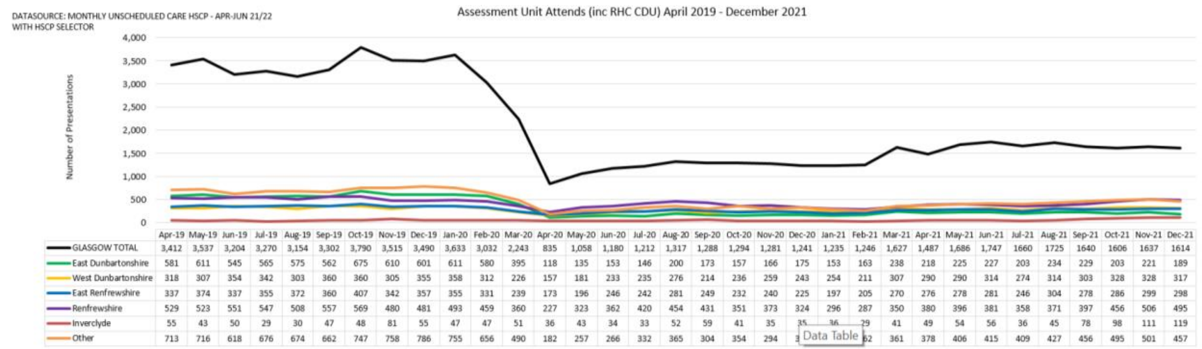

| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 17,592 | 17,957 | 17,613 | 17,561 | 17,758 | 18,204 | 18,134 | 18,200 | 17,014 | 17,161 | 15,891 | 11,790 | 7,053 | 9,653 | 11,186 | 12,324 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |

| | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 13,384 | 13,382 | 12,557 | 11,950 | 11,276 | 10,822 | 10,005 | 13,108 | 14,253 | 15,494 | 16,877 | 16278 | 16222 | 15995 | 15366 | 14857 | 13381 |
| East Dunbartonshire | 1,854 | 1,950 | 1,778 | 1,666 | 1,572 | 1,522 | 1,465 | 1,767 | 2,101 | 2,252 | 2,379 | 2,307 | 2,319 | 2,339 | 2,111 | 2,084 | 1,784 |
| West Dunbartonshire | 2,215 | 2,220 | 1,998 | 1,953 | 1,838 | 1,675 | 1,620 | 2,103 | 2,314 | 2,583 | 2,717 | 2,489 | 2,507 | 2,361 | 2,372 | 2,251 | 2,097 |
| East Renfrewshire | 1,568 | 1,480 | 1,452 | 1,256 | 1,336 | 1,213 | 1,121 | 1,485 | 1,738 | 1,799 | 1,921 | 1,781 | 1,877 | 1,790 | 1,729 | 1,685 | 1,610 |
| Renfrewshire | 4,025 | 3,885 | 3,541 | 3,338 | 3,325 | 2,979 | 2,929 | 3,879 | 4,461 | 4,762 | 5,055 | 4,961 | 5,005 | 4,651 | 4,443 | 4,130 | 3,899 |
| Inverclyde | 2,095 | 1,946 | 1,910 | 1,850 | 1,742 | 1,532 | 1,486 | 2,034 | 2,286 | 2,602 | 2,752 | 2,522 | 2,538 | 2,535 | 2,275 | 2,307 | 2,090 |
| Other | 3,711 | 3,619 | 3,356 | 2,920 | 2,805 | 2,548 | 2,370 | 3,256 | 3,698 | 4,150 | 4,420 | 4,708 | 4,842 | 4,641 | 4,411 | 4,315 | 3,916 |



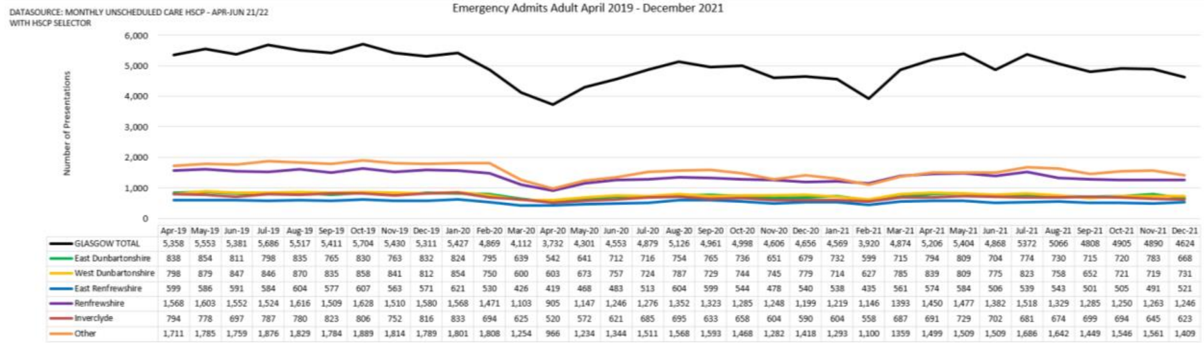

| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 11,869 | 11,940 | 11,864 | 12,278 | 12,131 | 11,999 | 12,103 | 11,768 | 11,222 | 11,548 | 10,721 | 7,795 | 5,713 | 7,695 | 8,862 | 9,389 | 9,701 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |

| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 9,142 | 8,924 | 8,285 | 8,064 | 7,888 | 7,225 | 9,019 | 9,877 | 10,448 | 11,149 | 11317 | 10879 | 10157 | 10134 | 9565 | 8948 |
| East Dunbartonshire | 1,026 | 959 | 929 | 873 | 941 | 879 | 1,007 | 1,131 | 1,269 | 1,249 | 1,296 | 1,248 | 1,166 | 1,156 | 1,106 | 1,006 |
| West Dunbartonshire | 1,892 | 1,711 | 1,661 | 1,602 | 1,434 | 1,403 | 1,786 | 1,983 | 2,162 | 2,266 | 2,147 | 2,128 | 1,872 | 1,916 | 1,815 | 1,715 |
| East Renfrewshire | 884 | 856 | 699 | 819 | 757 | 717 | 900 | 1,014 | 1,060 | 1,106 | 1,056 | 1,063 | 956 | 925 | 864 | 923 |
| Renfrewshire | 3,420 | 3,143 | 2,916 | 2,893 | 2,668 | 2,607 | 3,404 | 3,942 | 4,077 | 4,361 | 4,374 | 4,309 | 3,832 | 3,668 | 3,366 | 3,211 |
| Inverclyde | 1,832 | 1,832 | 1,765 | 1,663 | 1,458 | 1,427 | 1,950 | 2,194 | 2,449 | 2,563 | 2,425 | 2,404 | 2,360 | 2,118 | 2,096 | 1,920 |
| Other | 2,384 | 2,203 | 1,921 | 1,960 | 1,774 | 1,603 | 2,188 | 2,514 | 2,682 | 2,892 | 3,192 | 3,242 | 2,959 | 2,901 | 2,772 | 2,589 |



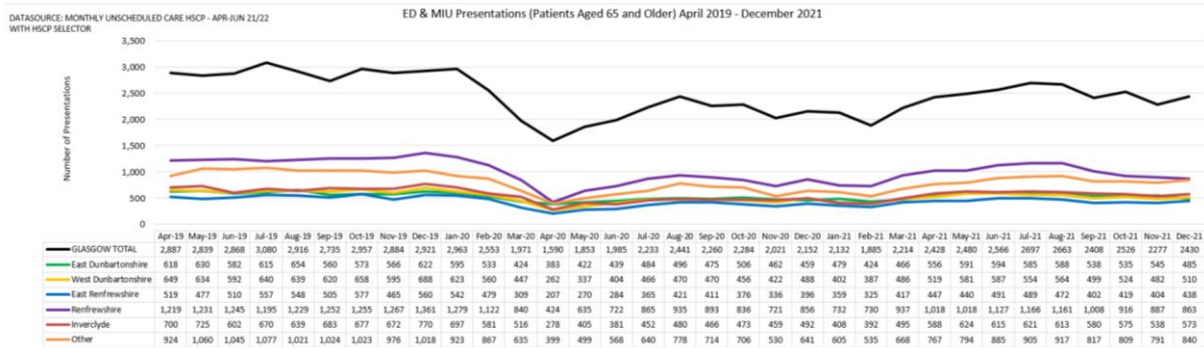

| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 3,412 | 3,537 | 3,204 | 3,270 | 3,154 | 3,302 | 3,790 | 3,515 | 3,490 | 3,633 | 3,032 | 2,243 | 835 | 1,058 | 1,180 | 1,212 | 1,317 |
| East Dunbartonshire | 581 | 611 | 545 | 565 | 575 | 562 | 675 | 610 | 601 | 611 | 580 | 395 | 118 | 135 | 153 | 146 | 200 |
| West Dunbartonshire | 318 | 307 | 354 | 342 | 303 | 360 | 360 | 305 | 355 | 358 | 312 | 226 | 157 | 181 | 233 | 235 | 276 |
| East Renfrewshire | 337 | 374 | 337 | 355 | 372 | 360 | 407 | 342 | 357 | 355 | 331 | 239 | 173 | 196 | 246 | 242 | 281 |
| Renfrewshire | 529 | 523 | 551 | 547 | 508 | 557 | 569 | 480 | 481 | 493 | 459 | 360 | 227 | 323 | 362 | 420 | 454 |
| Inverclyde | 55 | 43 | 50 | 29 | 30 | 47 | 48 | 81 | 55 | 47 | 47 | 51 | 36 | 43 | 34 | 33 | 52 |
| Other | 713 | 716 | 618 | 676 | 674 | 662 | 747 | 758 | 786 | 755 | 656 | 490 | 182 | 257 | 266 | 332 | 365 |

| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 1,288 | 1,294 | 1,281 | 1,241 | 1,235 | 1,246 | 1,627 | 1,487 | 1,686 | 1,747 | 1660 | 1725 | 1640 | 1606 | 1637 | 1614 |
| East Dunbartonshire | 173 | 157 | 166 | 175 | 153 | 163 | 238 | 218 | 225 | 227 | 203 | 234 | 229 | 203 | 221 | 189 |
| West Dunbartonshire | 214 | 236 | 259 | 243 | 254 | 211 | 307 | 290 | 290 | 314 | 274 | 314 | 303 | 328 | 328 | 317 |
| East Renfrewshire | 249 | 232 | 240 | 225 | 197 | 205 | 270 | 276 | 278 | 281 | 246 | 304 | 278 | 286 | 299 | 298 |
| Renfrewshire | 431 | 351 | 373 | 324 | 296 | 287 | 350 | 380 | 396 | 381 | 358 | 371 | 397 | 456 | 506 | 495 |
| Inverclyde | 59 | 41 | 35 | 35 | 36 | 29 | 41 | 49 | 54 | 56 | 36 | 45 | 78 | 98 | 111 | 119 |
| Other | 304 | 354 | 294 | [illegible] | [illegible] | [illegible] | 361 | 378 | 406 | 415 | 409 | 427 | 456 | 495 | 501 | 457 |



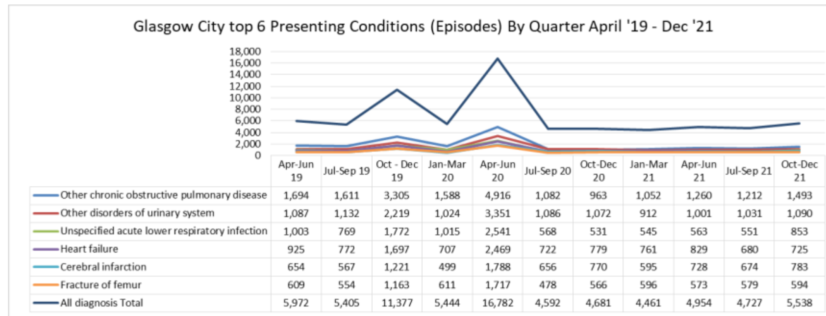

| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 5,358 | 5,553 | 5,381 | 5,686 | 5,517 | 5,411 | 5,704 | 5,430 | 5,311 | 5,427 | 4,869 | 4,112 | 3,732 | 4,301 | 4,553 | 4,879 |
| East Dunbartonshire | 838 | 854 | 811 | 798 | 835 | 765 | 830 | 763 | 832 | 824 | 795 | 639 | 542 | 641 | 712 | 716 |
| West Dunbartonshire | 798 | 879 | 847 | 846 | 870 | 835 | 858 | 841 | 812 | 854 | 750 | 600 | 603 | 673 | 757 | 724 |
| East Renfrewshire | 599 | 586 | 591 | 584 | 604 | 577 | 607 | 563 | 571 | 621 | 530 | 426 | 419 | 468 | 483 | 513 |
| 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 |
| Inverclyde | 794 | 778 | 697 | 787 | 780 | 823 | 806 | 752 | 816 | 833 | 694 | 625 | 520 | 572 | 621 | 685 |
| 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 |

| | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 5,126 | 4,961 | 4,998 | 4,606 | 4,656 | 4,569 | 3,920 | 4,874 | 5,206 | 5,404 | 4,868 | 5372 | 5066 | 4808 | 4905 | 4890 | 4624 |
| East Dunbartonshire | 754 | 765 | 736 | 651 | 679 | 732 | 599 | 715 | 794 | 809 | 704 | 774 | 730 | 715 | 720 | 783 | 668 |
| West Dunbartonshire | 787 | 729 | 744 | 745 | 779 | 714 | 627 | 785 | 839 | 809 | 775 | 823 | 758 | 652 | 721 | 719 | 731 |
| East Renfrewshire | 604 | 599 | 544 | 478 | 540 | 538 | 435 | 561 | 574 | 584 | 506 | 539 | 543 | 501 | 505 | 491 | 521 |
| Renfrewshire | 1,352 | 1,323 | 1,285 | 1,248 | 1,199 | 1,219 | 1,146 | 1393 | 1,450 | 1,477 | 1,382 | 1,518 | 1,329 | 1,285 | 1,250 | 1,263 | 1,246 |
| Inverclyde | 695 | 633 | 658 | 604 | 590 | 604 | 558 | 687 | 691 | 729 | 702 | 681 | 674 | 699 | 694 | 645 | 623 |
| Other | 1,568 | 1,593 | 1,468 | 1,282 | 1,418 | 1,293 | 1,100 | 1359 | 1,499 | 1,509 | 1,509 | 1,686 | 1,642 | 1,449 | 1,546 | 1,561 | 1,409 |

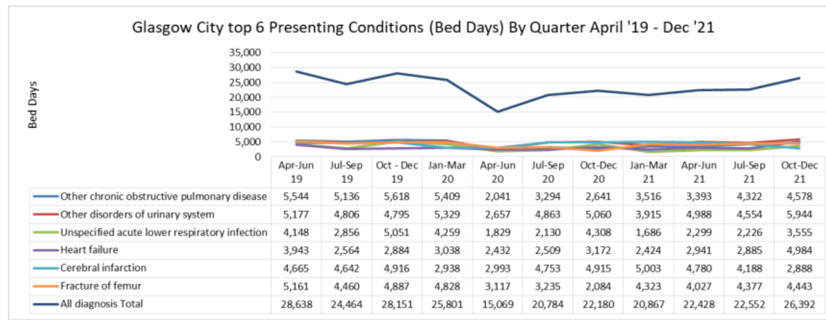



| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 2,887 | 2,839 | 2,868 | 3,080 | 2,916 | 2,735 | 2,957 | 2,884 | 2,921 | 2,963 | 2,553 | 1,971 | 1,590 | 1,853 | 1,985 | 2,233 |
| East Dunbartonshire | 618 | 630 | 582 | 615 | 654 | 560 | 573 | 566 | 622 | 595 | 533 | 424 | 383 | 422 | 439 | 484 |
| West Dunbartonshire | 649 | 634 | 592 | 640 | 639 | 620 | 658 | 595 | 688 | 623 | 560 | 447 | 262 | 337 | 404 | 466 |
| East Renfrewshire | 519 | 477 | 510 | 557 | 548 | 505 | 577 | 465 | 560 | 542 | 479 | 309 | 207 | 270 | 284 | 365 |
| 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 |
| Inverclyde | 700 | 725 | 602 | 670 | 639 | 683 | 677 | 672 | 770 | 697 | 581 | 516 | 278 | 405 | 381 | 452 |
| Other | 924 | 1,060 | 1,045 | 1,077 | 1,021 | 1,024 | 1,023 | 976 | 1,018 | 923 | 867 | 635 | 399 | 499 | 568 | 640 |

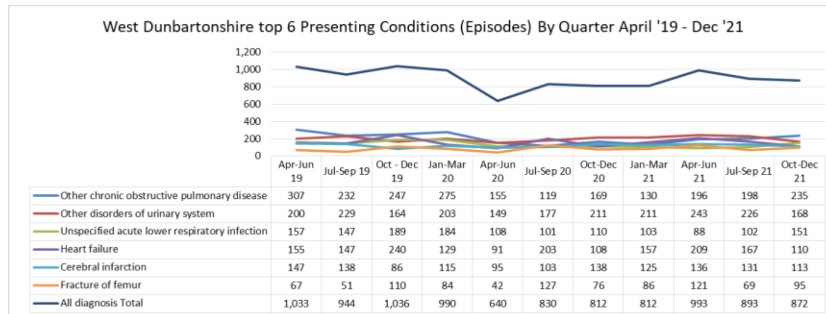
| | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLASGOW TOTAL | 2,441 | 2,260 | 2,284 | 2,021 | 2,152 | 2,132 | 1,885 | 2,214 | 2,428 | 2,480 | 2,566 | 2697 | 2663 | 2408 | 2526 | 2277 | 2430 |
| East Dunbartonshire | 496 | 475 | 506 | 462 | 459 | 479 | 424 | 466 | 556 | 591 | 594 | 585 | 588 | 538 | 535 | 545 | 485 |
| West Dunbartonshire | 470 | 470 | 456 | 422 | 488 | 402 | 387 | 486 | 519 | 581 | 587 | 554 | 564 | 499 | 524 | 482 | 510 |
| East Renfrewshire | 421 | 411 | 376 | 336 | 396 | 359 | 325 | 417 | 447 | 440 | 491 | 489 | 472 | 402 | 419 | 404 | 438 |
| Renfrewshire | 935 | 893 | 836 | 721 | 856 | 732 | 730 | 937 | 1,018 | 1,018 | 1,127 | 1,166 | 1,161 | 1,008 | 916 | 887 | 863 |
| Inverclyde | 480 | 466 | 473 | 459 | 492 | 408 | 392 | 495 | 588 | 624 | 615 | 621 | 613 | 580 | 575 | 538 | 573 |
| Other | 778 | 714 | 706 | 530 | 641 | 605 | 535 | 668 | 767 | 794 | 885 | 905 | 917 | 817 | 809 | 791 | 840 |



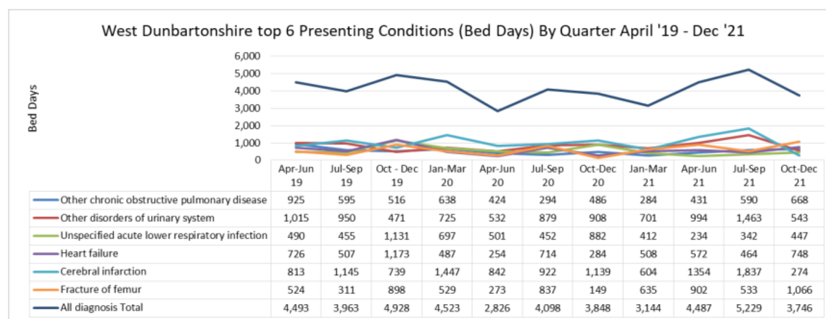

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 1,694 | 1,611 | 3,305 | 1,588 | 4,916 | 1,082 | 963 | 1,052 | 1,260 | 1,212 | 1,493 |
| Other disorders of urinary system | 1,087 | 1,132 | 2,219 | 1,024 | 3,351 | 1,086 | 1,072 | 912 | 1,001 | 1,031 | 1,090 |
| Unspecified acute lower respiratory infection | 1,003 | 769 | 1,772 | 1,015 | 2,541 | 568 | 531 | 545 | 563 | 551 | 853 |
| Heart failure | 925 | 772 | 1,697 | 707 | 2,469 | 722 | 779 | 761 | 829 | 680 | 725 |
| Cerebral infarction | 654 | 567 | 1,221 | 499 | 1,788 | 656 | 770 | 595 | 728 | 674 | 783 |
| Fracture of femur | 609 | 554 | 1,163 | 611 | 1,717 | 478 | 566 | 596 | 573 | 579 | 594 |
| All diagnosis Total | 5,972 | 5,405 | 11,377 | 5,444 | 16,782 | 4,592 | 4,681 | 4,461 | 4,954 | 4,727 | 5,538 |



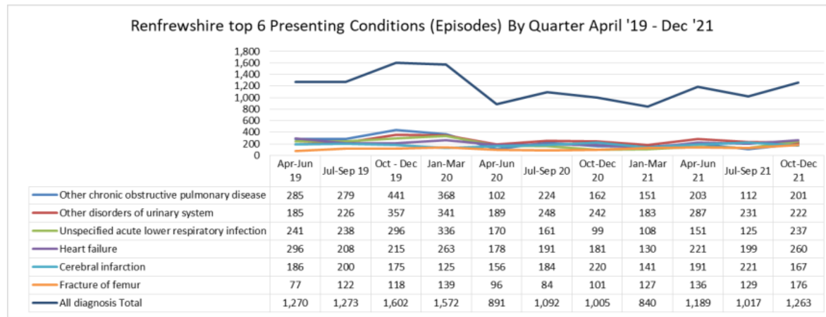

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 5,544 | 5,136 | 5,618 | 5,409 | 2,041 | 3,294 | 2,641 | 3,516 | 3,393 | 4,322 | 4,578 |
| Other disorders of urinary system | 5,177 | 4,806 | 4,795 | 5,329 | 2,657 | 4,863 | 5,060 | 3,915 | 4,988 | 4,554 | 5,944 |
| Unspecified acute lower respiratory infection | 4,148 | 2,856 | 5,051 | 4,259 | 1,829 | 2,130 | 4,308 | 1,686 | 2,299 | 2,226 | 3,555 |
| Heart failure | 3,943 | 2,564 | 2,884 | 3,038 | 2,432 | 2,509 | 3,172 | 2,424 | 2,941 | 2,885 | 4,984 |
| Cerebral infarction | 4,665 | 4,642 | 4,916 | 2,938 | 2,993 | 4,753 | 4,915 | 5,003 | 4,780 | 4,188 | 2,888 |
| Fracture of femur | 5,161 | 4,460 | 4,887 | 4,828 | 3,117 | 3,235 | 2,084 | 4,323 | 4,027 | 4,377 | 4,443 |
| All diagnosis Total | 28,638 | 24,464 | 28,151 | 25,801 | 15,069 | 20,784 | 22,180 | 20,867 | 22,428 | 22,552 | 26,392 |



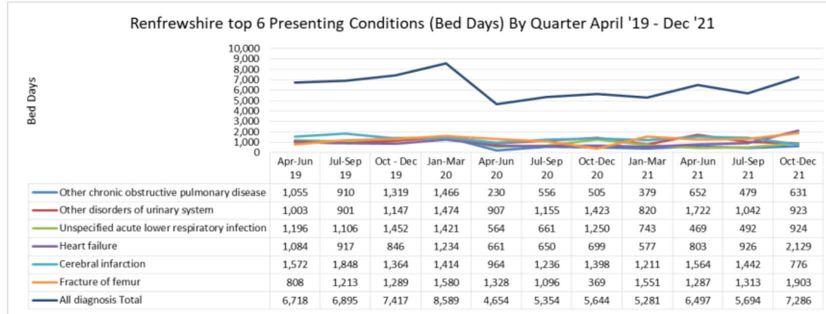

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 307 | 232 | 247 | 275 | 155 | 119 | 169 | 130 | 196 | 198 | 235 |
| Other disorders of urinary system | 200 | 229 | 164 | 203 | 149 | 177 | 211 | 211 | 243 | 226 | 168 |
| Unspecified acute lower respiratory infection | 157 | 147 | 189 | 184 | 108 | 101 | 110 | 103 | 88 | 102 | 151 |
| Heart failure | 155 | 147 | 240 | 129 | 91 | 203 | 108 | 157 | 209 | 167 | 110 |
| Cerebral infarction | 147 | 138 | 86 | 115 | 95 | 103 | 138 | 125 | 136 | 131 | 113 |
| Fracture of femur | 67 | 51 | 110 | 84 | 42 | 127 | 76 | 86 | 121 | 69 | 95 |
| All diagnosis Total | 1,033 | 944 | 1,036 | 990 | 640 | 830 | 812 | 812 | 993 | 893 | 872 |



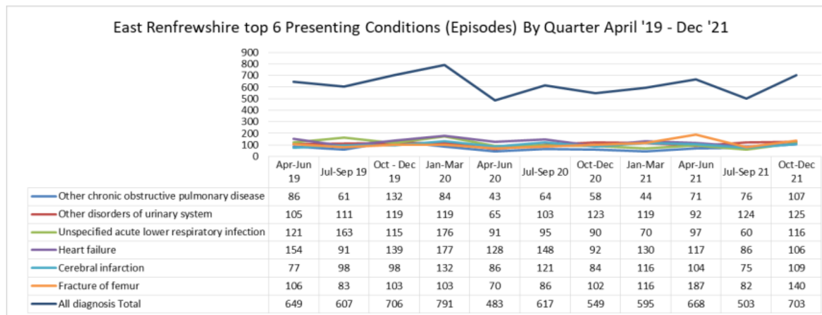

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 925 | 595 | 516 | 638 | 424 | 294 | 486 | 284 | 431 | 590 | 668 |
| Other disorders of urinary system | 1,015 | 950 | 471 | 725 | 532 | 879 | 908 | 701 | 994 | 1,463 | 543 |
| Unspecified acute lower respiratory infection | 490 | 455 | 1,131 | 697 | 501 | 452 | 882 | 412 | 234 | 342 | 447 |
| Heart failure | 726 | 507 | 1,173 | 487 | 254 | 714 | 284 | 508 | 572 | 464 | 748 |
| Cerebral infarction | 813 | 1,145 | 739 | 1,447 | 842 | 922 | 1,139 | 604 | 1354 | 1,837 | 274 |
| Fracture of femur | 524 | 311 | 898 | 529 | 273 | 837 | 149 | 635 | 902 | 533 | 1,066 |
| All diagnosis Total | 4,493 | 3,963 | 4,928 | 4,523 | 2,826 | 4,098 | 3,848 | 3,144 | 4,487 | 5,229 | 3,746 |



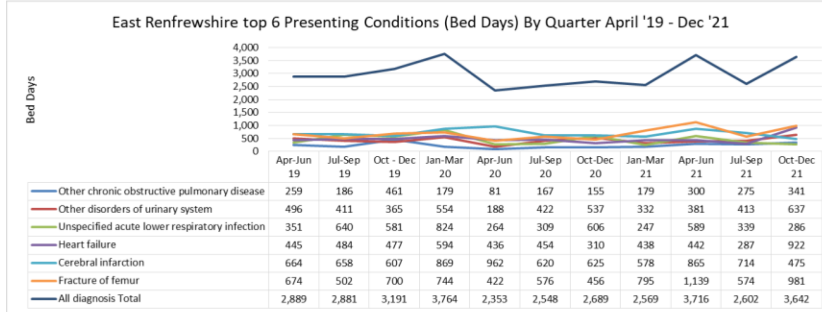

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 285 | 279 | 441 | 368 | 102 | 224 | 162 | 151 | 203 | 112 | 201 |
| Other disorders of urinary system | 185 | 226 | 357 | 341 | 189 | 248 | 242 | 183 | 287 | 231 | 222 |
| Unspecified acute lower respiratory infection | 241 | 238 | 296 | 336 | 170 | 161 | 99 | 108 | 151 | 125 | 237 |
| Heart failure | 296 | 208 | 215 | 263 | 178 | 191 | 181 | 130 | 221 | 199 | 260 |
| Cerebral infarction | 186 | 200 | 175 | 125 | 156 | 184 | 220 | 141 | 191 | 221 | 167 |
| Fracture of femur | 77 | 122 | 118 | 139 | 96 | 84 | 101 | 127 | 136 | 129 | 176 |
| All diagnosis Total | 1,270 | 1,273 | 1,602 | 1,572 | 891 | 1,092 | 1,005 | 840 | 1,189 | 1,017 | 1,263 |



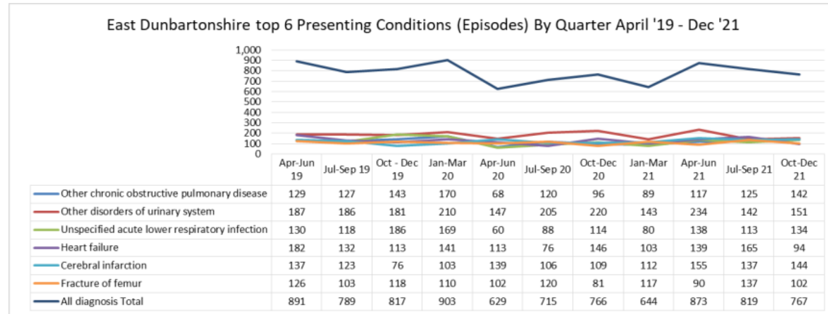

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 1,055 | 910 | 1,319 | 1,466 | 230 | 556 | 505 | 379 | 652 | 479 | 631 |
| Other disorders of urinary system | 1,003 | 901 | 1,147 | 1,474 | 907 | 1,155 | 1,423 | 820 | 1,722 | 1,042 | 923 |
| Unspecified acute lower respiratory infection | 1,196 | 1,106 | 1,452 | 1,421 | 564 | 661 | 1,250 | 743 | 469 | 492 | 924 |
| Heart failure | 1,084 | 917 | 846 | 1,234 | 661 | 650 | 699 | 577 | 803 | 926 | 2,129 |
| Cerebral infarction | 1,572 | 1,848 | 1,364 | 1,414 | 964 | 1,236 | 1,398 | 1,211 | 1,564 | 1,442 | 776 |
| Fracture of femur | 808 | 1,213 | 1,289 | 1,580 | 1,328 | 1,096 | 369 | 1,551 | 1,287 | 1,313 | 1,903 |
| All diagnosis Total | 6,718 | 6,895 | 7,417 | 8,589 | 4,654 | 5,354 | 5,644 | 5,281 | 6,497 | 5,694 | 7,286 |



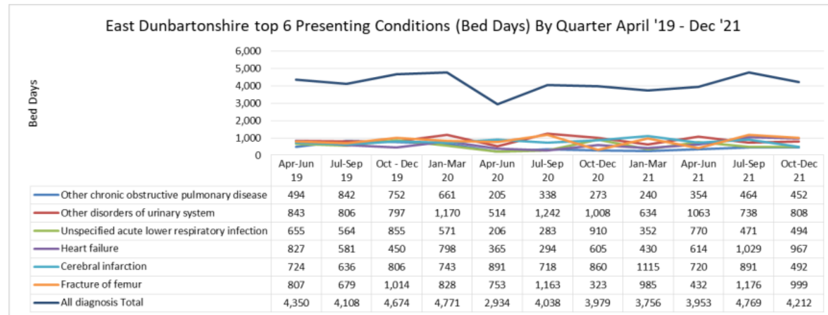

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 86 | 61 | 132 | 84 | 43 | 64 | 58 | 44 | 71 | 76 | 107 |
| Other disorders of urinary system | 105 | 111 | 119 | 119 | 65 | 103 | 123 | 119 | 92 | 124 | 125 |
| Unspecified acute lower respiratory infection | 121 | 163 | 115 | 176 | 91 | 95 | 90 | 70 | 97 | 60 | 116 |
| Heart failure | 154 | 91 | 139 | 177 | 128 | 148 | 92 | 130 | 117 | 86 | 106 |
| Cerebral infarction | 77 | 98 | 98 | 132 | 86 | 121 | 84 | 116 | 104 | 75 | 109 |
| Fracture of femur | 106 | 83 | 103 | 103 | 70 | 86 | 102 | 116 | 187 | 82 | 140 |
| All diagnosis Total | 649 | 607 | 706 | 791 | 483 | 617 | 549 | 595 | 668 | 503 | 703 |



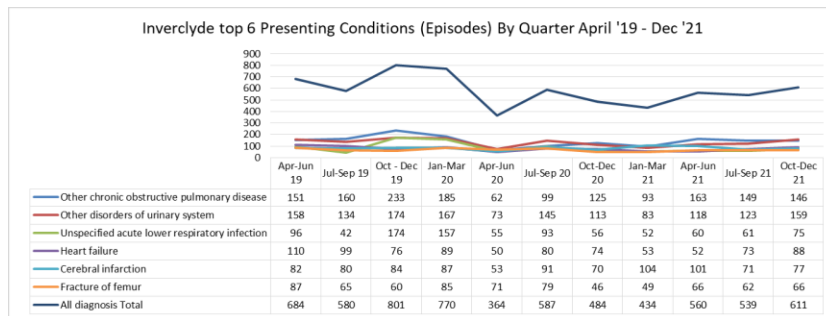

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 259 | 186 | 461 | 179 | 81 | 167 | 155 | 179 | 300 | 275 | 341 |
| Other disorders of urinary system | 496 | 411 | 365 | 554 | 188 | 422 | 537 | 332 | 381 | 413 | 637 |
| Unspecified acute lower respiratory infection | 351 | 640 | 581 | 824 | 264 | 309 | 606 | 247 | 589 | 339 | 286 |
| Heart failure | 445 | 484 | 477 | 594 | 436 | 454 | 310 | 438 | 442 | 287 | 922 |
| Cerebral infarction | 664 | 658 | 607 | 869 | 962 | 620 | 625 | 578 | 865 | 714 | 475 |
| Fracture of femur | 674 | 502 | 700 | 744 | 422 | 576 | 456 | 795 | 1,139 | 574 | 981 |
| All diagnosis Total | 2,889 | 2,881 | 3,191 | 3,764 | 2,353 | 2,548 | 2,689 | 2,569 | 3,716 | 2,602 | 3,642 |



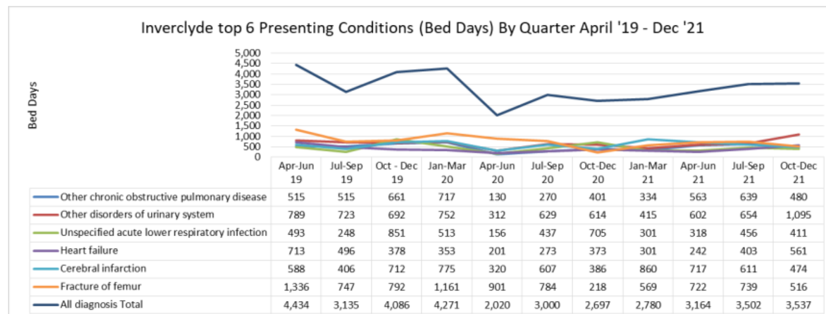

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 129 | 127 | 143 | 170 | 68 | 120 | 96 | 89 | 117 | 125 | 142 |
| Other disorders of urinary system | 187 | 186 | 181 | 210 | 147 | 205 | 220 | 143 | 234 | 142 | 151 |
| Unspecified acute lower respiratory infection | 130 | 118 | 186 | 169 | 60 | 88 | 114 | 80 | 138 | 113 | 134 |
| Heart failure | 182 | 132 | 113 | 141 | 113 | 76 | 146 | 103 | 139 | 165 | 94 |
| Cerebral infarction | 137 | 123 | 76 | 103 | 139 | 106 | 109 | 112 | 155 | 137 | 144 |
| Fracture of femur | 126 | 103 | 118 | 110 | 102 | 120 | 81 | 117 | 90 | 137 | 102 |
| All diagnosis Total | 891 | 789 | 817 | 903 | 629 | 715 | 766 | 644 | 873 | 819 | 767 |



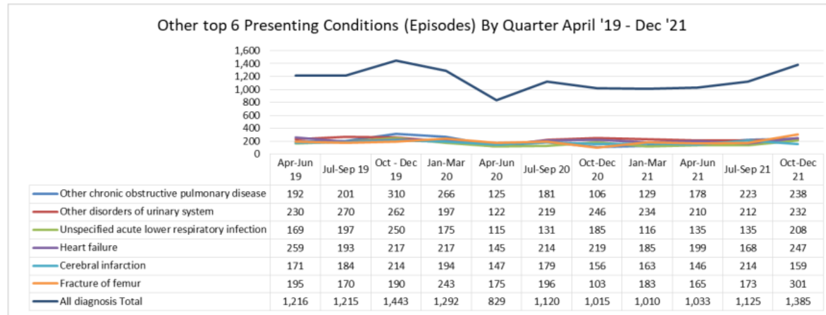

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 494 | 842 | 752 | 661 | 205 | 338 | 273 | 240 | 354 | 464 | 452 |
| Other disorders of urinary system | 843 | 806 | 797 | 1,170 | 514 | 1,242 | 1,008 | 634 | 1063 | 738 | 808 |
| Unspecified acute lower respiratory infection | 655 | 564 | 855 | 571 | 206 | 283 | 910 | 352 | 770 | 471 | 494 |
| Heart failure | 827 | 581 | 450 | 798 | 365 | 294 | 605 | 430 | 614 | 1,029 | 967 |
| Cerebral infarction | 724 | 636 | 806 | 743 | 891 | 718 | 860 | 1115 | 720 | 891 | 492 |
| Fracture of femur | 807 | 679 | 1,014 | 828 | 753 | 1,163 | 323 | 985 | 432 | 1,176 | 999 |
| All diagnosis Total | 4,350 | 4,108 | 4,674 | 4,771 | 2,934 | 4,038 | 3,979 | 3,756 | 3,953 | 4,769 | 4,212 |



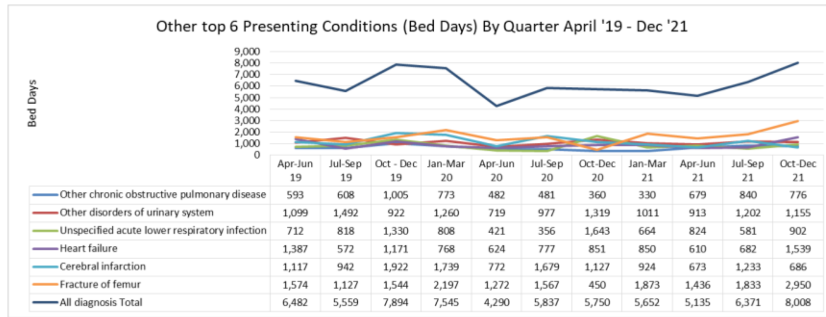

| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 151 | 160 | 233 | 185 | 62 | 99 | 125 | 93 | 163 | 149 | 146 |
| Other disorders of urinary system | 158 | 134 | 174 | 167 | 73 | 145 | 113 | 83 | 118 | 123 | 159 |
| Unspecified acute lower respiratory infection | 96 | 42 | 174 | 157 | 55 | 93 | 56 | 52 | 60 | 61 | 75 |
| Heart failure | 110 | 99 | 76 | 89 | 50 | 80 | 74 | 53 | 52 | 73 | 88 |
| Cerebral infarction | 82 | 80 | 84 | 87 | 53 | 91 | 70 | 104 | 101 | 71 | 77 |
| Fracture of femur | 87 | 65 | 60 | 85 | 71 | 79 | 46 | 49 | 66 | 62 | 66 |
| All diagnosis Total | 684 | 580 | 801 | 770 | 364 | 587 | 484 | 434 | 560 | 539 | 611 |




| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 515 | 515 | 661 | 717 | 130 | 270 | 401 | 334 | 563 | 639 | 480 |
| Other disorders of urinary system | 789 | 723 | 692 | 752 | 312 | 629 | 614 | 415 | 602 | 654 | 1,095 |
| Unspecified acute lower respiratory infection | 493 | 248 | 851 | 513 | 156 | 437 | 705 | 301 | 318 | 456 | 411 |
| Heart failure | 713 | 496 | 378 | 353 | 201 | 273 | 373 | 301 | 242 | 403 | 561 |
| Cerebral infarction | 588 | 406 | 712 | 775 | 320 | 607 | 386 | 860 | 717 | 611 | 474 |
| Fracture of femur | 1,336 | 747 | 792 | 1,161 | 901 | 784 | 218 | 569 | 722 | 739 | 516 |
| All diagnosis Total | 4,434 | 3,135 | 4,086 | 4,271 | 2,020 | 3,000 | 2,697 | 2,780 | 3,164 | 3,502 | 3,537 |




| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 192 | 201 | 310 | 266 | 125 | 181 | 106 | 129 | 178 | 223 | 238 |
| Other disorders of urinary system | 230 | 270 | 262 | 197 | 122 | 219 | 246 | 234 | 210 | 212 | 232 |
| Unspecified acute lower respiratory infection | 169 | 197 | 250 | 175 | 115 | 131 | 185 | 116 | 135 | 135 | 208 |
| Heart failure | 259 | 193 | 217 | 217 | 145 | 214 | 219 | 185 | 199 | 168 | 247 |
| Cerebral infarction | 171 | 184 | 214 | 194 | 147 | 179 | 156 | 163 | 146 | 214 | 159 |
| Fracture of femur | 195 | 170 | 190 | 243 | 175 | 196 | 103 | 183 | 165 | 173 | 301 |
| All diagnosis Total | 1,216 | 1,215 | 1,443 | 1,292 | 829 | 1,120 | 1,015 | 1,010 | 1,033 | 1,125 | 1,385 |




| | Apr-Jun 19 | Jul-Sep 19 | Oct - Dec 19 | Jan-Mar 20 | Apr-Jun 20 | Jul-Sep 20 | Oct-Dec 20 | Jan-Mar 21 | Apr-Jun 21 | Jul-Sep 21 | Oct-Dec 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Other chronic obstructive pulmonary disease | 593 | 608 | 1,005 | 773 | 482 | 481 | 360 | 330 | 679 | 840 | 776 |
| Other disorders of urinary system | 1,099 | 1,492 | 922 | 1,260 | 719 | 977 | 1,319 | 1011 | 913 | 1,202 | 1,155 |
| Unspecified acute lower respiratory infection | 712 | 818 | 1,330 | 808 | 421 | 356 | 1,643 | 664 | 824 | 581 | 902 |
| Heart failure | 1,387 | 572 | 1,171 | 768 | 624 | 777 | 851 | 850 | 610 | 682 | 1,539 |
| Cerebral infarction | 1,117 | 942 | 1,922 | 1,739 | 772 | 1,679 | 1,127 | 924 | 673 | 1,233 | 686 |
| Fracture of femur | 1,574 | 1,127 | 1,544 | 2,197 | 1,272 | 1,567 | 450 | 1,873 | 1,436 | 1,833 | 2,950 |
| All diagnosis Total | 6,482 | 5,559 | 7,894 | 7,545 | 4,290 | 5,837 | 5,750 | 5,652 | 5,135 | 6,371 | 8,008 |

**ANNEX B**

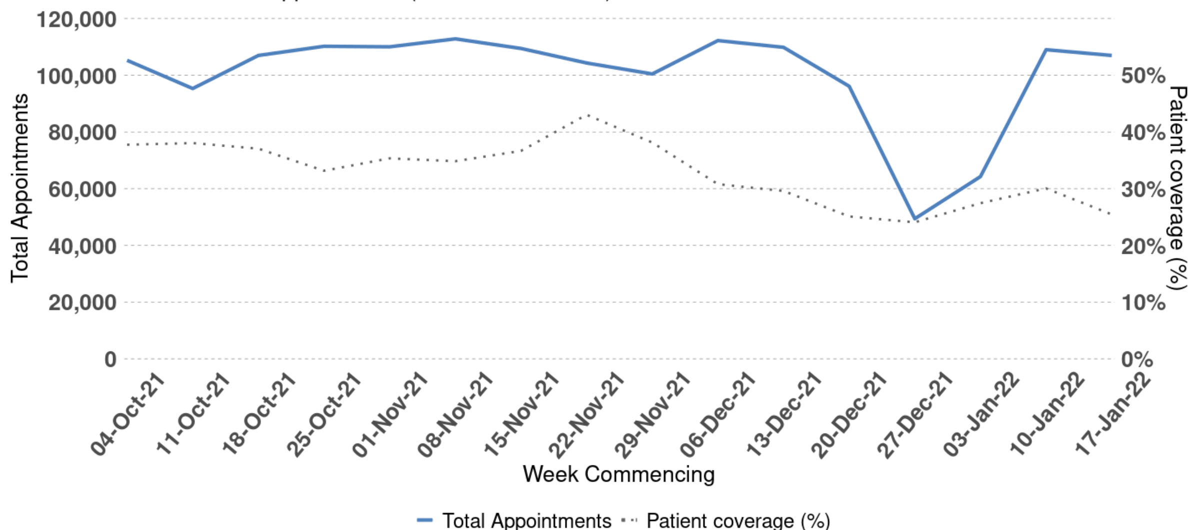
# Unscheduled Care: A look back over the period of the Pandemic

## Introduction

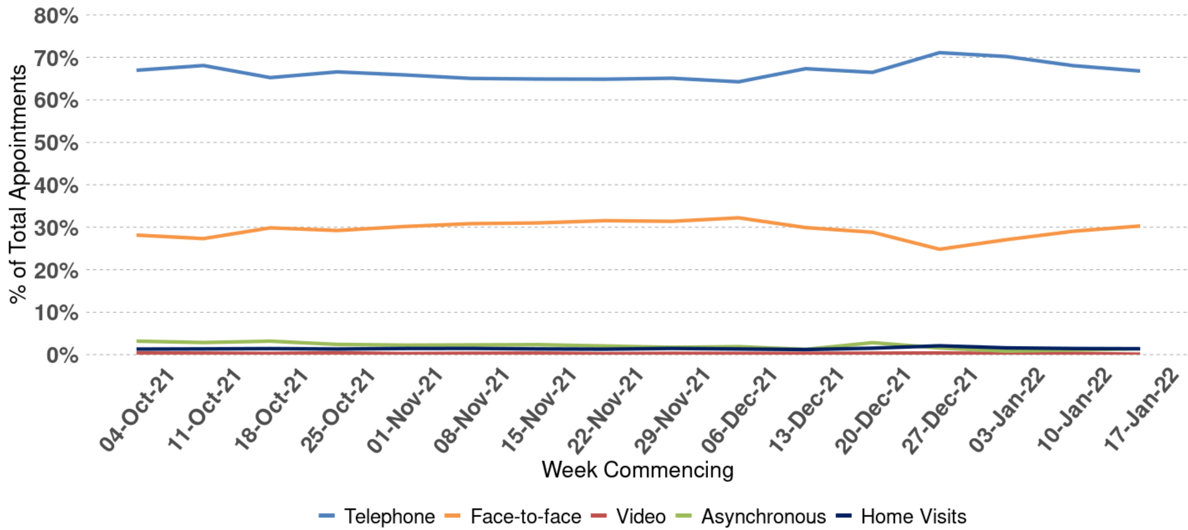
The impact of the COVID-19 pandemic and our response to it has disrupted Unscheduled Care activity levels and the previously understood seasonal trends. It is unclear the extent to which this disruption will have a long-term impact or whether previous trends will reassert themselves. This summary provides an overview of the key dynamics following the flow of demand from Primary Care through the interface to Secondary Care. The response to the pandemic has resulted in the rapid adoption of new ways of working, utilising digital and virtual technology, as well mechanisms such as the Flow Navigation Hub to support direction of patients to the most appropriate services.

## Primary Care

Aggregate data on access to GPs is not generally available but in response to concerns about the pressure on these services, a cohort of practices across NHSGGC - accounting for approximately 25% of patients - have participated in a survey to enable estimated trends of demand to be developed. The study suggests that GPs have delivered between 100,000 and 120,000 appointments per week (dip on week of 20 December reflects Christmas holiday period and weekend impact).

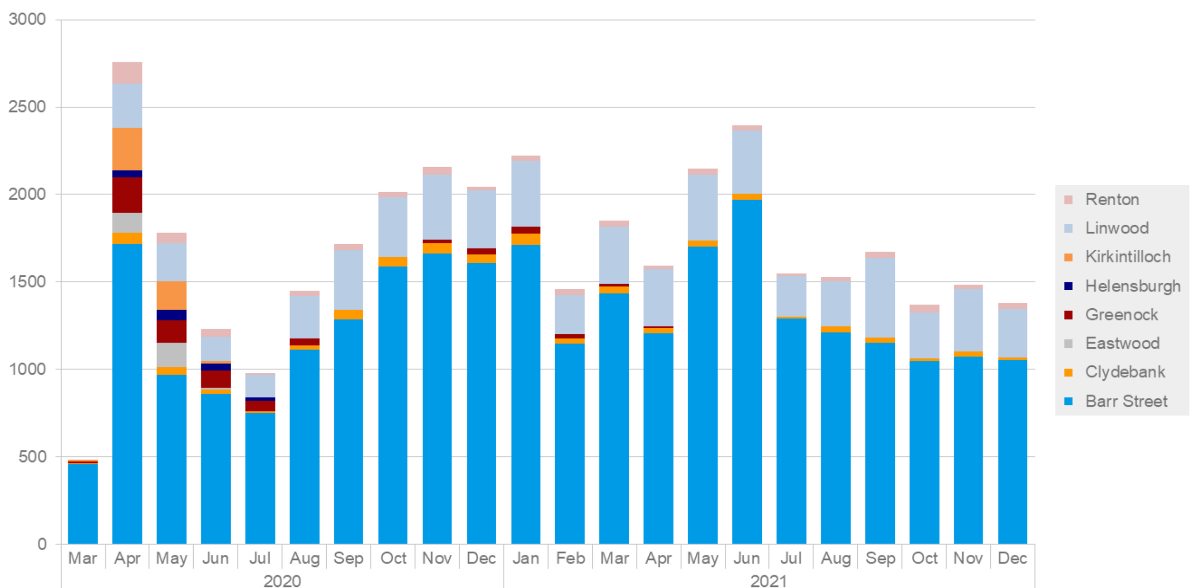



The study also indicates the extent to which telephone appointments account for around two-thirds of all appointments.



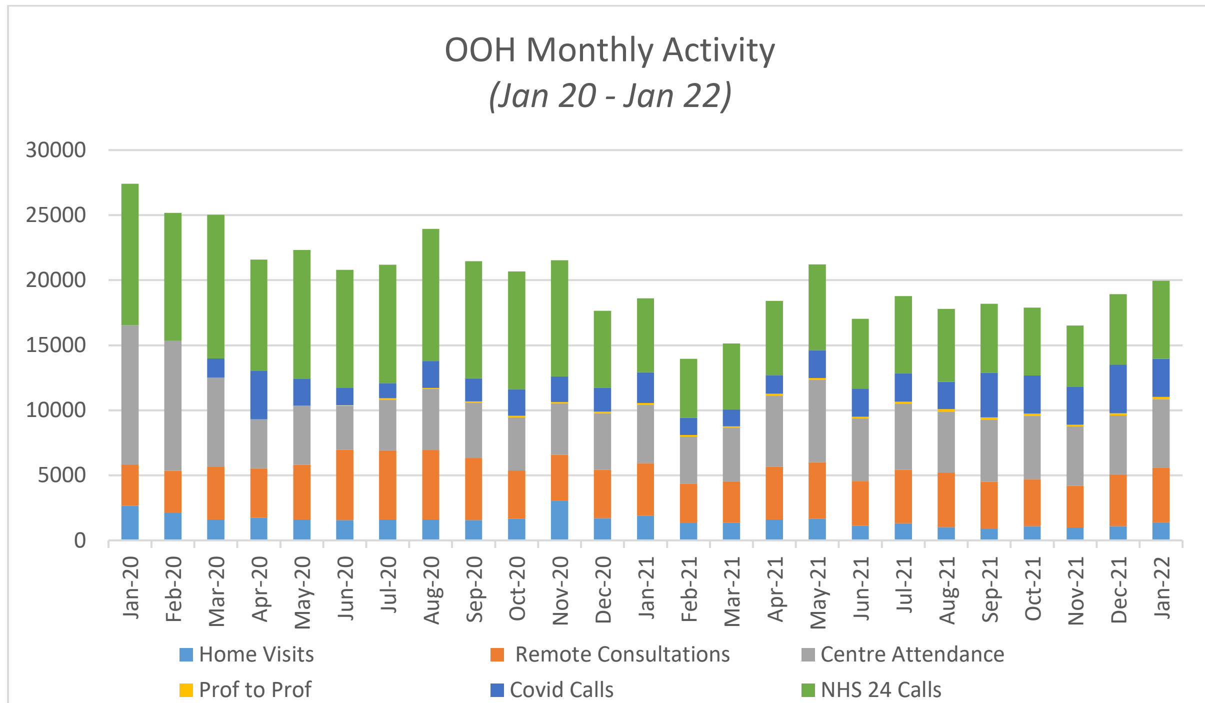

## Community Assessment Centres

Established to support GPs to provide safe and rapid access for patients with suspected diagnosis of COVID-19, Community Assessment Centres were set up across NHSGGC. At peak times, 8 were in operation, with a plan to close these facilities by March 2022. These centres operated 12 hours per day with the GP Out of Hours (GPOOH) Service addressing demand when they were closed. Demand has clearly fluctuated over the duration, averaging 1,700 per month but peaking at between 2,100 and 2,700 appointments.



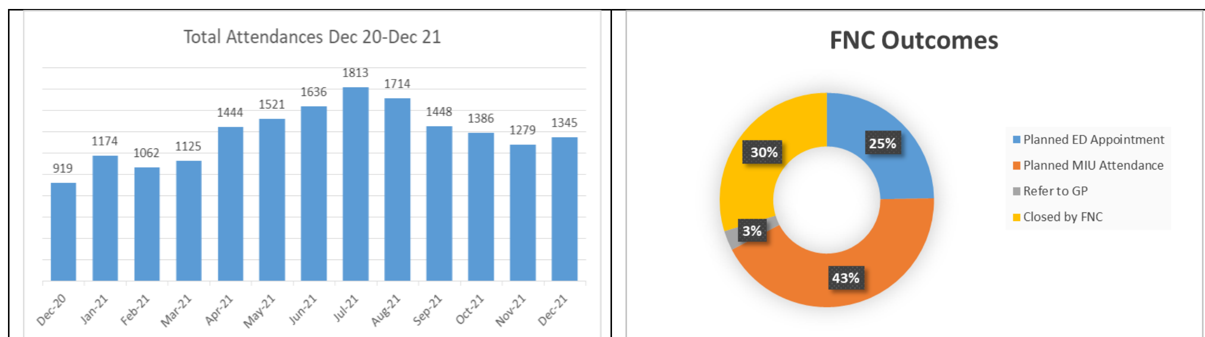
## GP Out of Hours (GPOOH)

The GPOOH service has similarly experienced high levels of demand, averaging around 20,000 calls per month. Calls recorded as related to COVID-19 represent approximately 11% of demand, a figure which has been rising over recent months.



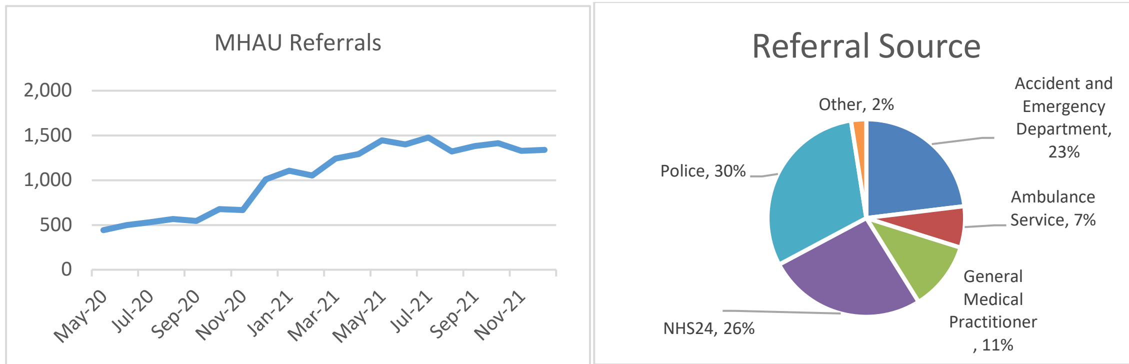

## Flow Navigation Hub

The Flow Navigation Hub was introduced in December 2020, providing a mechanism for patients to be referred by NHS111 and be connected with the most appropriate response. This would be delivered as a 'Near Me' virtual consultation or telephone call in the first instance, aiming to avoid a face-to-face presentation where appropriate. There has been a steady progression of care pathways that can be managed in this way.



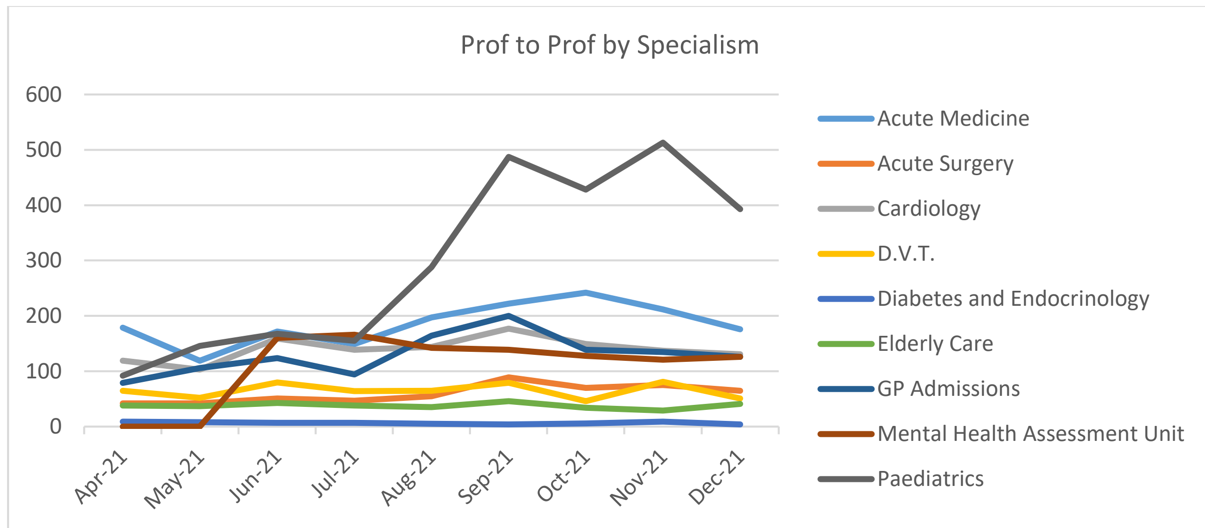

## Mental Health Assessment Unit

The Mental Health Assessment Unit was a planned development, which coincided with the onset of the pandemic. This has now proven itself to be a core part of the Urgent Care response and is integrated into the Flow Navigation Hub, managing in the region of 1,400 referrals per month. Analysis of the source of referrals shows the impact this service is having in diverting 70% of presentations that would otherwise have gone straight to A&E departments.



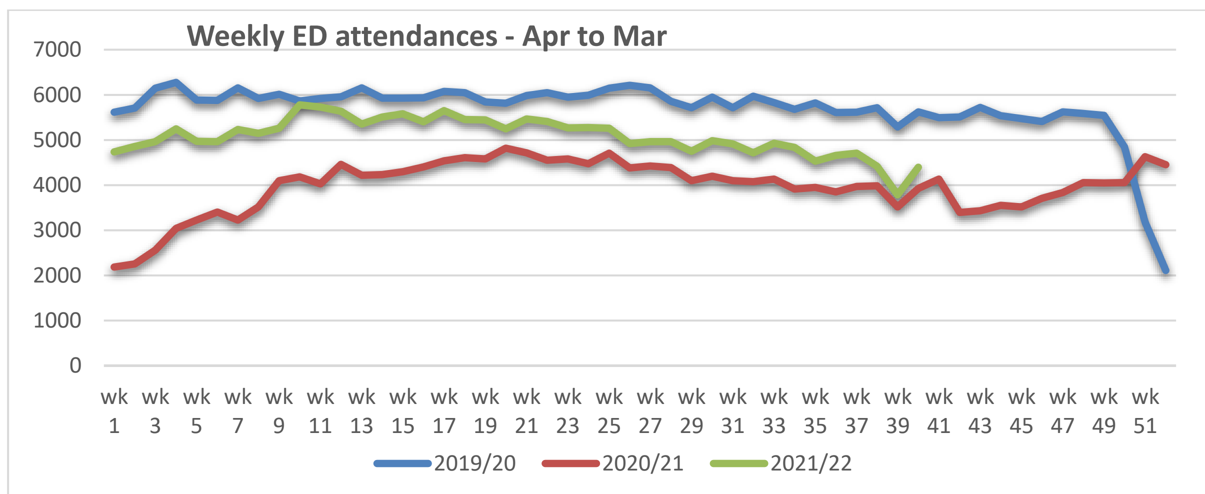

## Professional to Professional

'Consultant Connect' is the digital telephone service that has been adopted by Secondary Care to provide rapid access for GPs to specialist advice as an alternative to an emergency admission. This has developed alongside the mechanisms above and is now handling over 1,000 calls per month.

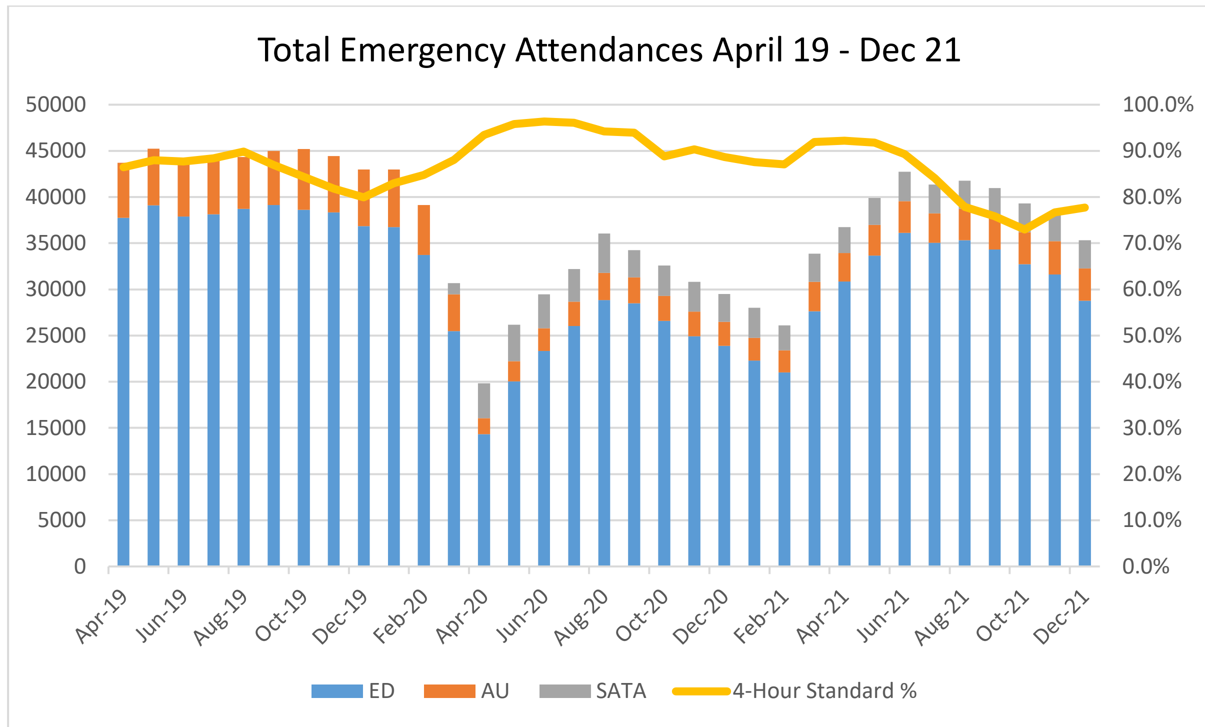



## Acute Hospital Attendances

ED attendances dropped substantially during the initial months of the pandemic. Whilst increasing during 2021, the weekly rates have yet to return to pre-pandemic levels.

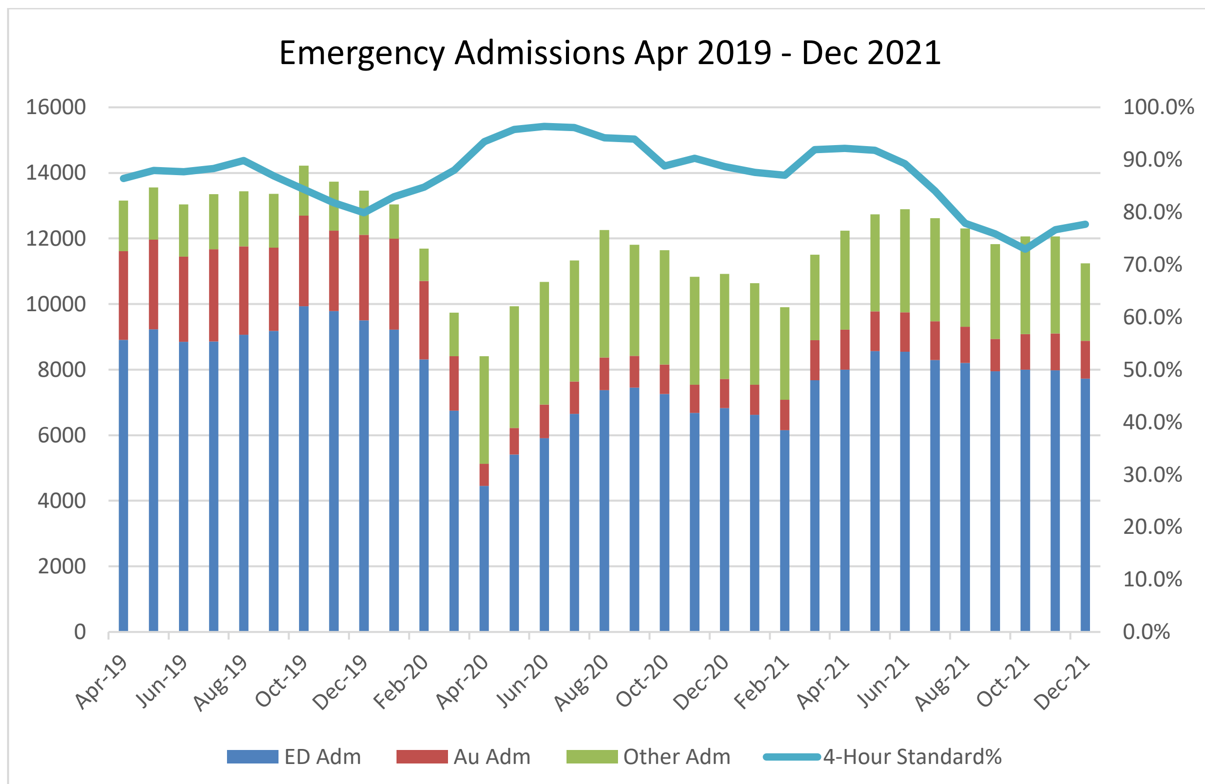


Further comparison - including SATA and Admission Unit attendances, which also contribute to the 4-hour target - clearly describes the profile of activity, which continues to be broadly 10% down on 2019/20 levels.

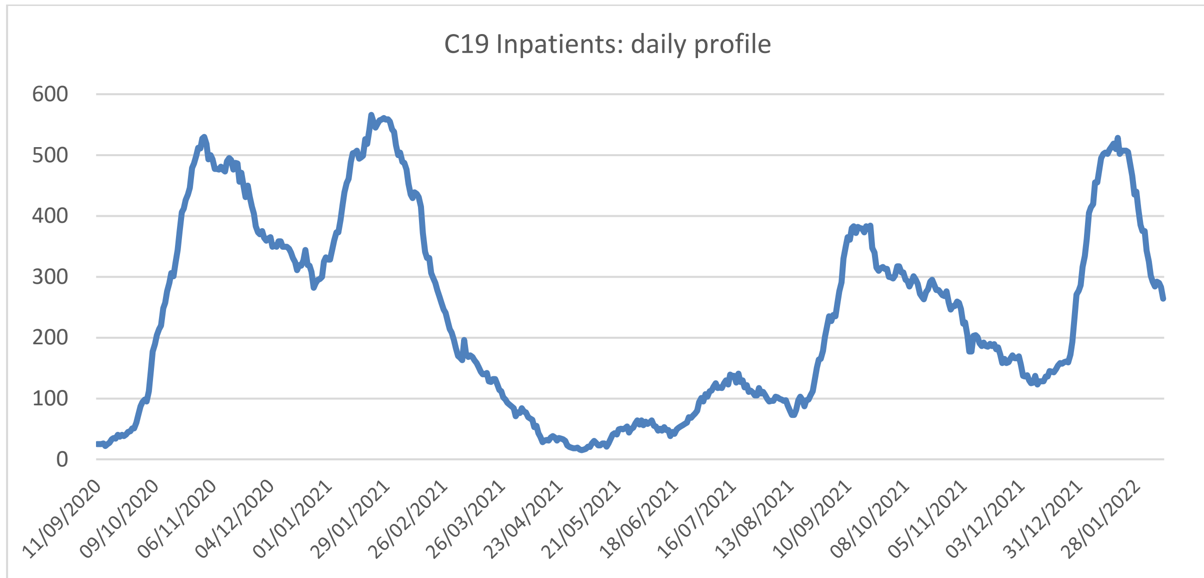



## Hospital Admissions

Emergency Admissions mirror the above profile, with demand continuing throughout 2021 to be broadly 9% below pre-pandemic levels.



The necessity of maintaining 'green' and 'red' pathways to separate COVID-19 patients for infection control issues is one of the significant challenges in managing demand efficiently, particularly with continuing high rates of bed occupancy for COVID-19 positive patients which have consistently accounted for 10% or more of bed capacity for unscheduled care admissions.




## Conclusion

The pandemic has continued to disrupt trends in demand throughout 2021. The development of new services has contributed to a further understanding of pathways, but not yet in a manner that can be used to project ongoing and future profiles.

**ANNEX C**

## Design & Delivery Action Plan

| Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions | | Phase (2 or 3) (2021/23) | Progress update |
|---|---|---|---|
| **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 | 2 & 3 | SG Comms campaign on-going re Right Person, Right Place. Opportunities to develop GGC wide comms and engagement strategy in development liaising with the Corporate Comms Team and Public Engagement Team. A number of awareness campaigns have taken place including Falls Week, ACP, and POA etc.<br>HSCP local signposting materials are being reviewed in a number of HSCPs to ensure they are fully reflective of changes |
| **Prevention & Early Intervention** | | | |

| Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions | | Phase (2 or 3) (2021/23) | Progress update |
|---|---|---|---|
| 2 | We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions | 2 & 3 | Via Falls & Frailty Programme Work stream 2: GGC ACP Design & Implementation Group well established with GGC Action Plan developed<br>HSCP ACP Implementation Groups established with implementation plans developed. ACP Standard Operating Procedure developed due to be implemented Jan 2022. Approval routes via Clinical Advisory Group and Quality Outcomes Group.<br>Number of ACPs on Clinical Portal has increased (working with eHealth to develop monthly reporting<br>Staff trained increased significantly in the last 12 months: since Aug 2020 till Dec 2021 818 completed emodule and 475 completed virtual training<br>ACP Champions across GGC has improved over the last 12 months with 35 across GG&C<br>Quality Assurance approach to be developed to ensure the information within the ACP is of a standard to support decision making |
| 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 | 2 & 3 | Work on-going with SAS to ensure all pathways are considered for patients who have had a fall but may not need conveyed to A&E. This is being progressed via the Falls & Frailty Work stream and RUC FNC. |

| Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions | | Phase (2 or 3) (2021/23) | Progress update |
|---|---|---|---|
| 4 | We will 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 | 2 & 3 | Approved MDT Interface model development with enhanced roles including Advanced Practice Frailty Practitioner and other roles operating within a hub and spoke model to support prevention of conveyance to front door, supporting individuals at home or their homely setting and early turnaround of those individuals to the community for those who do not require clinical care within the hospital setting. Frailty Pathway and Operating Model being developed to support the implementation of the enhanced MDT teams for RAH and QEUH. This will include the identification of frailty within the population and pathways to community supports (volunteers and managed services) |
| 5 | We will increase support to carers as part of implementation of the Carer's Act | 2 & 3 | Being monitored locally by each HSCP via their Carer's Plan. Connections and opportunities are considered across all the Falls & Frailty Work streams. |
| 6 | We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc. | 2 & 3 | Community capacity building will be tracked within this programme via Work Stream 5 Sub Group 1A. |
| 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 | 2 & 3 | Community Respiratory Pathway ToC with SAS - North Glasgow Pilot for COPD patients already known to the CRT. |
| 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 | 2 & 3 | Activity on-going to extend the range of alternatives. Performance updates provided via RMP process.<br>OOHs pathways for Palliative and Care Homes in development |

| Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions | | Phase (2 or 3) (2021/23) | Progress update |
|---|---|---|---|
| 9 | We will further develop access to "step up" services for GPs as an alternative to hospital admission | 2 & 3 | HSCP models being monitored. Work Stream 5 Sub Groups considering alternatives pathways to support individuals within the community to minimise the risk of an admission to hospital |
| 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 | 2 & 3 | Nursing/Care Home Falls Pathway via Flow Navigation Centre test phase OOHs pathway being developed |
| 11 | We will explore extending the care home local enhanced service to provide more GP support to care homes | 2 & 3 | 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 | **2 & 3** | NHSGGC representatives have collaborated with Scottish Government colleagues to produce a National Redirection Policy guidance document that was launched on 02/12/2021 This updated guidance supports a 'Once for Scotland' approach. NHS Boards, Health and Social Care Partnerships, (H&SCPs), Primary Care (PC) and the Royal College of Emergency Medicine (RCEM) have worked collaboratively with the Scottish Government to review and amalgamate best practice examples from across the country and translate them into implementable guidance. GGC have developed local procedures in line with the policy and a standard technical solution to recording activity and providing automated feedback to GP's is now being explored. |

| Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions | | Phase (2 or 3) (2021/23) | Progress update |
|---|---|---|---|
| 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 | 2 & 3 | As part of the Redesign of Urgent Care programme aligned to the Right Care in the Right Place at the Right Time, NHSGGC designed and implemented a Flow Navigation Centre (FNC) to provide a new planned urgent care service in partnership with NHS24. The FNC directly receives clinical referrals through the NHS111 service providing rapid access to an appropriate clinical decision maker within the multidisciplinary team, optimising digital health through a telephone or video consultation where possible, minimising the need to attend A&E. The service has developed multiple specialty outflow pathways designed to provide an urgent but planned appointment that enables patients to be seen by the most appropriate clinician avoiding attendance at the ED, MIU and/or Assessment Units. This work continues with focus on further pathway development and interconnections between other health and social care service providers. |
| 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 | √ | NHSGGC has three designated MIU's at Stobhill, Victoria and Vale of Leven. During the pandemic both GRI and QEUH established designated MIU areas adjacent to the ED. Within RAH and IRH site configuration and resources have facilitated designated areas for minor injury patients to enable patients to be streamed accordingly, these are not adjacent units but areas within the existing units. |
| 15 | We will incentivise patients to attend MIUs rather than A&E with non-emergencies through the testing of a tow hour treatment target. | 3 | The Redesign of Urgent Care has included the introduction of planned urgent care services through the FNC and appointment based attendance at MIU's. This action has been aligned to phase 3 of the programme as it is anticipated that the changes made in the service provision to accommodate appointments within the MIU's may supersede the previous thinking around this specific action. |

| | Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions | Phase (2 or 3) (2021/23) | Progress update |
|---|---|---|---|
| 16 | We will explore extending MIU hours of operation to better match demand | 3 | The Redesign of Urgent Care work continues to review and align hours of operation to meet service demands. This action has been aligned to phase 3 of the programme as it is anticipated that the FNC pathway development and the virtual appointment based system now in place may provide alternative options to extending MIU opening times that might achieve extended access for non-urgent minor injuries. |
| 17 | We will improve urgent access to mental health services | 2 & 3 | Mental Health Assessment Units (MHAU) were established as part of the immediate response to Covid-19. NHSGGC's MHAU provides access for patients through the NHS111 service where further specialist assessment is required and in addition now provides direct access routes for ED's, SAS, and the Police and in addition we have established in hours and out of hours GP access. The service is now also enhanced through a professional to professional advice service where clinicians can discuss and refer patients of concern and rapid action taken to provide specialist input. |
| 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. | 2 & 3 | During the pandemic ED's have introduced the signposting and redirection policy and in addition at a local level a number of bespoke approaches developed to ensure appropriate treatment plans are in place for individuals with high attendances. We have not progressed any whole systems change and therefore this action will be reviewed at a later date to agree how to progress. |
| 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 | 3 | This is a phase 3 action, work has however commenced on specialty pathways aligned to the FNC with a test of change completed at the QEUH relative to developing a planned response for GP referrals. This work will continue through the Redesign of Urgent Care and future updates provided accordingly. |

| **Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions** | | **Phase (2 or 3) (2021/23)** | **Progress update** |
|---|---|---|---|
| 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) | 2 & 3 | H@H pilot to launch February 2022. A significant programme of work has been undertaken to design the concept of a 'virtual ward' with technical and clinical processes developed to support the delivery of NHSGGC's H@H model. We will be in a position to report progress following the Feb 2022 launch. |
| 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 | 2 & 3 | Programme underway and to be reported vis routine performance reports to Health Board meetings |
| **Improving Discharge** | | □ | |
| 21 | 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 | 2 & 3 | A number of actions underway:<br>- Discharge to Assess Policy implementation (review of implementation required)<br>- Hospital @ Home Pilot<br>- MDT Interface Model |
| 22 | 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. | 2 & 3 | Discharge to Assess Policy Implementation of the MDT Interface Hub and Spoke Model |
| 23 | 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 | 2 & 3 | Being developed within Work Stream 5 of the Falls & Frailty Programme |

| Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions | | Phase (2 or 3) (2021/23) | Progress update |
|---|---|---|---|
| 24 | 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 | 3 | All of the above actions will support this ambition |

## ANNEX D

# UNSCHEDULED CARE FINANCIAL FRAMEWORK

| Unscheduled Care : Financial Framework | | Glasgow City IA | | | | | Inverclyde IA | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
| **Phase 1** | | | | | | | | | | | |
| **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. | N/R | £74,000 | £0 | £0 | £74,000 | R | £10,000 | £10,000 | £0 | £20,000 |
| **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 | £52,460 | £10,287 | £0 | £62,747 | R | £66,200 | £22,067 | £0 | £88,267 |
| 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. | R | £52,060 | £17,353 | £0 | £69,414 | | £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. | R | £791,231 | £71,744 | £0 | £862,974 | R | £11,000 | £0 | £0 | £11,000 |
| 5 | We will increase support to carers as part of implementation of the Carer's Act. | | £0 | £0 | £0 | £0 | | £0 | £0 | £0 | £0 |
| 6 | We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc | | £0 | £0 | £0 | £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 | £0 | £0 | £0 | | £0 | £0 | £0 | £0 |
| 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 | £0 | £0 | £0 | | £0 | £0 | £0 | £0 |
| **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 | £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 | £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 | N/R | £5,000 | £0 | £0 | £5,000 |
| 17 | We will improve urgent access to mental health services. | R | £683,694 | £0 | £0 | £683,694 | R | £93,453 | £0 | £0 | £93,453 |
| 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). | N/R | £1,353,000 | £0 | £0 | £1,353,000 | | £0 | £0 | £0 | £0 |
| 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 | £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. | N/R | £210,000 | £200,000 | £0 | £410,000 | | £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. | N/R and R | £210,000 | £0 | £0 | £210,000 | N/R | £10,000 | £0 | £0 | £10,000 |
| **Total** | | | **£3,426,445** | **£299,384** | **£0** | **£3,725,829** | | **£195,653** | **£32,067** | **£0** | **£227,720** |

| | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Recurring | £1,679,445 | £99,384 | £0 | £1,778,829 | £180,653 | £32,067 | £0 | £212,720 |
| Non Recurring | £1,747,000 | £200,000 | £0 | £1,947,000 | £15,000 | £0 | £0 | £15,000 |
| **Total** | **£3,426,445** | **£299,384** | **£0** | **£3,725,829** | **£195,653** | **£32,067** | **£0** | **£227,720** |

| Funding : Recurring Expenditure | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Scottish Government Funding | £676,000 | £0 | £0 | £676,000 | £11,000 | £0 | £0 | £11,000 |
| Scottish Government Funding : COVID | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| IJB Budget | £319,751 | £99,384 | £0 | £419,135 | £10,000 | £10,000 | £0 | £20,000 |
| **Total Funding Recurring** | **£995,751** | **£99,384** | **£0** | **£1,095,135** | **£21,000** | **£10,000** | **£0** | **£31,000** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Funding Gap** | **£683,694** | **£0** | **£0** | **£683,694** | **£159,653** | **£22,067** | **£0** | **£181,720** |

| Funding : Non Recurring Expenditure | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Earmarked Reserves | £0 | £0 | £0 | £0 | £15,000 | £0 | £0 | £15,000 |
| Manage within HSCP Budget | £284,000 | £200,000 | £0 | £484,000 | £0 | £0 | £0 | £0 |
| Scottish Government Funding | £1,463,000 | £0 | £0 | £1,463,000 | £0 | £0 | £0 | £0 |
| **Total Funding Non Recurring** | **£1,747,000** | **£200,000** | **£0** | **£1,947,000** | **£15,000** | **£0** | **£0** | **£15,000** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Funding Gap** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** |

| Unscheduled Care : Financial Framework | | East Renfrewshire IA | | | | | West Dunbartonshire IA | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
| **Phase 1** | | | | | | | | | | | |
| **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 | £10,000 | £0 | £0 | £10,000 | R | £10,000 | £0 | £0 | £10,000 |
| **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 | £21,652 | £7,217 | £0 | £28,869 | R | £8,482 | £0 | £0 | £8,482 |
| 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 | £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. | | £77,508 | £25,836 | £0 | £103,344 | R | £126,268 | £0 | £0 | £126,268 |
| 5 | We will increase support to carers as part of implementation of the Carer's Act. | | £0 | £0 | £0 | £0 | | £0 | £0 | £0 | £0 |
| 6 | We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc | | £0 | £0 | £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 | £85,696 | £28,565 | £0 | £114,262 | | £0 | £0 | £0 | £0 |
| 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 | £93,194 | £31,065 | £0 | £124,259 | R | £61,876 | £0 | £0 | £61,876 |
| **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 | £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 | £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 | £0 | £0 |
| 17 | We will improve urgent access to mental health services. | R | £91,161 | £0 | £0 | £91,161 | R | £103,638 | £0 | £0 | £103,638 |
| 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 | £0 | £0 |
| 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 | £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 | R | £617,925 | £0 | £0 | £617,925 |
| 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 | R | £599,109 | £0 | £0 | £599,109 |
| **Total** | | | **£379,211** | **£92,683** | **£0** | **£471,895** | | **£1,527,298** | **£0** | **£0** | **£1,527,298** |

| | East Renfrewshire 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | West Dunbartonshire 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Recurring | £379,211 | £92,683 | £0 | £471,895 | £1,527,298 | £0 | £0 | £1,527,298 |
| Non Recurring | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| **Total** | **£379,211** | **£92,683** | **£0** | **£471,895** | **£1,527,298** | **£0** | **£0** | **£1,527,298** |

| Funding : Recurring Expenditure | East Renfrewshire 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | West Dunbartonshire 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Scottish Government Funding | £203,204 | £54,401 | £0 | £257,605 | £1,405,178 | £0 | £0 | £1,405,178 |
| Scottish Government Funding : COVID | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| IJB Budget | £84,846 | -£84,846 | £0 | £0 | £18,482 | £0 | £0 | £18,482 |
| **Total Funding Recurring** | **£288,050** | **-£30,445** | **£0** | **£257,605** | **£1,423,660** | **£0** | **£0** | **£1,423,660** |
| **Funding Gap** | **£91,161** | **£123,128** | **£0** | **£214,290** | **£103,638** | **£0** | **£0** | **£103,638** |

| Funding : Non Recurring Expenditure | East Renfrewshire 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | West Dunbartonshire 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Earmarked Reserves | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| Manage within HSCP Budget | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| Scottish Government Funding | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| **Total Funding Non Recurring** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** |
| **Funding Gap** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** |

| | Unscheduled Care : Financial Framework | East Dunbartonshire IA | | | | | Renfrewshire IA | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
| **Phase 1** | | | | | | | | | | | |
| **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 | £10,000 | £0 | £0 | £10,000 | | £0 | £0 | £0 | £0 |
| **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 | £0 | £0 | £0 | N/R | £20,000 | £0 | £0 | £20,000 |
| 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 | R | £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. | R | £393,679 | £139,634 | £0 | £533,313 | R | £2,367,365 | £0 | £0 | £2,367,365 |
| 5 | We will increase support to carers as part of implementation of the Carer's Act. | | £0 | £0 | £0 | £0 | | £0 | £0 | £0 | £0 |
| 6 | We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc | | £0 | £0 | £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 | £400,648 | £13,125 | £0 | £413,773 | R | £620,000 | £0 | £0 | £620,000 |
| 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 | £326,991 | £0 | £0 | £326,991 | R and N/R | £0 | £0 | £0 | £0 |
| **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 | N/R | £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 | £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 | £0 | £0 |
| 17 | We will improve urgent access to mental health services. | R | £106,312 | £0 | £0 | £106,312 | R | £194,672 | £0 | £0 | £194,672 |
| 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 | £0 | £0 |
| 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 | £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. | | £182,007 | £0 | £0 | £182,007 | | £530,112 | £0 | £0 | £530,112 |
| 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. | R | £1,072,745 | £0 | £0 | £1,072,745 | N/R | £20,000 | £0 | £0 | £20,000 |
| **Total** | | | **£2,492,382** | **£152,759** | **£0** | **£2,645,141** | | **£3,752,149** | **£0** | **£0** | **£3,752,149** |

| | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Recurring | £2,492,382 | £152,759 | £0 | £2,645,141 | £3,712,149 | £0 | £0 | £3,712,149 |
| Non Recurring | £0 | £0 | £0 | £0 | £40,000 | £0 | £0 | £40,000 |
| **Total** | **£2,492,382** | **£152,759** | **£0** | **£2,645,141** | **£3,752,149** | **£0** | **£0** | **£3,752,149** |

| **Funding : Recurring Expenditure** | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Scottish Government Funding | £2,059,079 | £152,759 | £0 | £2,211,838 | £3,517,477 | £0 | £0 | £3,517,477 |
| Scottish Government Funding : COVID | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| IJB Budget | £326,991 | £0 | £0 | £326,991 | £0 | £0 | £0 | £0 |
| **Total Funding Recurring** | **£2,386,070** | **£152,759** | **£0** | **£2,538,829** | **£3,517,477** | **£0** | **£0** | **£3,517,477** |

| **Funding Gap** | **£106,312** | **£0** | **£0** | **£106,312** | **£194,672** | **£0** | **£0** | **£194,672** |
|---|---|---|---|---|---|---|---|---|

| **Funding : Non Recurring Expenditure** | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Earmarked Reserves | £0 | £0 | £0 | £0 | £40,000 | £0 | £0 | £40,000 |
| Manage within HSCP Budget | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| Scottish Government Funding | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| **Total Funding Non Recurring** | **£0** | **£0** | **£0** | **£0** | **£40,000** | **£0** | **£0** | **£40,000** |

| **Funding Gap** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** |
|---|---|---|---|---|---|---|---|---|

| Unscheduled Care : Financial Framework | | Greater Glasgow and Clyde Health Board | | | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
| **Phase 1** | | | | | | | | | | |
| **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 | £0 | £0 | £0 | £114,000 | £10,000 | £0 | £124,000 |
| **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 | £0 | £0 | £0 | £168,794 | £39,571 | £0 | £208,365 |
| 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 | £52,060 | £17,353 | £0 | £69,414 |
| 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 | £3,767,051 | £237,214 | £0 | £4,004,265 |
| 5 | We will increase support to carers as part of implementation of the Carer's Act. | | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| 6 | We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc | | £0 | £0 | £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 | £0 | £0 | £0 | £1,106,344 | £41,690 | £0 | £1,148,035 |
| 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 | £0 | £0 | £0 | £482,061 | £31,065 | £0 | £513,126 |
| **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. | R | £1,200,000 | £0 | £0 | £1,200,000 | £1,200,000 | £0 | £0 | £1,200,000 |
| 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. | R | £2,546,221 | £0 | £0 | £2,546,221 | £2,546,221 | £0 | £0 | £2,546,221 |
| 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. | R | £728,000 | £0 | £0 | £728,000 | £733,000 | £0 | £0 | £733,000 |
| 17 | We will improve urgent access to mental health services. | | £0 | £0 | £0 | £0 | £1,272,930 | £0 | £0 | £1,272,930 |
| 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 | £1,353,000 | £0 | £0 | £1,353,000 |
| 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 | N/R | £20,000,000 | £0 | £0 | £20,000,000 | £20,000,000 | £0 | £0 | £20,000,000 |
| **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 | £1,540,044 | £200,000 | £0 | £1,740,044 |
| 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 | £1,911,854 | £0 | £0 | £1,911,854 |
| **Total** | | | **£24,474,221** | **£0** | **£0** | **£24,474,221** | **£16,247,359** | **£576,893** | **£0** | **£36,824,252** |

| | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Recurring | £4,474,221 | £0 | £0 | £4,474,221 | £14,445,359 | £376,893 | £0 | £14,822,252 |
| Non Recurring | £20,000,000 | £0 | £0 | £20,000,000 | £21,802,000 | £200,000 | £0 | £22,002,000 |
| **Total** | **£24,474,221** | **£0** | **£0** | **£24,474,221** | **£36,247,359** | **£576,893** | **£0** | **£36,824,252** |

| **Funding : Recurring Expenditure** | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Scottish Government Funding | £2,840,252 | -£2,840,252 | £0 | £0 | £10,712,190 | -£2,633,092 | £0 | £8,079,098 |
| Scottish Government Funding : COVID | £581,000 | -£581,000 | £0 | £0 | £581,000 | -£581,000 | £0 | £0 |
| IJB Budget | £0 | £0 | £0 | £0 | £760,070 | £24,538 | £0 | £784,608 |
| **Total Funding Recurring** | **£3,421,252** | **-£3,421,252** | **£0** | **£0** | **£12,053,260** | **-£3,189,554** | **£0** | **£8,863,706** |
| | | | | | | | | |
| **Funding Gap** | **£1,052,969** | **£3,421,252** | **£0** | **£4,474,221** | **£2,392,099** | **£3,566,447** | **£0** | **£5,958,546** |

| **Funding : Non Recurring Expenditure** | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|
| Earmarked Reserves | £20,000,000 | £0 | £0 | £20,000,000 | £20,055,000 | £0 | £0 | £20,055,000 |
| Manage within HSCP Budget | £0 | £0 | £0 | £0 | £284,000 | £200,000 | £0 | £484,000 |
| Scottish Government Funding | £0 | £0 | £0 | £0 | £1,463,000 | £0 | £0 | £1,463,000 |
| **Total Funding Non Recurring** | **£20,000,000** | **£0** | **£0** | **£20,000,000** | **£21,802,000** | **£200,000** | **£0** | **£22,002,000** |
| | | | | | | | | |
| **Funding Gap** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** |

| Unscheduled Care : Financial Framework | Renfrewshire IA | | | | | | East Dunbartonshire IA | | | | | Glasgow City IA | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Recurring (R)/ Non Recurring (N/R) | 2021/22 (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | Recurring (R)/ Non Recurring (N/R) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
| **Phase 2 and 3** | | | | | | | | | | | | | | | | |
| **Prevention & Early Intervention** | | | | | | | | | | | | | | | | |
| 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 | N/R | £103,357 | £212,916 | £122,526 | £0 | £438,799 | R | £43,384 | £14,461 | £0 | £57,845 | | £0 | £0 | £0 | £0 |
| 11 We will explore extending the care home local enhanced service to provide more GP support to care homes | | £0 | £0 | £0 | £0 | £0 | R | £103,267 | £0 | £0 | £103,267 | | £0 | £0 | £0 | £0 |
| **Primary Care & Secondary Care Interface** | | | | | | | | | | | | | | | | |
| 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. | R | £0 | £0 | £0 | £0 | £0 | | £0 | £0 | £0 | £0 | | £0 | £0 | £0 | £0 |
| **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 | R | £0 | £82,032 | £14,011 | £0 | £96,043 | R | £63,649 | £21,216 | £0 | £84,866 | N/R | £10,000 | £0 | £0 | £10,000 |
| 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 | R | £0 | £159,268 | £0 | £0 | £159,268 | R | £380,244 | £162,846 | £0 | £543,090 | R and N/R | £220,000 | £0 | £0 | £220,000 |
| **Total** | | **£103,357** | **£454,216** | **£136,537** | **£0** | **£694,111** | | **£590,544** | **£198,524** | **£0** | **£789,068** | | **£230,000** | **£0** | **£0** | **£230,000** |

| | Renfrewshire 2021/22 (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | East Dunbartonshire 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | Glasgow City 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Recurring | £0 | £241,300 | £14,011 | £0 | £255,311 | £590,544 | £198,524 | £0 | £789,068 | £210,000 | £0 | £0 | £210,000 |
| Non Recurring | £103,357 | £212,916 | £122,526 | £0 | £438,799 | £0 | £0 | £0 | £0 | £20,000 | £0 | £0 | £20,000 |
| **Total** | **£103,357** | **£454,216** | **£136,537** | **£0** | **£694,111** | **£590,544** | **£198,524** | **£0** | **£789,068** | **£230,000** | **£0** | **£0** | **£230,000** |

| **Funding** | Renfrewshire 2021/22 (£) | 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | East Dunbartonshire 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) | Glasgow City 2022/23 (£) | 2023/24 (£) | 2024/25 (£) | Total (£) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Earmarked Reserves | £103,357 | £212,916 | £122,526 | £0 | £438,799 | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| Scottish Government Funding | £0 | £241,300 | £14,011 | £0 | £255,311 | £590,544 | £198,524 | £0 | £789,068 | £230,000 | £0 | £0 | £230,000 |
| **Total Funding Non Recurring** | **£103,357** | **£454,216** | **£136,537** | **£0** | **£694,111** | **£590,544** | **£198,524** | **£0** | **£789,068** | **£230,000** | **£0** | **£0** | **£230,000** |
| **Funding Gap** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** | **£0** |

**ANNEX E**

## 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**
  - attendances by age, sex and deprivation
  - admissions and discharges

- **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 F**

**EMERGENCY ADMISSIONS (65+) PROJECTIONS**

**2022/23-2024/25**

# Design and Delivery Plan Projections

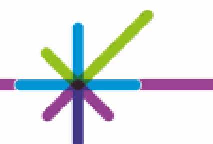
## NHSGGC Emergency Admissions Projections (Ages 65+)

3 December 2021 (update to RMP4)

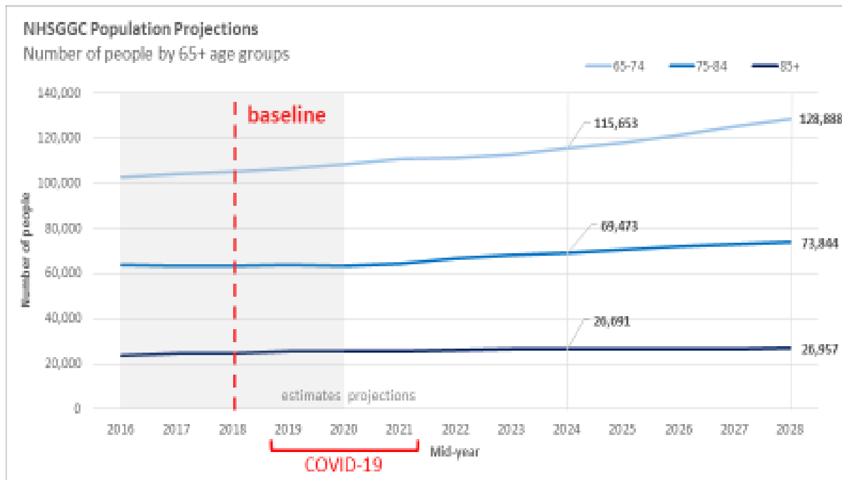
**Gary King**
Local Intelligence Support Team (LIST)

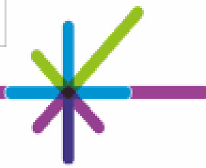
## Summary

- Population Projections 2018 to 2028 — NRS data
  - Age groups 65-74, 75-84 & 85+
  - Age group 65+ alone
- Emergency Admissions Projections (Age 65+) — NHS GGC data
  - 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 3 scenarios for 2021/22 to 2024/25
  - Taking into consideration RMP4 target for 2021/22

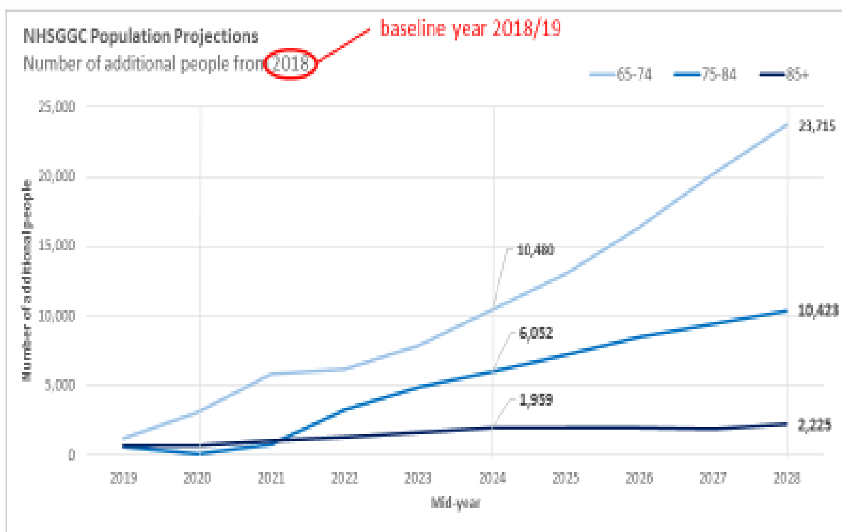


# Population Projections
Number of people (aged 65+ groups)



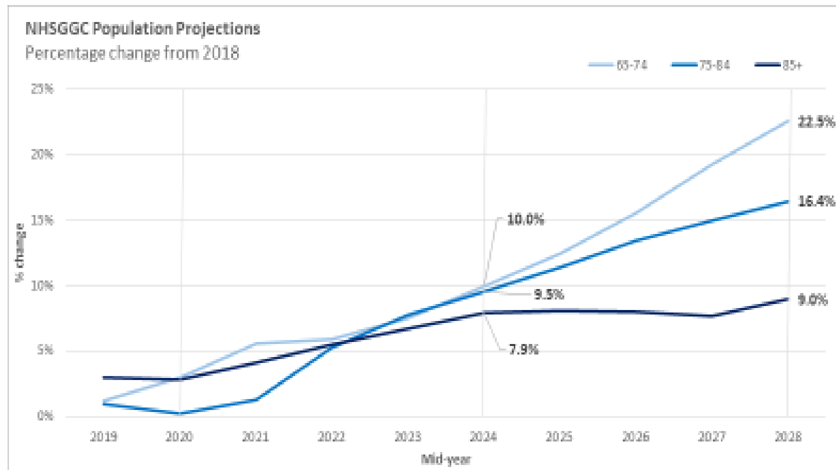



# Population Projections
Number of additional people (aged 65+ groups)



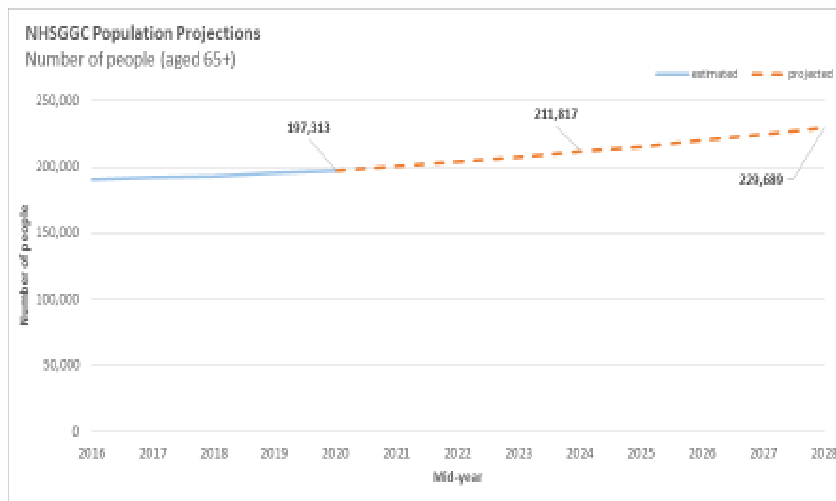
## Population Projections

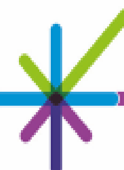
Percentage change from 2018 (aged 65+ groups)



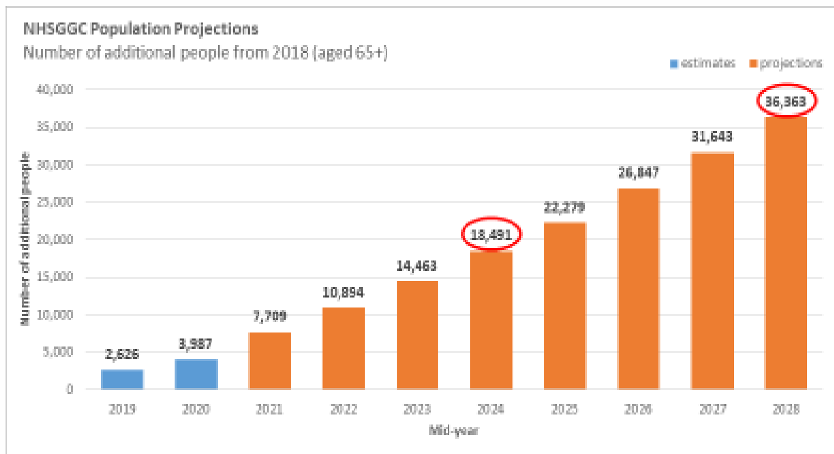
## Population Projections

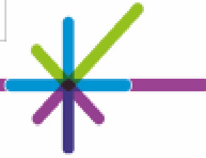
Number of people (aged 65+)



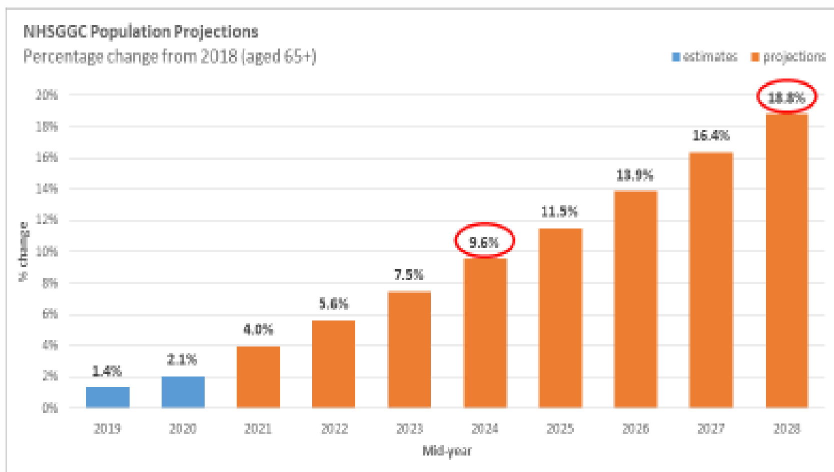



## Population Projections
Additional people from 2018 (aged 65+)

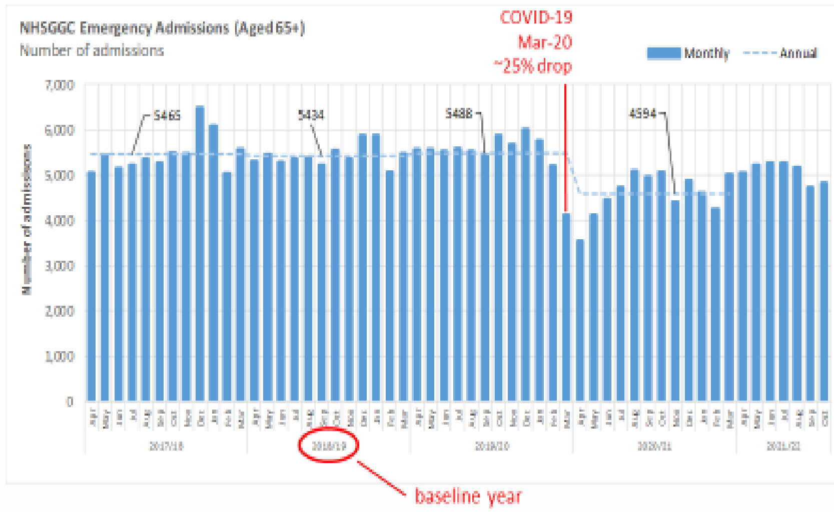


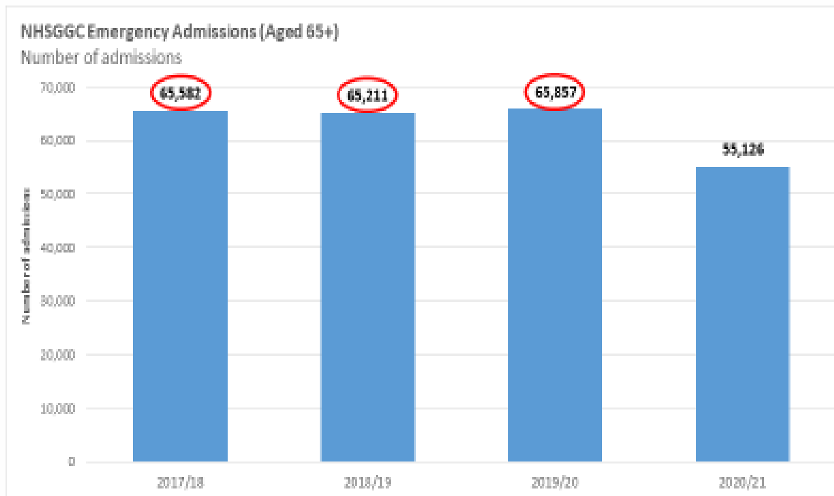
## Population Projections
Change from 2018 (aged 65+)



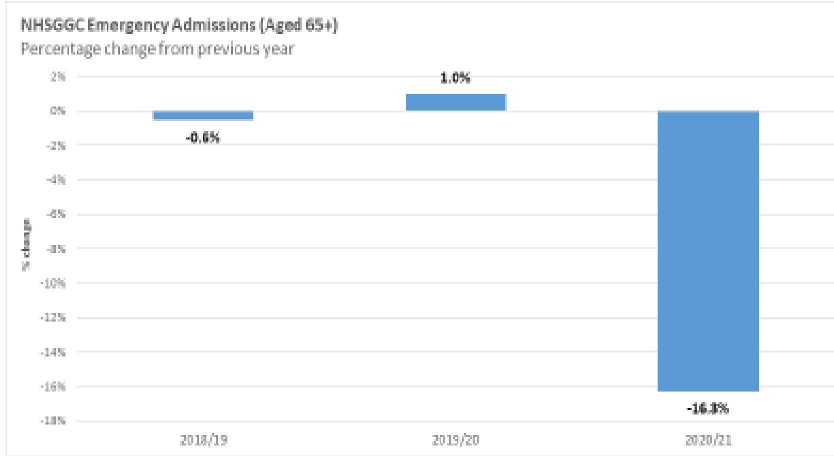
## Emergency Admissions (Ages 65+)
Number of admissions



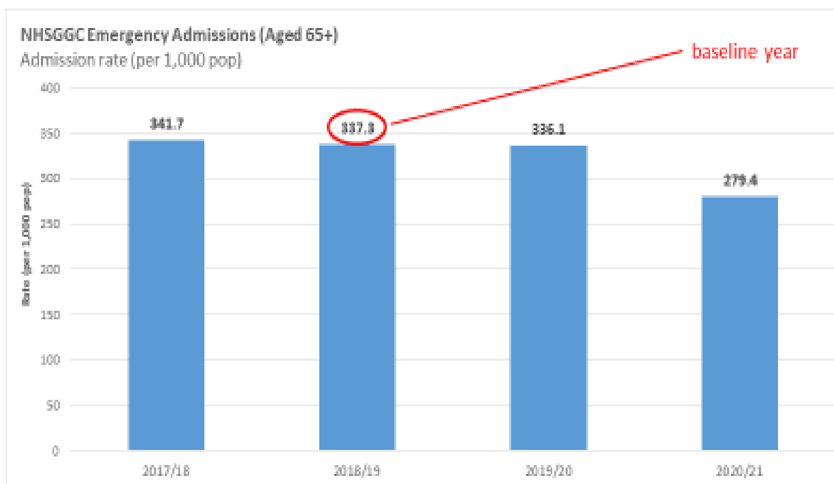

## Emergency Admissions Ages 65+
Number of admissions

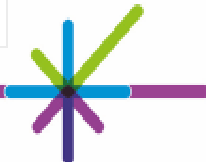


## Emergency Admissions Ages 65+
% change from previous year



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



## Emergency Admissions Ages 65+
Projections Theory

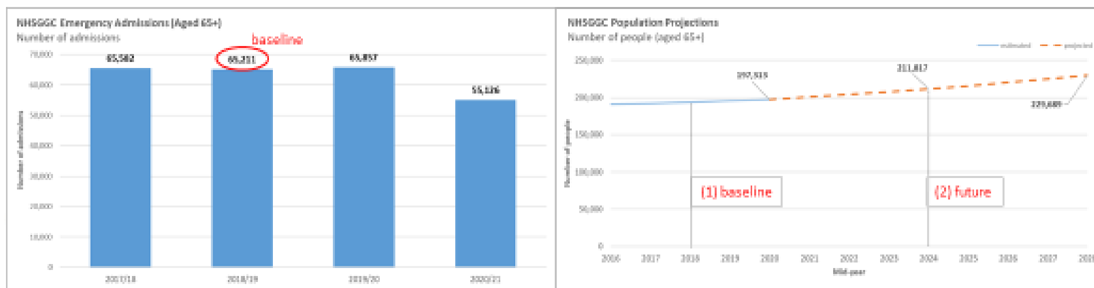
- Use baseline admission rate with population projections to estimate future number of admissions

(1) $\text{Admission rate (per 1,000 pop)} = \dfrac{\text{Number of admissions}}{\text{Population}}$ ⇨ $\text{Admission rate (2018/19 baseline)} = \dfrac{65{,}211}{193{,}326} \times 1{,}000 = 337.3$

(2) $\text{Number of admissions} = \text{Population} \times \dfrac{\text{Admission rate}}{\text{(per 1,000 pop)}}$ ⇨ $\text{Number of admissions (2024/25)} = 211{,}817 \times \dfrac{337.3}{1{,}000} = \mathbf{71,448}$

9.6% increase from baseline

⇨ Admission rate stays the same but number of admissions increase due to increase in 65+ population




## Emergency Admissions Ages 65+
Projection Scenarios

<u>Scenario 1</u>

No implementation ⇨ No reduction in 2018/19 baseline admission rate

<u>Scenario 2</u>

Partial implementation ⇨ 5% reduction

<u>Scenario 3</u>

Full implementation ⇨ 10% reduction

RMP4 is a 7.5% reduction from 2018/19 baseline

⇨ While factoring in RMP4 targets for 2021/22

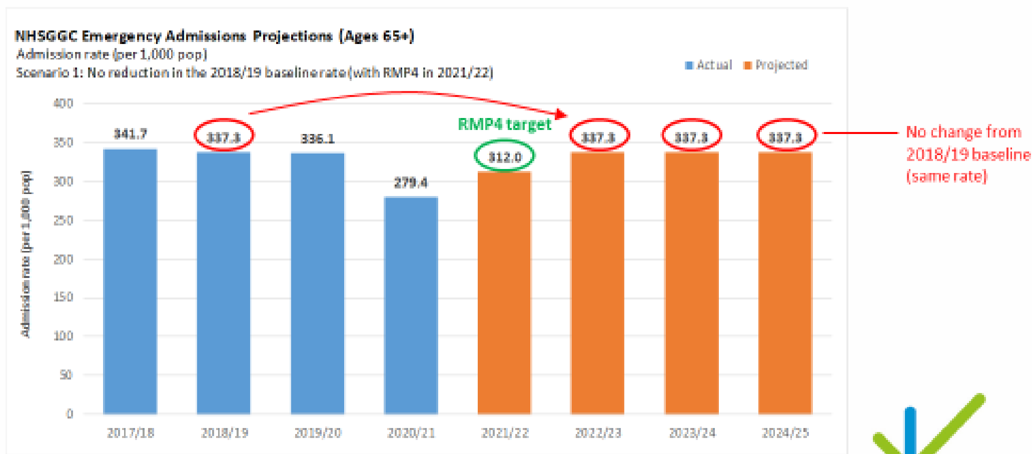
**RMP4 target 2021/22:**
149,333 (All ages)

**Estimate for ages 65+:**
149,333 x 42%
= 62,720

Ratio of EAs: Age 65+ / All ages

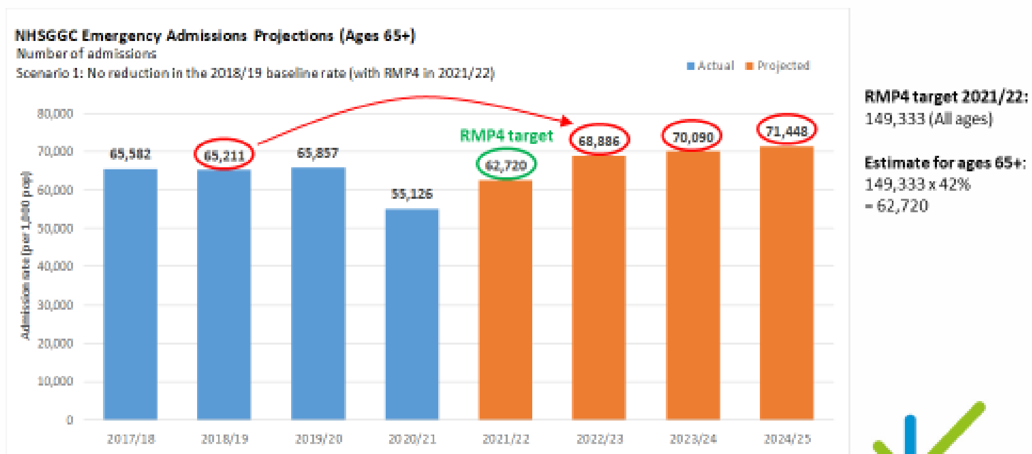
## Scenario 1: No reduction in 2018/19 baseline (no implementation)

Admission rates (per 1,000 population)



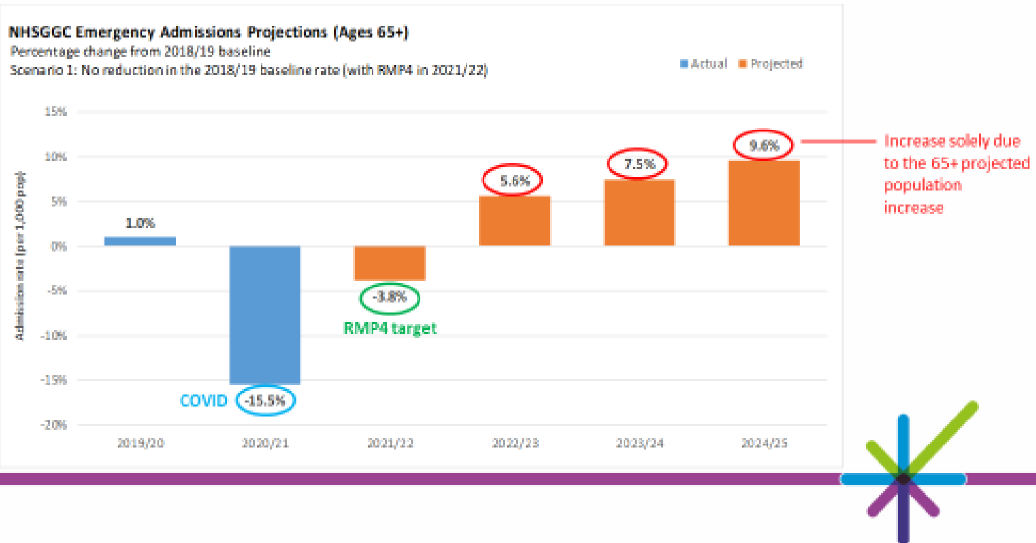

## Scenario 1 No reduction in 2018/19 baseline (no implementation)

Number of Admissions



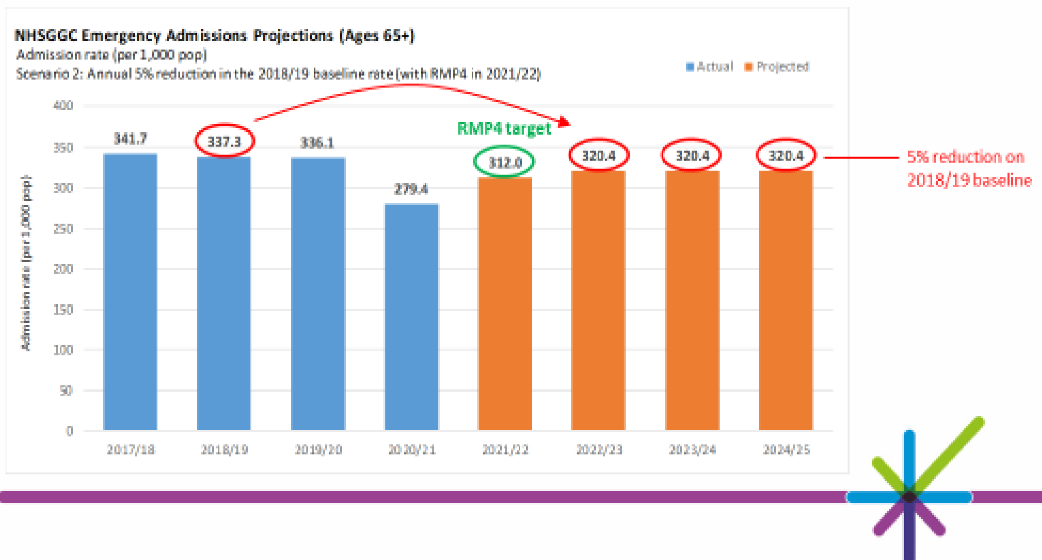
## Scenario 1: No reduction in 2018/19 baseline (no implementation)

Percentage change from 2018/19 baseline



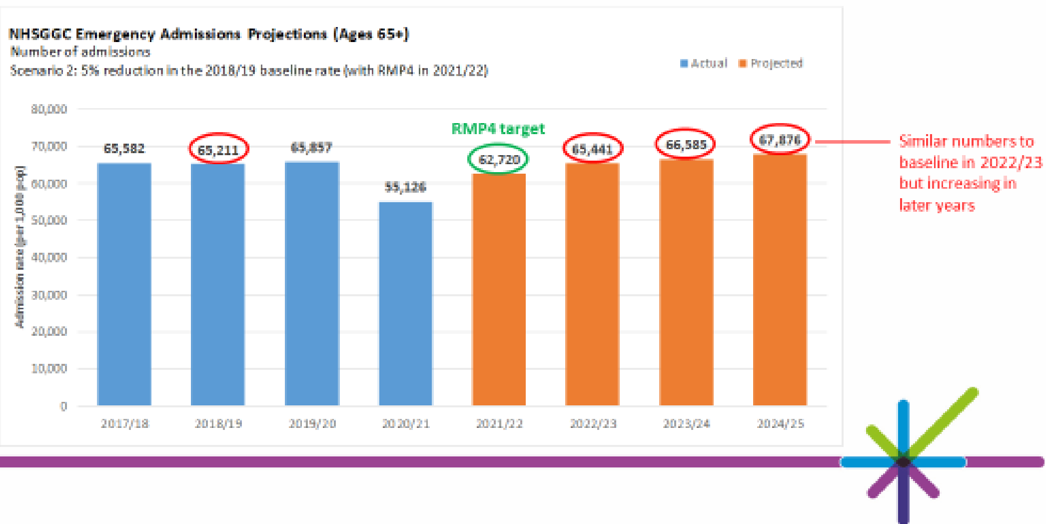

## Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Admission rates (per 1,000 population)



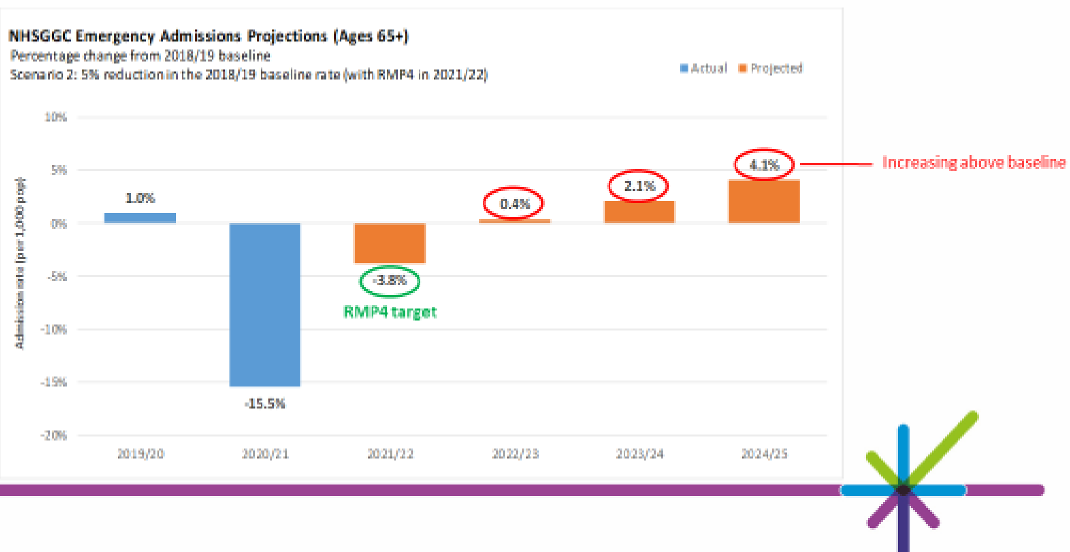
## Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Number of Admissions



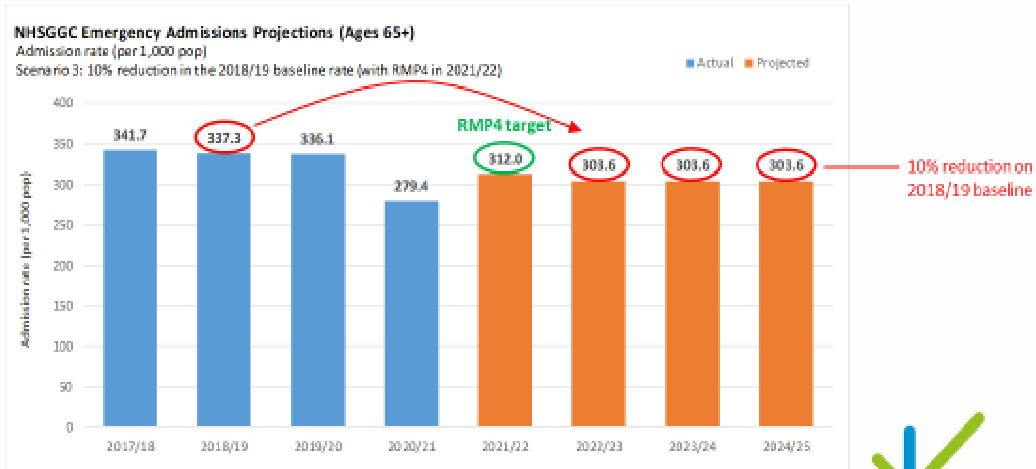

## Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Percentage change from 2018/19 baseline



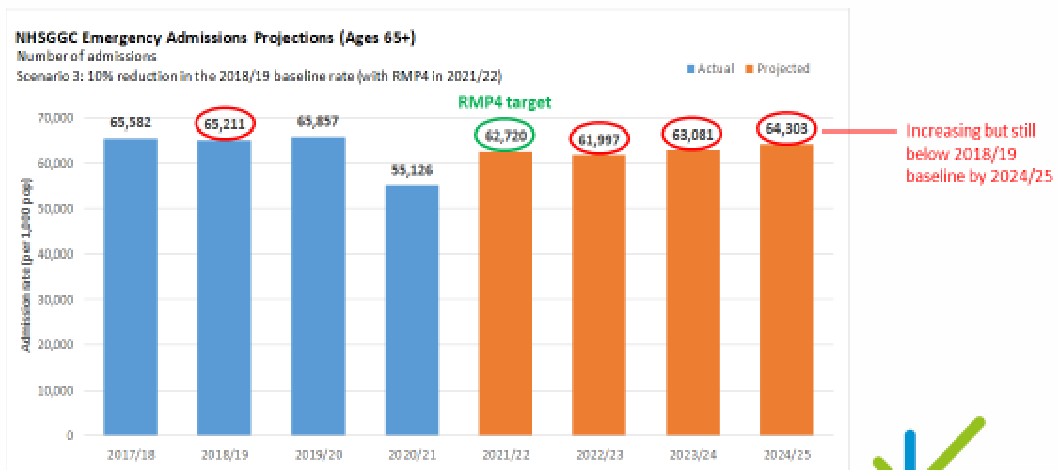
## <u>Scenario 3:</u> 10% reduction in 2018/19 baseline (full impl.)

Admission rates (per 1,000 population)




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

Number of Admissions



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

Percentage change from 2018/19 baseline