NHS GREATER GLASGOW & CLYDE

UNSCHEDULED CARE
JOINT COMISSIONING PLAN

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

ANNEXES

August 2021

CONTENTS

ANNEX A

2020 Unscheduled Care Programme

Progress overview of activity against key actions 2020

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

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

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

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

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

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

Signposting and Redirection Policy

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

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

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

Discharge to Assess Policy

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

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

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

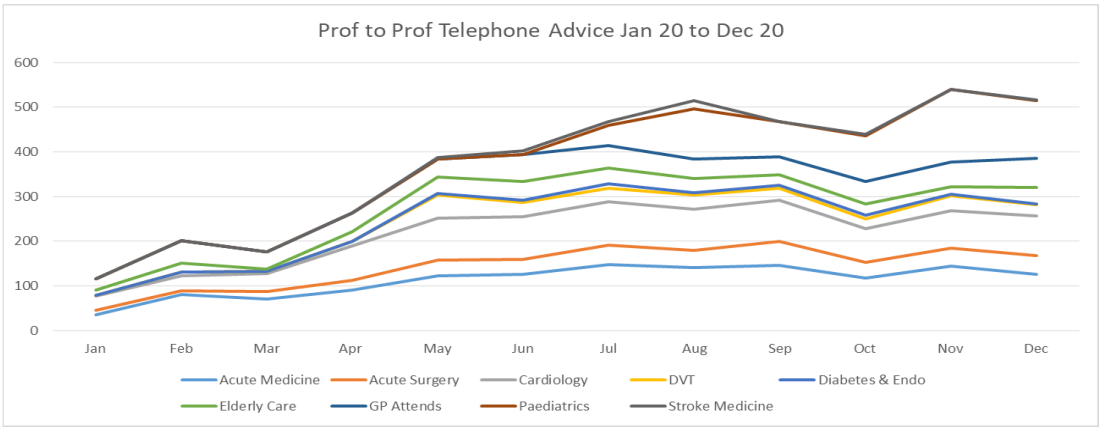
Key to successful implementation is Person Centred Care and Multi-Disciplinary Team working. The aim of all members of the MDT should be to commence planning for discharge as early as possible within the patient journey. Individual's, their family/carers will be central to decision making and engaged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

Digital Professional to Professional Advice Solutions

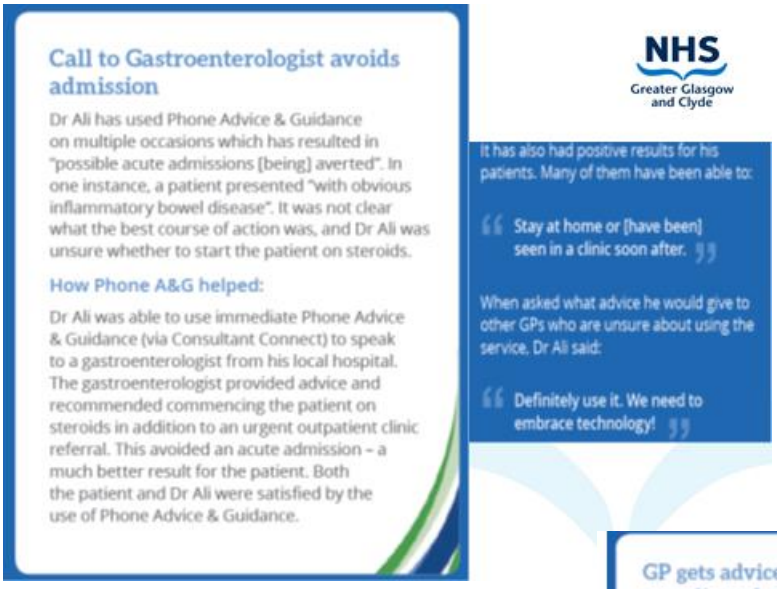
The aim of the professional to professional advice service is to provide GPs and other health care professionals with access to Specialty Advice, to ensure we are able to direct patients to the right care at the right time and in the right place. NHSGGC has introduced a telephone and app based service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

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

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



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



OOHs Urgent Care Resource Hub and Local Response Hub Model

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

Colleagues from across the Health and

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

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

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

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

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

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

Importantly there is no change for patients, service users and cares in how they access services in the OOHs period as they will continue to use existing numbers/existing pathways to access services. This is a change in where some staff are located and how all services will work together.

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

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

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

ANNEX B

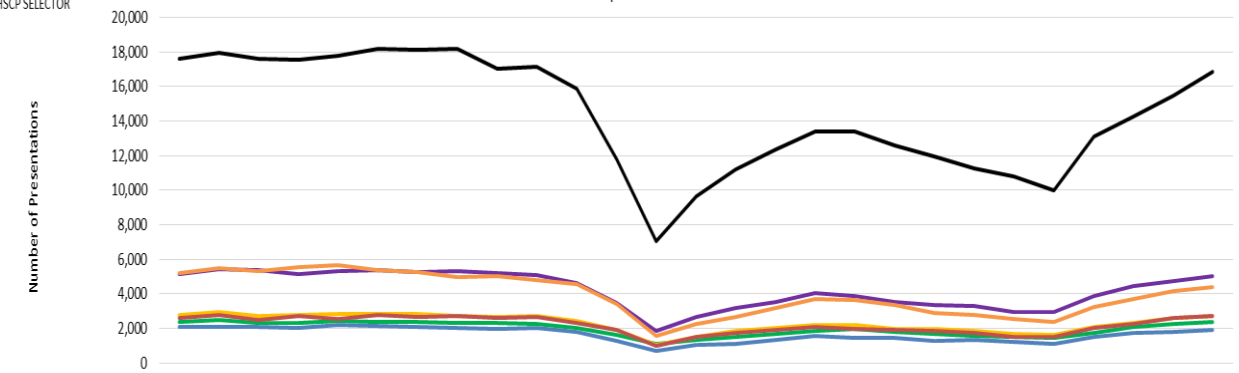
Rear View Mirror Slides

Unscheduled Care activity

2019-2021

by HSCP and GG&C

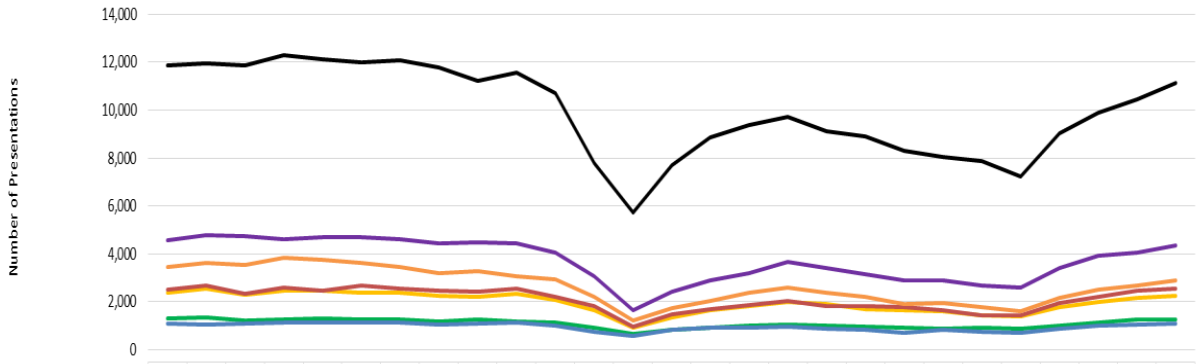
DATASOURCE: MONTHLY UNSCHEDULED CARE HSCP - APR-Jun 21/22
WITH HSCP SELECTOR



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

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

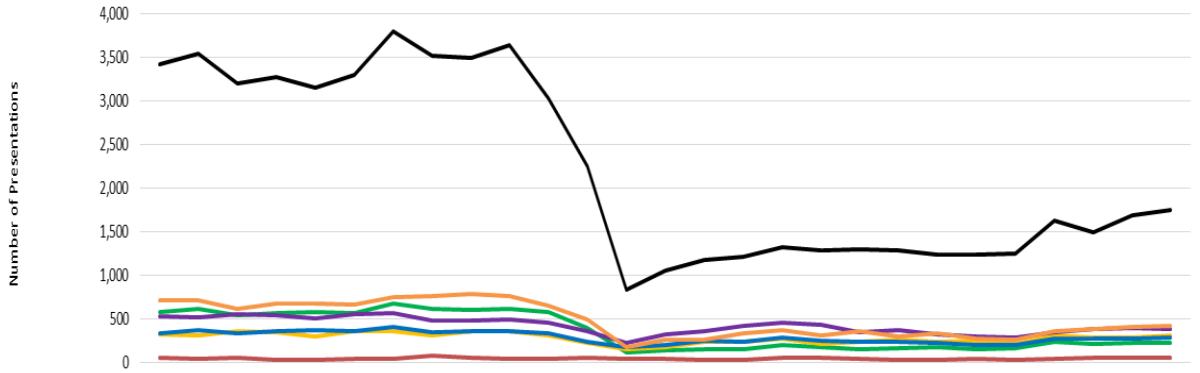
ED Presentations (Excluding MIU & RHC) April 2019 - June 2021



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

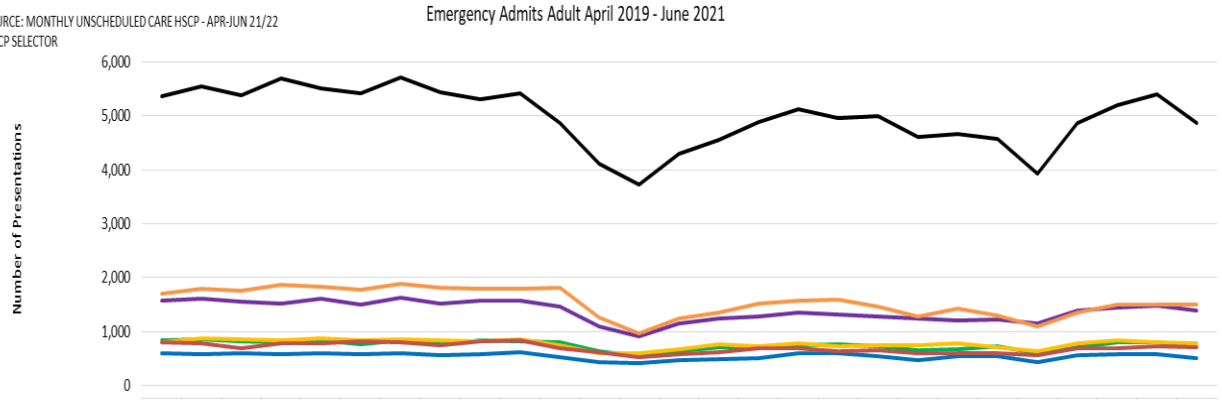
DATASOURCE: MONTHLY UNSCHEDULED CARE HSCP - APR-JUN 21/22
WITH HSCP SELECTOR

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



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

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



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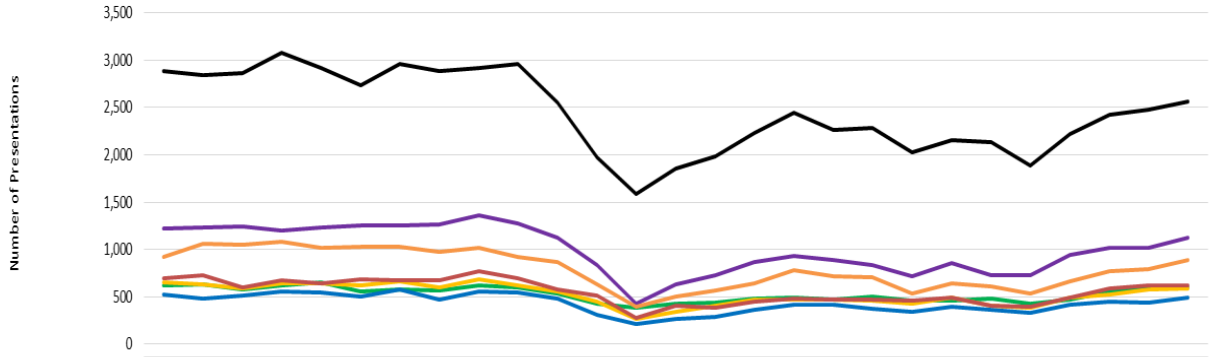
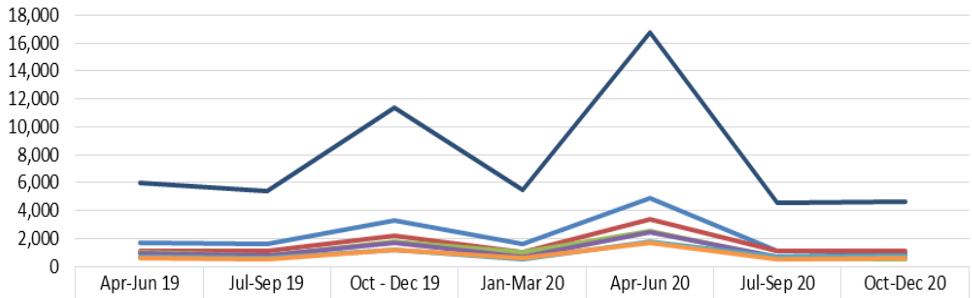
GLASGOW TOTAL	5,358	5,553	5,381	5,686	5,517	5,411	5,704	5,430	5,311	5,427	4,869	4,112	3,732	4,301	4,553	4,879	5,126	4,961	4,998	4,606	4,656	4,569	3,920	4,874	5,206	5,404	4,868
East Dunbartonshire	838	854	811	798	835	765	830	763	832	824	795	639	542	641	712	716	754	765	736	651	679	732	599	715	794	809	704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

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



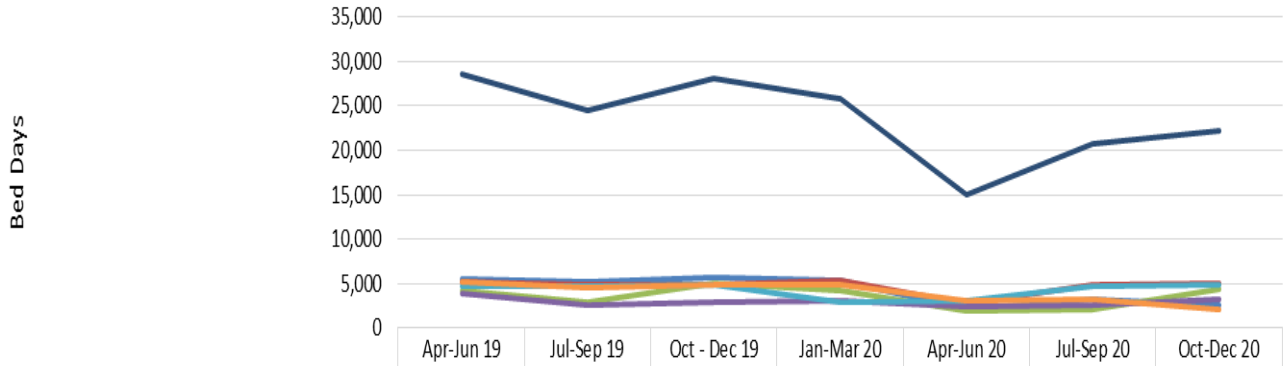
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
GLASGOW TOTAL	2,887	2,839	2,868	3,080	2,916	2,735	2,957	2,884	2,921	2,963	2,553	1,971	1,590	1,853	1,985	2,233	2,441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

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



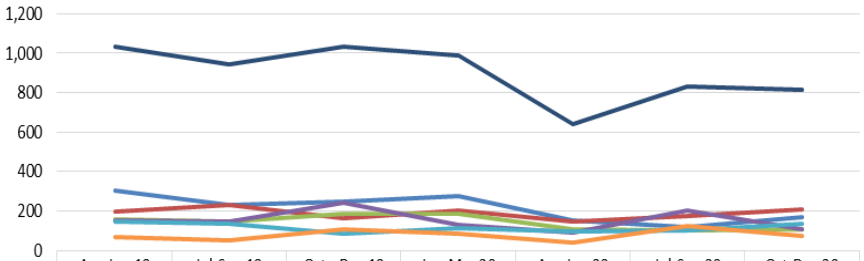
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	1,694	1,611	3,305	1,588	4,916	1,082	963
Other disorders of urinary system	1,087	1,132	2,219	1,024	3,351	1,086	1,072
Unspecified acute lower respiratory infection	1,003	769	1,772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

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



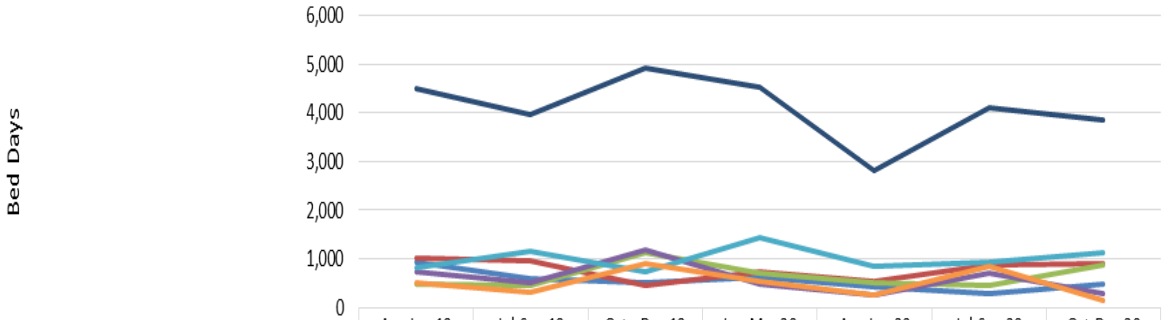
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	5,544	5,136	5,618	5,409	2,041	3,294	2,641
Other disorders of urinary system	5,177	4,806	4,795	5,329	2,657	4,863	5,060
Unspecified acute lower respiratory infection	4,148	2,856	5,051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

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



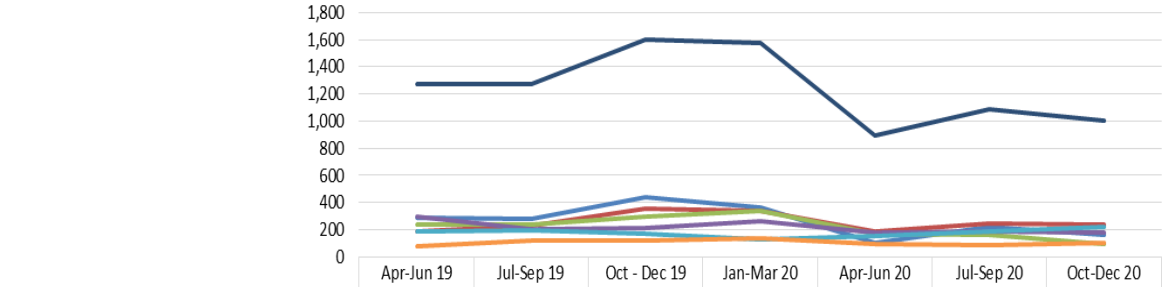
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	307	232	247	275	155	119	169
Other disorders of urinary system	200	229	164	203	149	177	211
Unspecified acute lower respiratory infection	157	147	189	184	108	101	110
Heart failure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

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



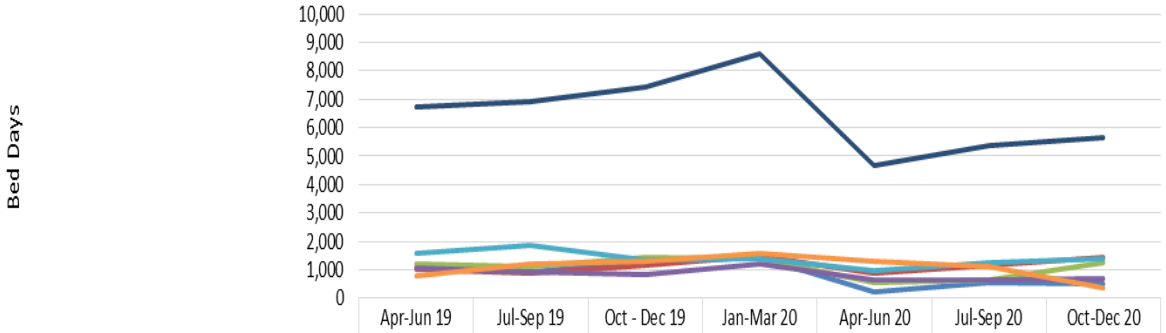
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	925	595	516	638	424	294	486
Other disorders of urinary system	1,015	950	471	725	532	879	908
Unspecified acute lower respiratory infection	490	455	1,131	697	501	452	882
Heart failure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

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



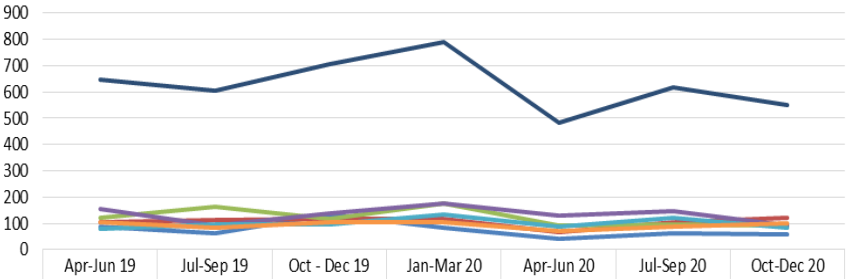
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	285	279	441	368	102	224	162
Other disorders of urinary system	185	226	357	341	189	248	242
Unspecified acute lower respiratory infection	241	238	296	336	170	161	99
Heart failure	296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

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



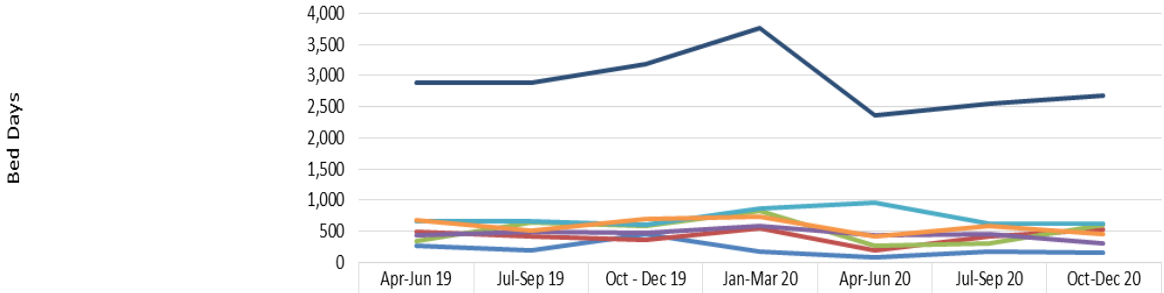
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	1,055	910	1,319	1,466	230	556	505
Other disorders of urinary system	1,003	901	1,147	1,474	907	1,155	1,423
Unspecified acute lower respiratory infection	1,196	1,106	1,452	1,421	564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

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



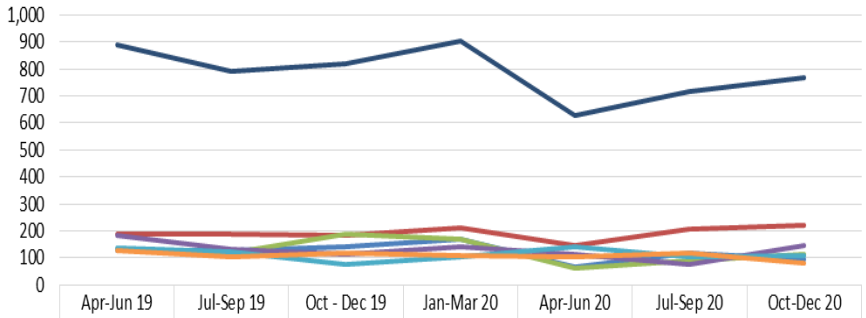
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	86	61	132	84	43	64	58
Other disorders of urinary system	105	111	119	119	65	103	123
Unspecified acute lower respiratory infection	121	163	115	176	91	95	90
Heart failure	154	91	139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

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



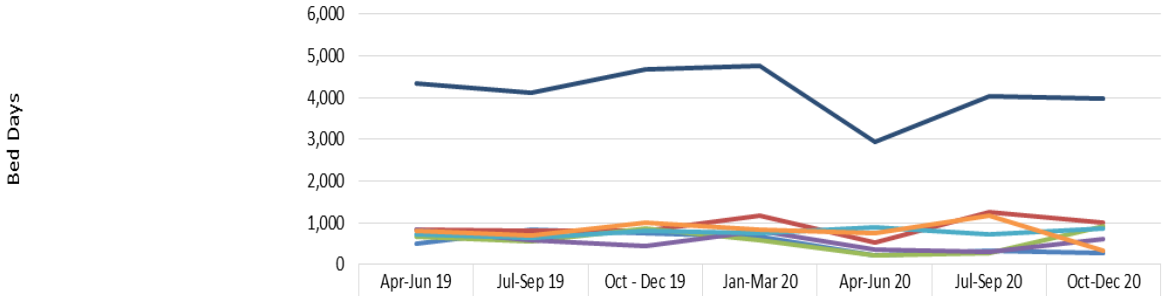
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	259	186	461	179	81	167	155
Other disorders of urinary system	496	411	365	554	188	422	537
Unspecified acute lower respiratory infection	351	640	581	824	264	309	606
Heart failure	445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

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



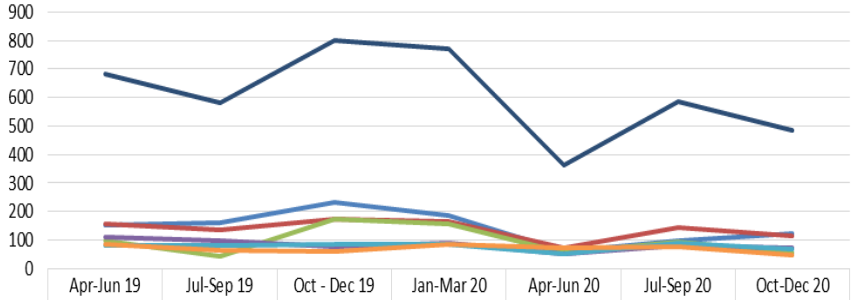
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	129	127	143	170	68	120	96
Other disorders of urinary system	187	186	181	210	147	205	220
Unspecified acute lower respiratory infection	130	118	186	169	60	88	114
Heart failure	182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

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



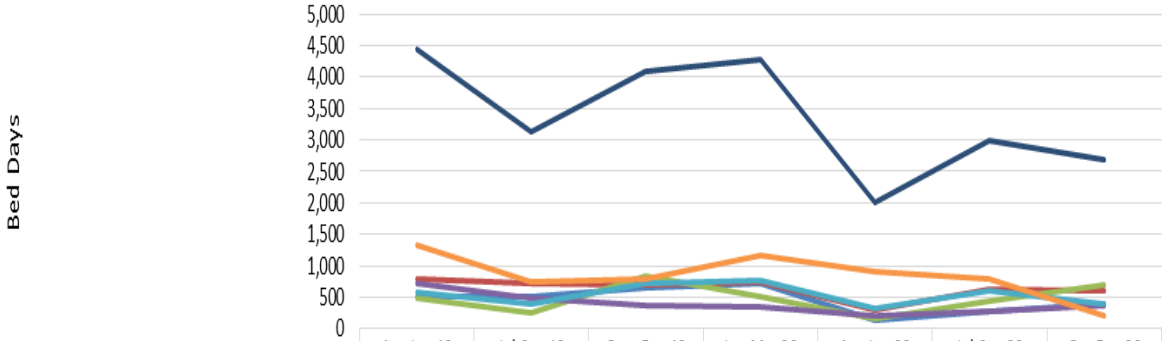
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	494	842	752	661	205	338	273
Other disorders of urinary system	843	806	797	1,170	514	1,242	1,008
Unspecified acute lower respiratory infection	655	564	855	571	206	283	910
Heart failure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

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



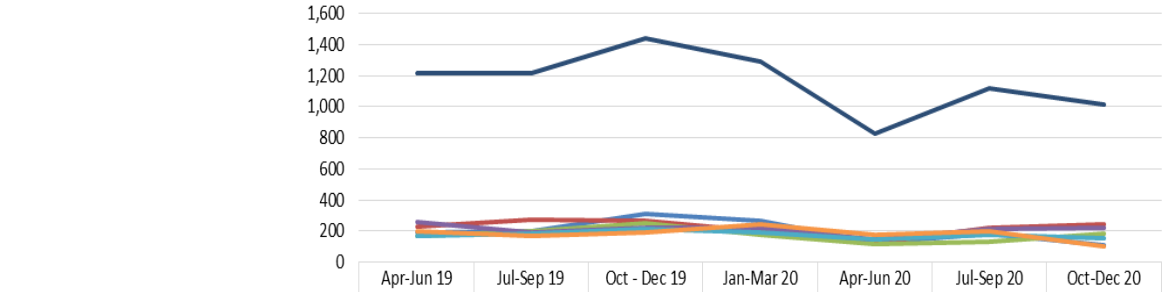
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	151	160	233	185	62	99	125
Other disorders of urinary system	158	134	174	167	73	145	113
Unspecified acute lower respiratory infection	96	42	174	157	55	93	56
Heart failure	110	99	76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

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



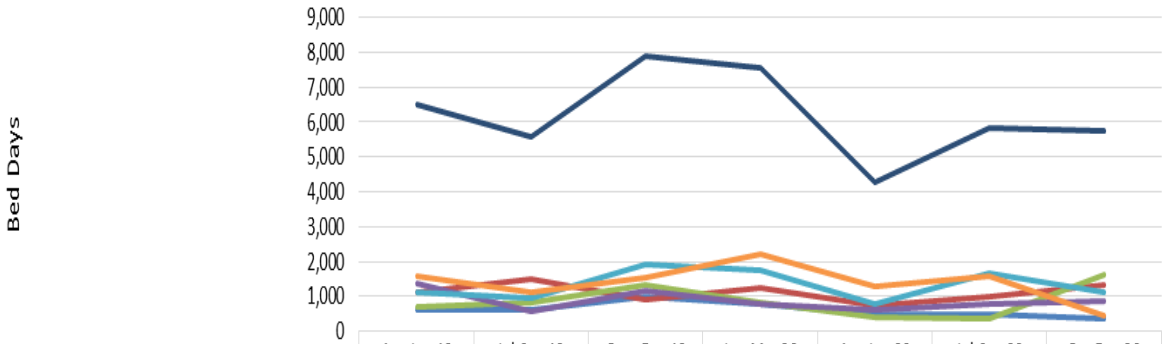
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	515	515	661	717	130	270	401
Other disorders of urinary system	789	723	692	752	312	629	614
Unspecified acute lower respiratory infection	493	248	851	513	156	437	705
Heart failure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

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

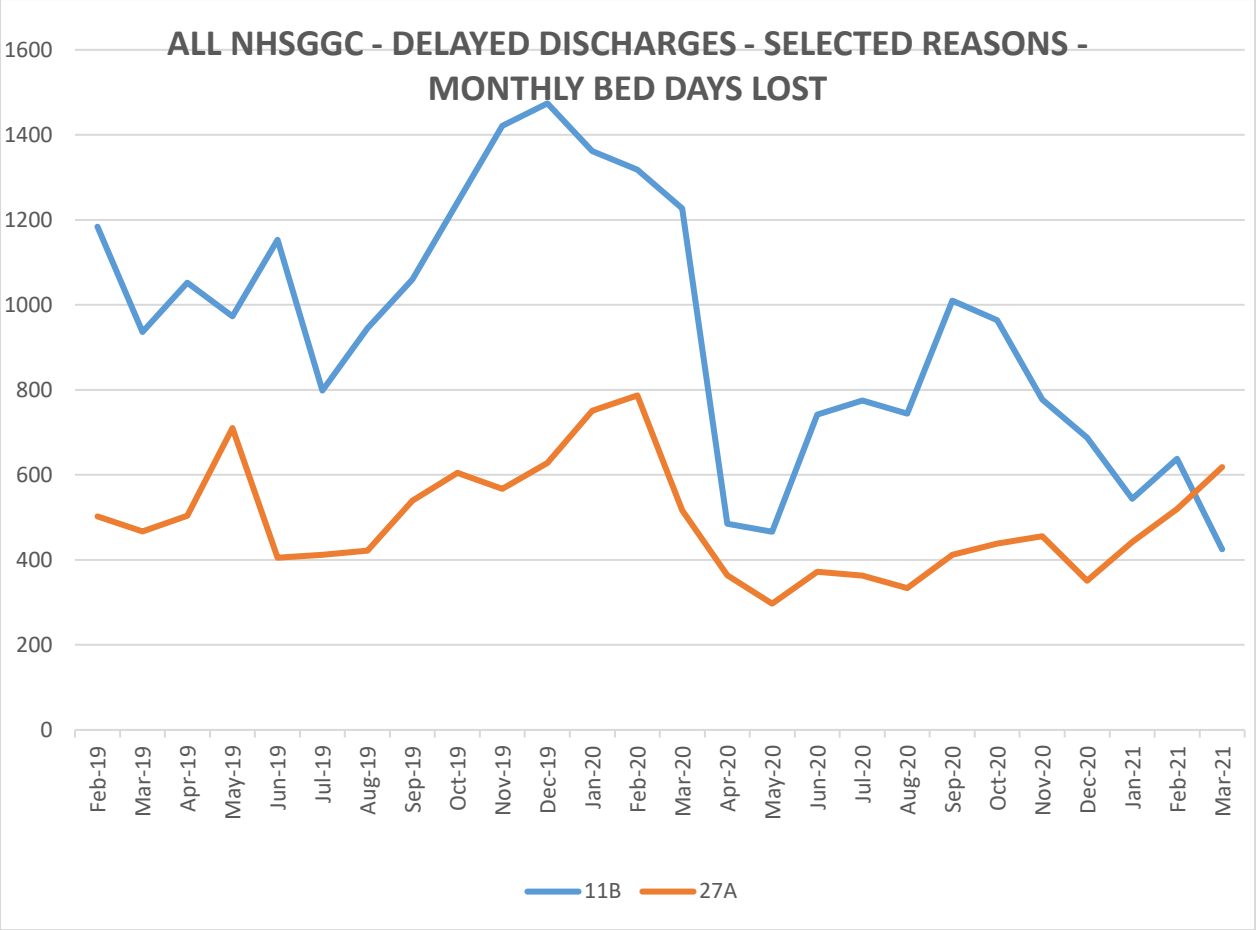


	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	192	201	310	266	125	181	106
Other disorders of urinary system	230	270	262	197	122	219	246
Unspecified acute lower respiratory infection	169	197	250	175	115	131	185
Heart failure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

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

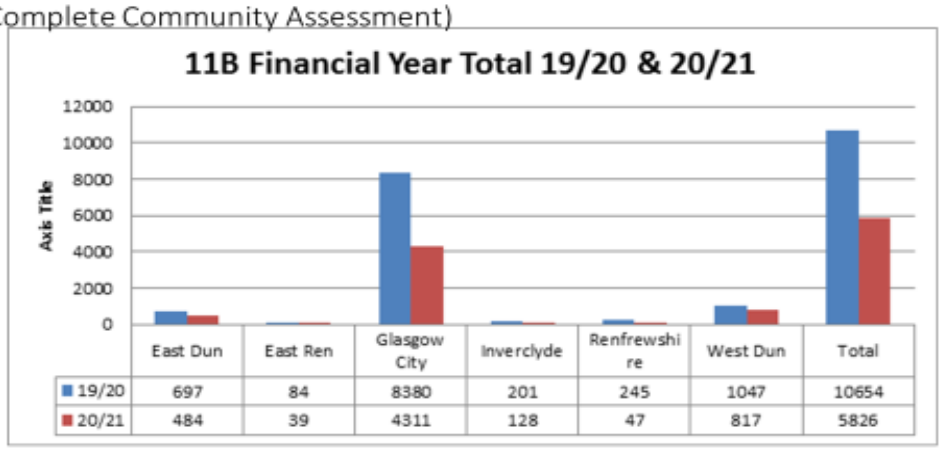


	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	593	608	1,005	773	482	481	360
Other disorders of urinary system	1,099	1,492	922	1,260	719	977	1,319
Unspecified acute lower respiratory infection	712	818	1,330	808	421	356	1,643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



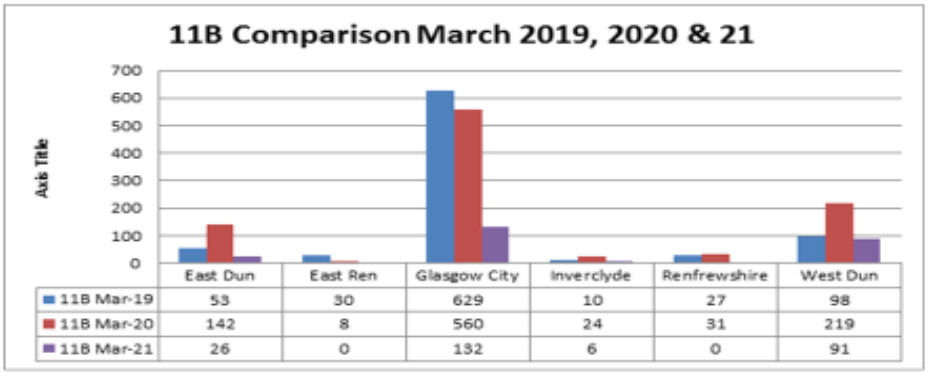
Bed Days Lost to 11B & 27A

11B (Complete Community Assessment)



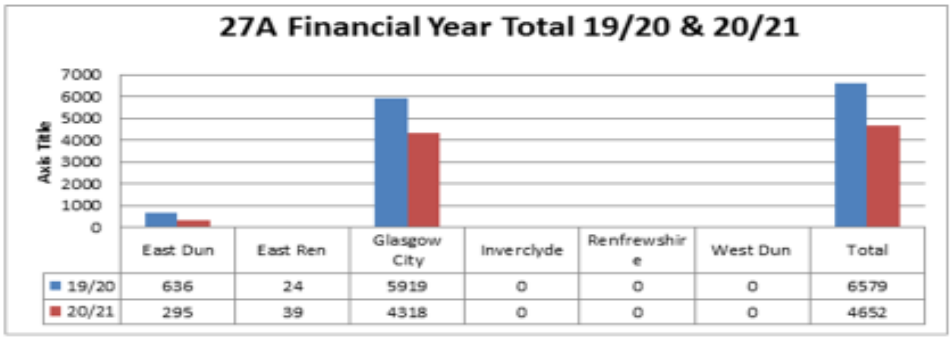
During financial year 2019/20 there were 10,654 bed days lost to 11B this has improved by 45% in 2020/21 with 5,826 bed days lost recorded

11B Comparison March 2019/20 & 21

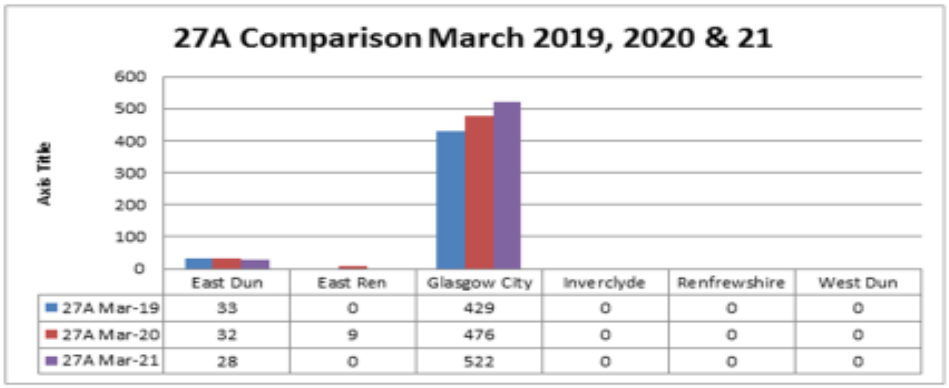


In March 2020 4/6 HSCPs evidenced an increase in bed days lost to 11B.
In March 2021 there is a marked reduction across all Partnerships.

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



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



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

ANNEX C

Urgent Care Service 11 Weeks Activity Review

01/04/2021 to 13/06/2021

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

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

TABLE: 1.1 - April 2021 to 13th June 2021

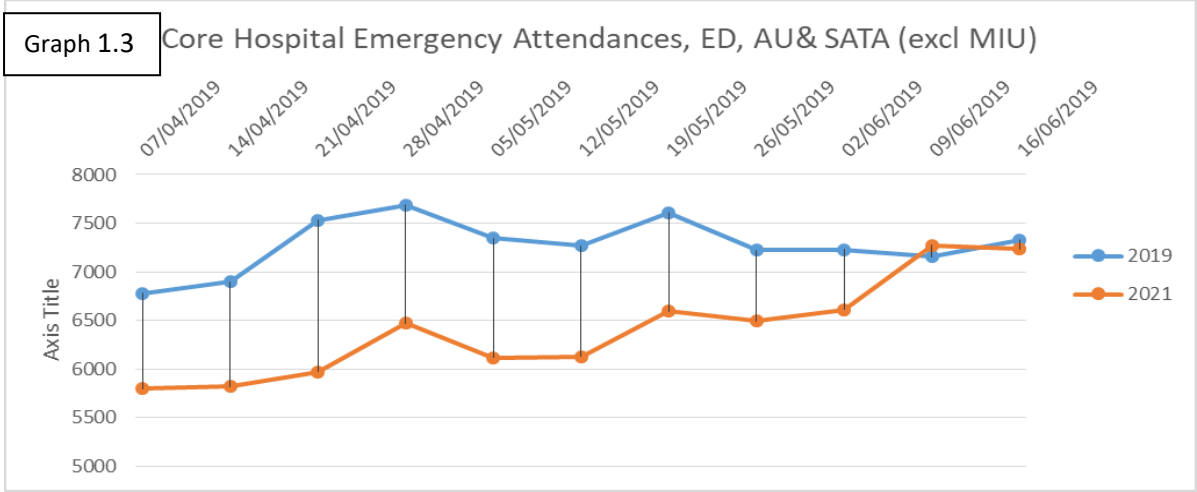
Week Ending - Core Sites	13/06/2021	06/06/2021	30/05/2021	23/05/2021	16/05/2021	09/05/2021	02/05/2021	25/04/2021	18/04/2021	11/04/2021	04/04/2021
Royal Alexandra Hospital	1346	1385	1269	1218	1169	1093	1210	1201	1215	1157	1102
Glasgow Royal Infirmary	1796	1690	1542	1558	1595	1524	1513	1654	1468	1436	1456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

TABLE: 1.2 - April 2019 to 16th June 2019

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

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

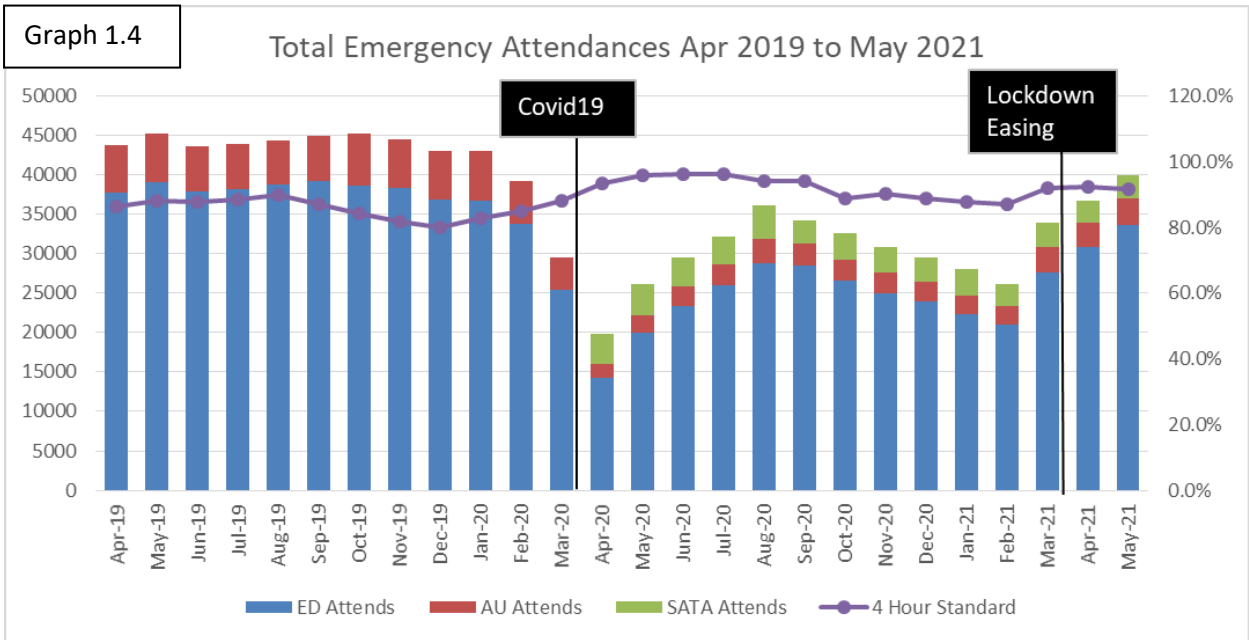
Graph 1.3



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

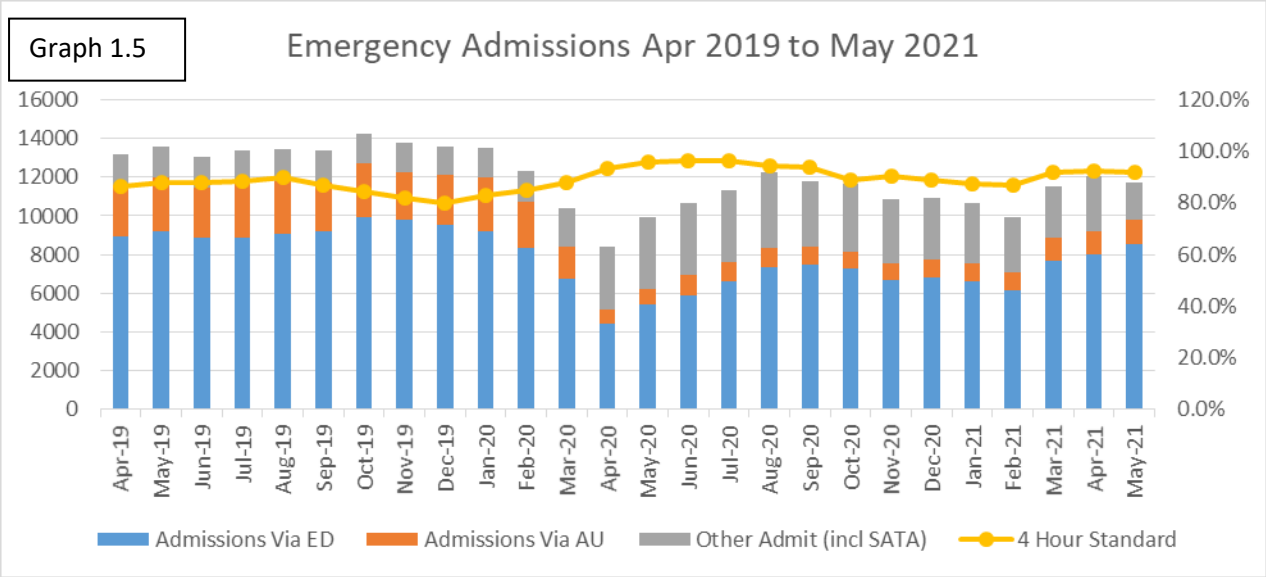
Graph 1.4 - The trend in cumulative emergency attendances from April 2019 through to May 2021 is provided below. This clearly illustrates the impact of Covid19 however there is increasing evidence of a step change in overall front door attendances to the end of May, June figures are not yet fully available.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

Graph 1.4



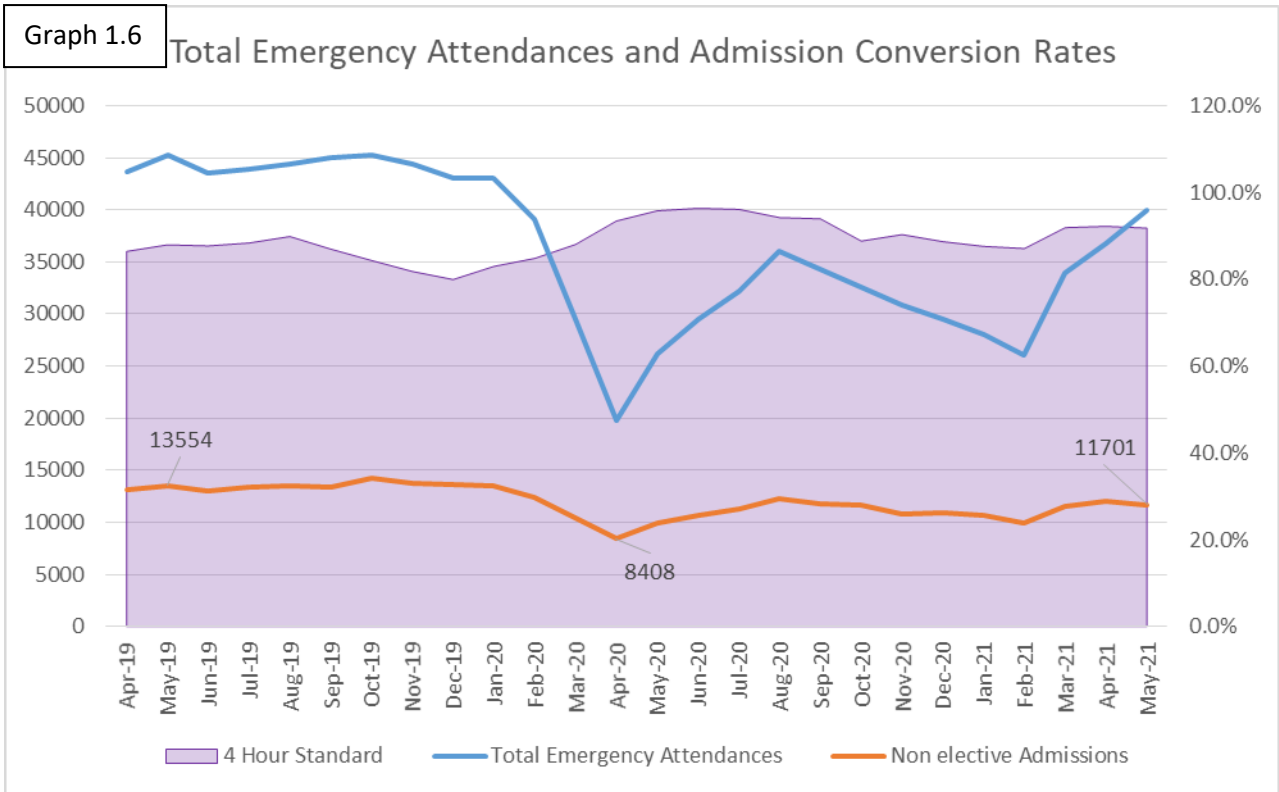
Acute Admissions: During the Covid19 pandemic the acute hospitals experienced an overall increase in the acuity of presentation with many patients requiring intensive care treatment in general new ways of working had to be quickly developed

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



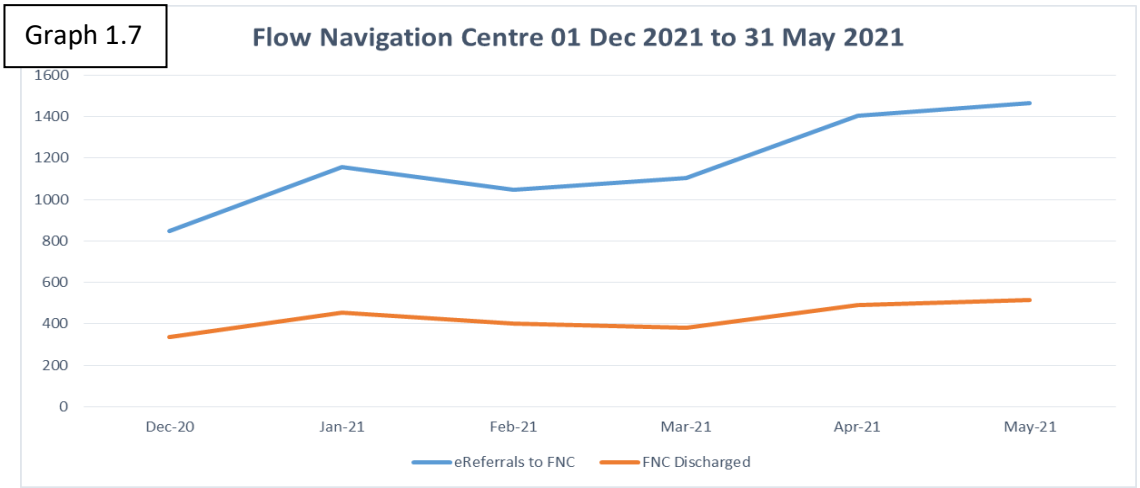
Emergency Admission Conversion Rates are detailed in Graph 1.6., whilst there is clearly a trend towards increasing admissions we have not yet reached pre Covid19 levels. Our significant efforts through the redesign of urgent care including the Covid19 Community Assessment Centres, the introduction of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

Graph 1.6



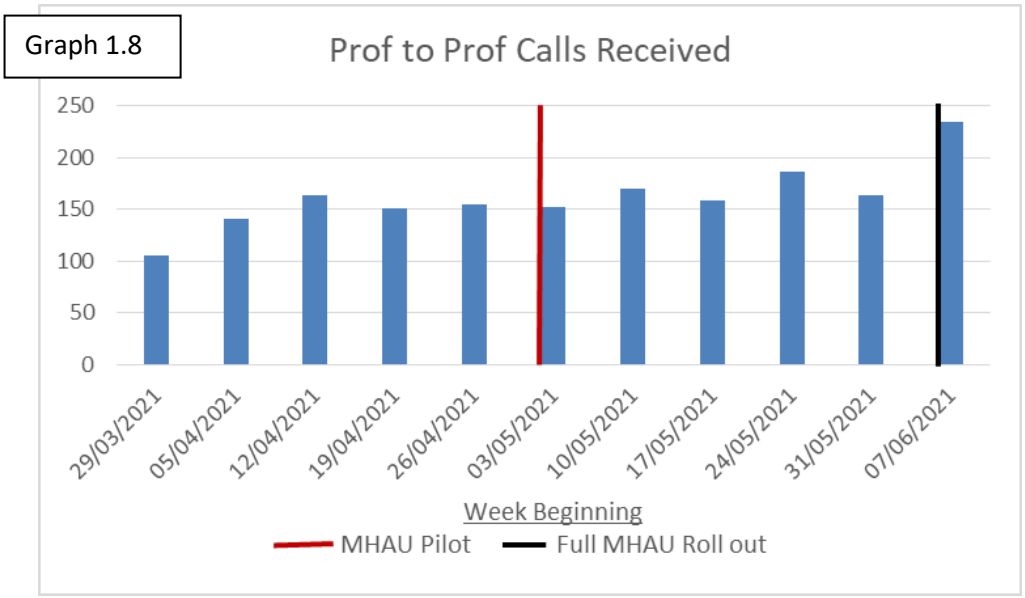
Flow Navigation Centre (FNC): The NHS111 service was launched on 1st December 2021 with eReferrals sent to the FNC for Near Me and telephone consultations. Graph 1.7 below shows the increasing number of referrals from NHS24 and a slower growth rate in the number of direct discharges from FNC. This is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

Graph 1.7

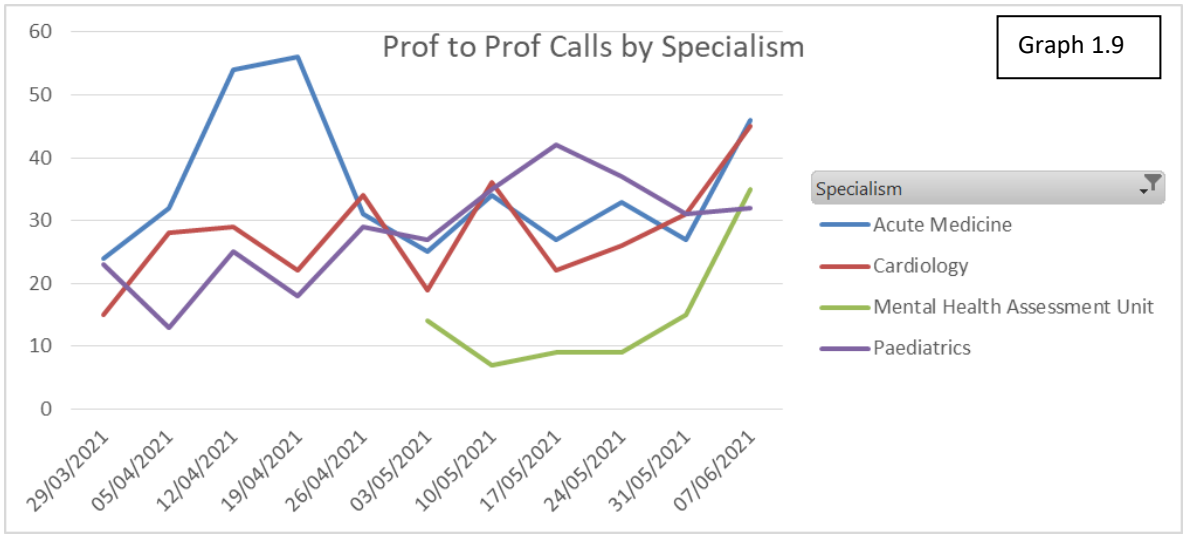


Professional to Professional Advice: The Acute hospital teams provide prof to prof specialty advice through a designated telephone system and a mobile device App. In March 20 the Mental Health Assessment Unit (MHAU) piloted a new prof to prof advice service for GP practices. This initially was for South GP's only to test the process and functionality however was fully rolled out to all GP's at the beginning of June.

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



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



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

Graph 1.10

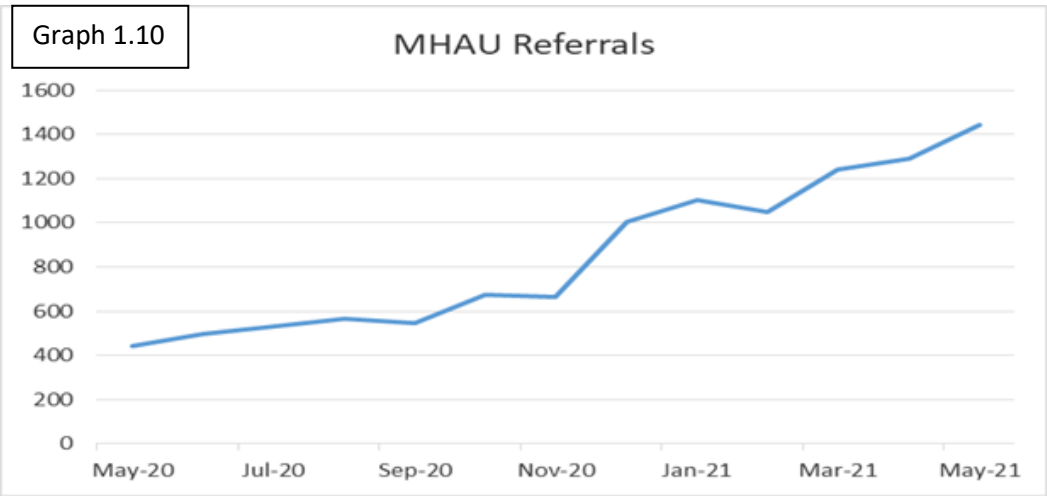


Table 1.8: MHAU Source of referral with a marked increase in referrals from NHS24.

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

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

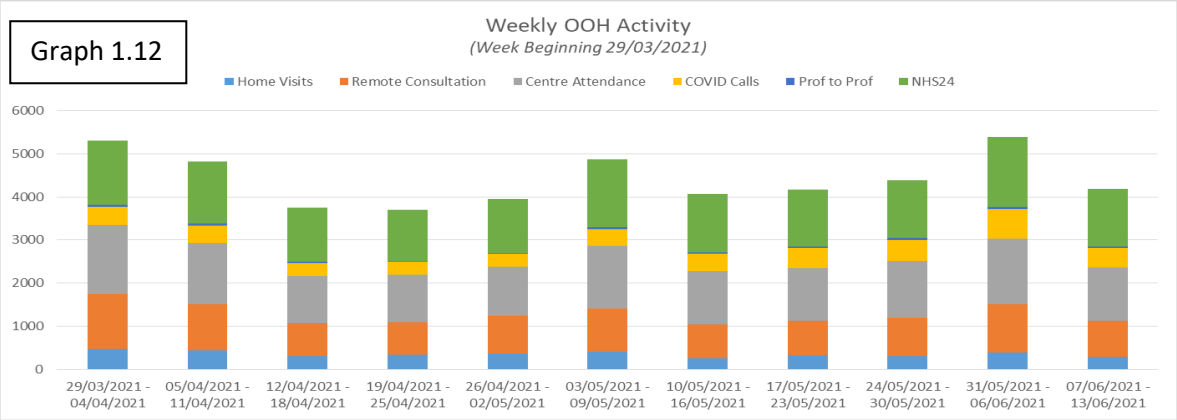
Table 1.11

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

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

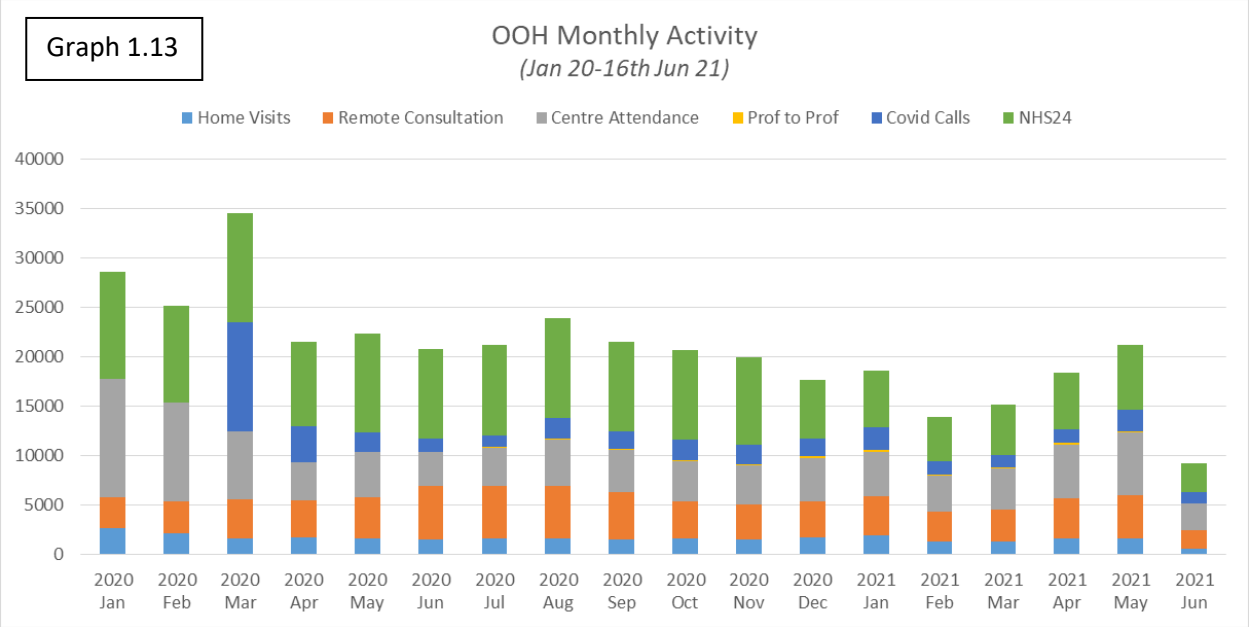
Graph 1.12 below reports the weekly GP OOH's activity week ending 04/04/2021 to 13/06/2021

Graph 1.12



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

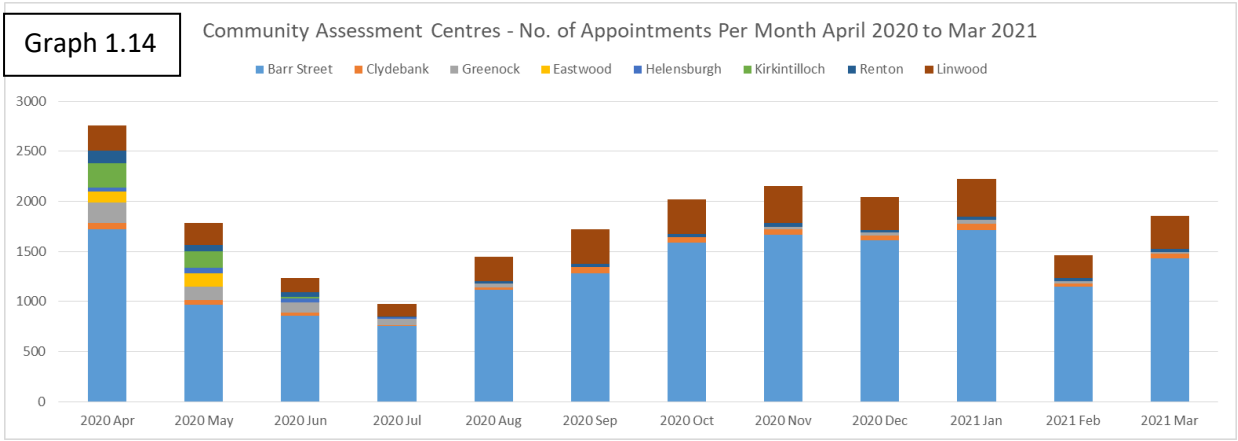
Graph 1.13



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

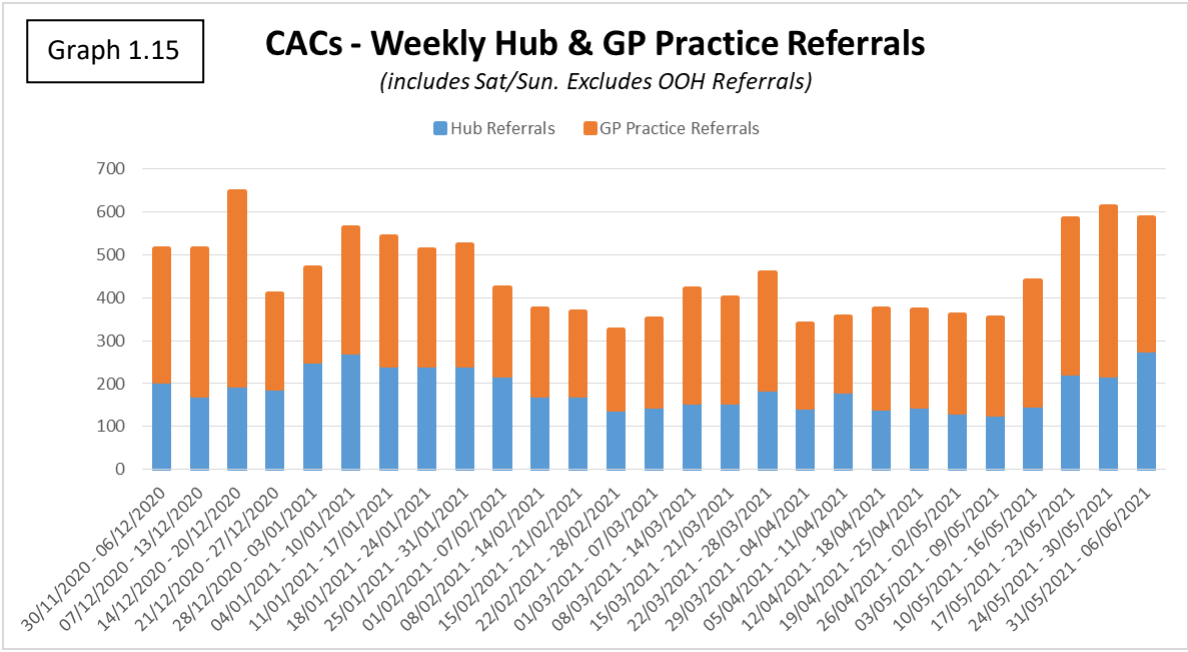
The profile of attendances in Graph 1.14 below shows peak attendance in April 2020 as the pandemic took hold and the pattern mirrors the high demand experienced during wave one, easing during the summer months when restrictions were lifted and then resumes in the autumn in line with wave two of the pandemic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

Graph 1.14



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

Graph 1.15

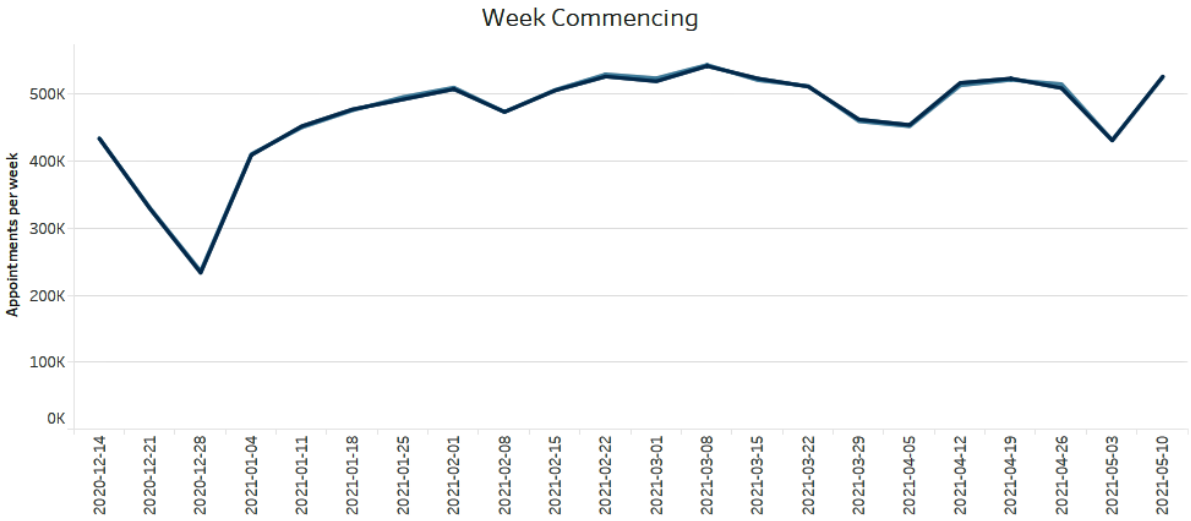


Primary Care: In the absence of available NHSGGC data we have used a combination of both the nationally published GP demand profile and an extract from two practices within NHSGGC who have shared their local data with us to support the analysis.

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

Graph 1.16

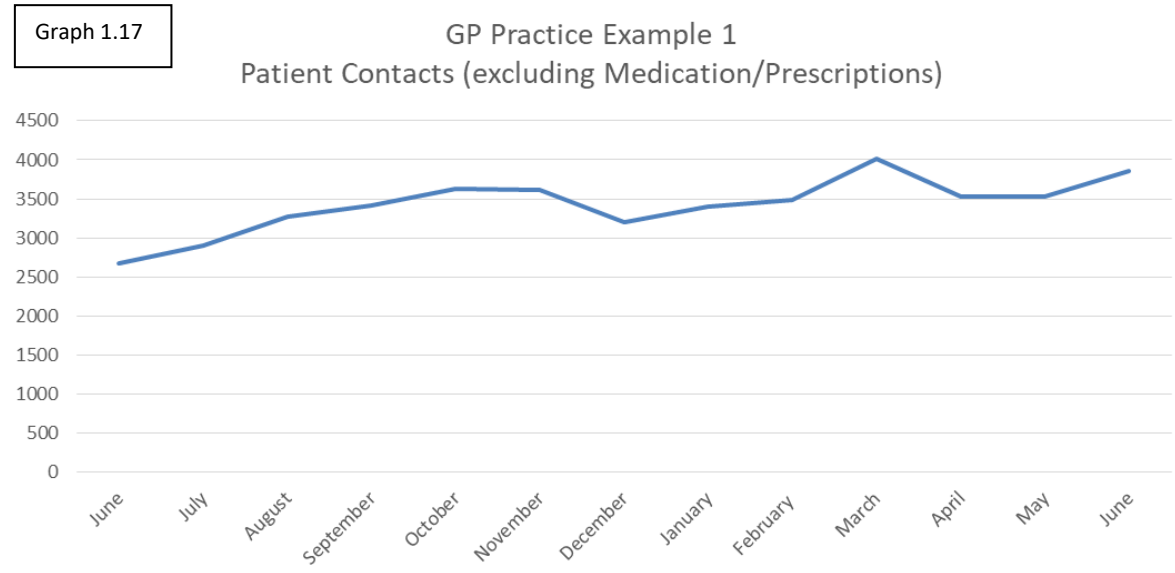
GP Activity Survey
Estimated number* of appointments in Scotland



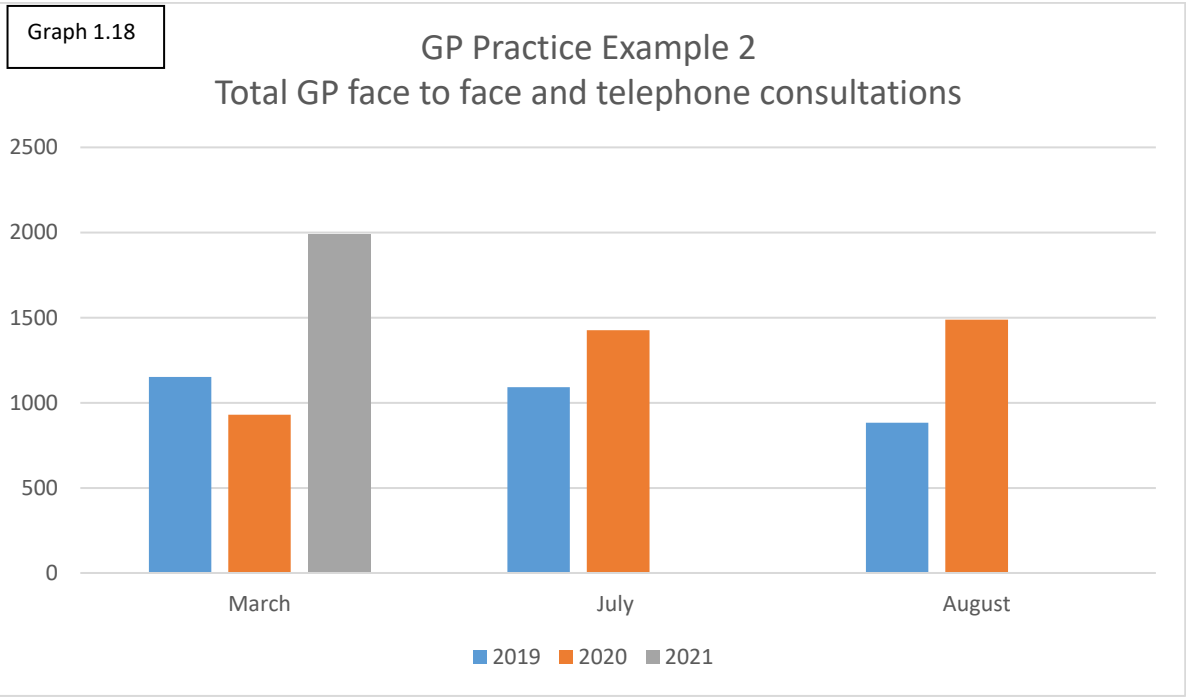
*NB data for weeks at Christmas, Easter and early May include public holidays so weekly activity is over 3-4 days

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

Graph 1.17



Graph 1.18



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

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

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

ANNEX D

Design & Delivery Plan Actions

Phased Delivery Matrix

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

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

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

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

Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions (Phased)		Phase 1&2 (21/23)	Work Stream or Programme to Progress	Phase 3 (22/23)	D&D Plan Section Reference
	care home residents and people with frailty. (PILOT ONLY)				
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		Discharge to Assess Frailty @ the Front Door Co-ordination & Integration of Community Models		
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.		Discharge to Assess Frailty @ the Front Door Co-ordination & Integration of Community Models		
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		Co-ordination and Integration of Community Models		
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-				

Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions (Phased)		Phase 1&2 (21/23)	Work Stream or Programme to Progress	Phase 3 (22/23)	D&D Plan Section Reference
	40,000 per year				

ANNEX E

GP ENGAGEMENT SESSIONS 2020

SUMMARY FEEDBACK

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

ANNEX F

Financial Framework

Phase 1 (Funding Gap) and Phase 2 Financial Framework

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

Unscheduled Care : Financial Framework		Total				
		2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Improving Discharge						
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.	£0	£200,000	£200,000	£0	£400,000
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.	£10,000	£99,040	£0	£0	£109,040
Total		**£7,098,793**	**£1,508,818**	**£254,080**	**£0**	**£8,861,691**

	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Recurring	£6,311,171	£971,958	£54,080	£0	£7,337,209
Non Recurring	£787,622	£536,860	£200,000	£0	£1,524,482
Total	**£7,098,793**	**£1,508,818**	**£254,080**	**£0**	**£8,861,691**

Funding : Recurring Expenditure	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Mental Health Assessment Unit - LMP/Additional Scottish Government Funding (to be confirmed)	£982,848	£0	£0	£0	£982,848
Scottish Government Funding : HB	£2,221,252	-£2,221,252	£0	£0	£0
HB Budget	£779,000	-£779,000	£0	£0	£0
IJB Budget	£1,124,896	£304,219	£0	£0	£1,429,115
PCIP Funding	£292,172	£0	£0	£0	£292,172
Total Funding Recurring	**£5,400,168**	**-£2,696,033**	**£0**	**£0**	**£2,704,135**
Funding Gap	**£911,002**	**£3,667,991**	**£54,080**	**£0**	**£4,633,073**

Funding : Non Recurring Expenditure	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Earmarked Reserves	£320,000	£45,000	£0	£0	£365,000
Manage within HSCP Budget	£242,322	£491,860	£200,000	£0	£934,182
Scottish Government Funding : HB	£0	£0	£0	£0	£0
Hospital at Home Pilot Funding - HIS	£175,000	£0	£0	£0	£175,000
PCIP Funding	£50,300	£0	£0	£0	£50,300
Total Funding Non Recurring	**£787,622**	**£536,860**	**£200,000**	**£0**	**£1,524,482**
Funding Gap	**£0**	**£0**	**£0**	**£0**	**£0**

ANNEX G

Unscheduled Care Performance Management Framework

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

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

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

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

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

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

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

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

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

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

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

ANNEX H

EMERGENCY ADMISSIONS (65+) PROJECTIONS

2022/23-2024/25

Design and Delivery Plan Projections

NHSGGC Emergency Admissions Projections (Ages 65+)

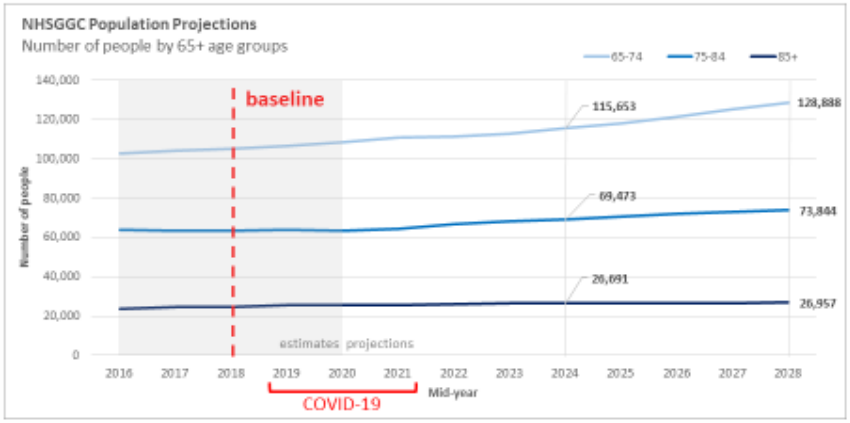
Gary King
Local Intelligence Support Team (LIST)

Public Health Scotland

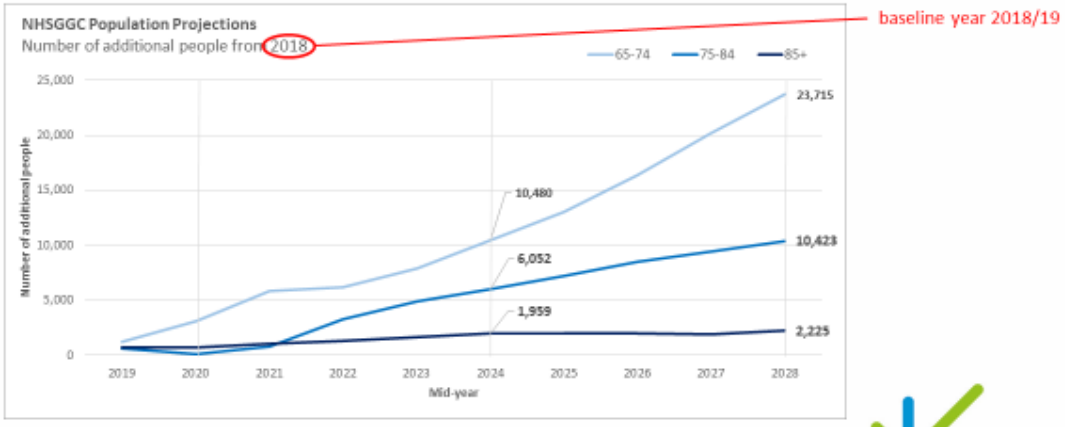
Summary

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

Population Projections
Number of people (aged 65+ groups)

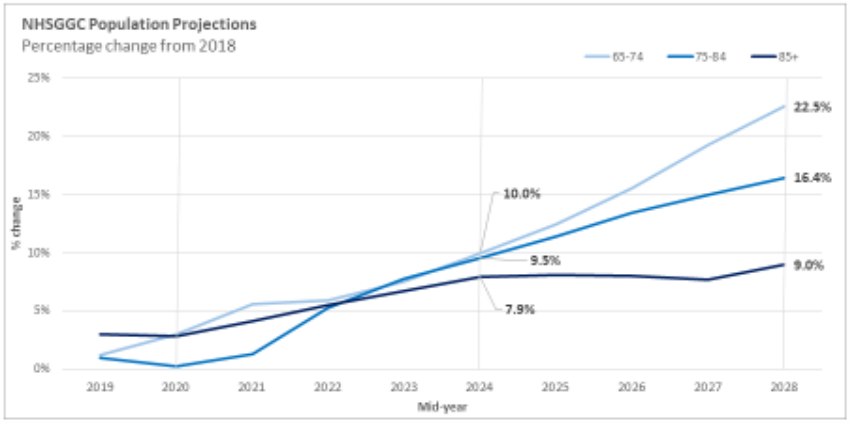


Population Projections
Number of additional people (aged 65+ groups)



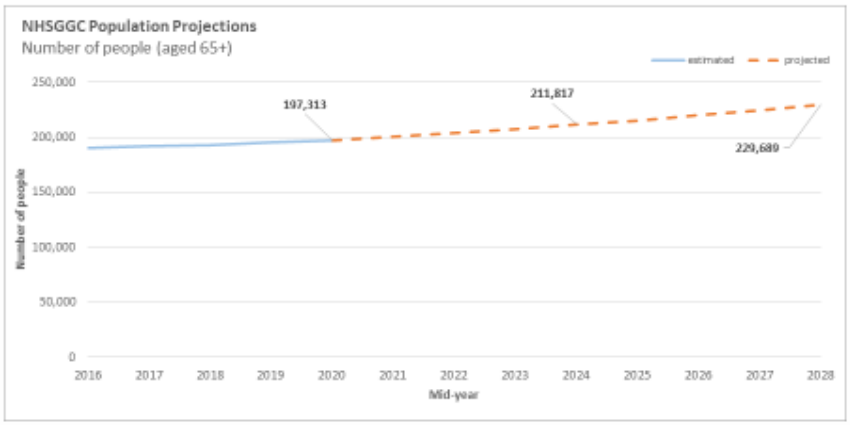
Population Projections

Percentage change from 2018 (aged 65+ groups)

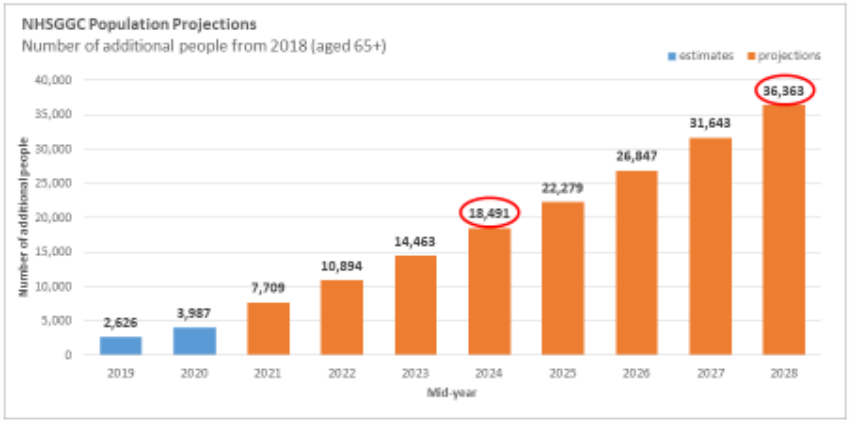


Population Projections

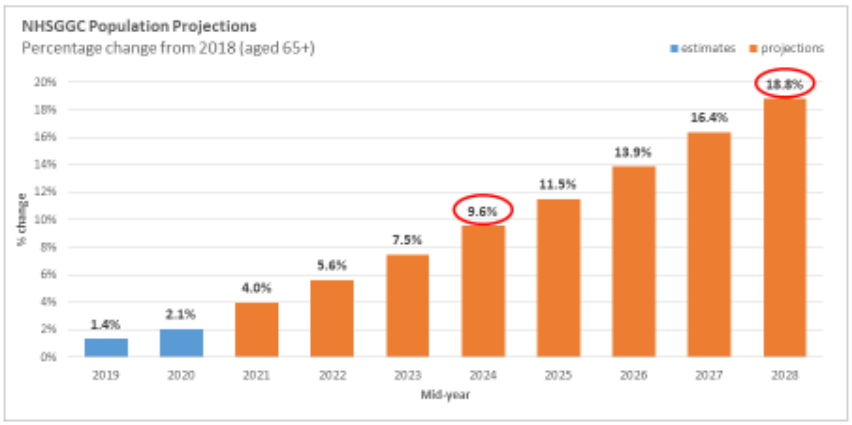
Number of people (aged 65+)



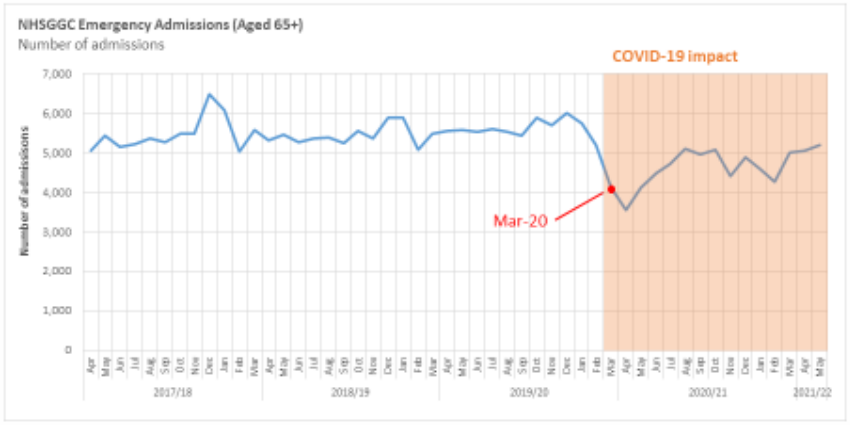
Population Projections
Additional people from 2018 (aged 65+)



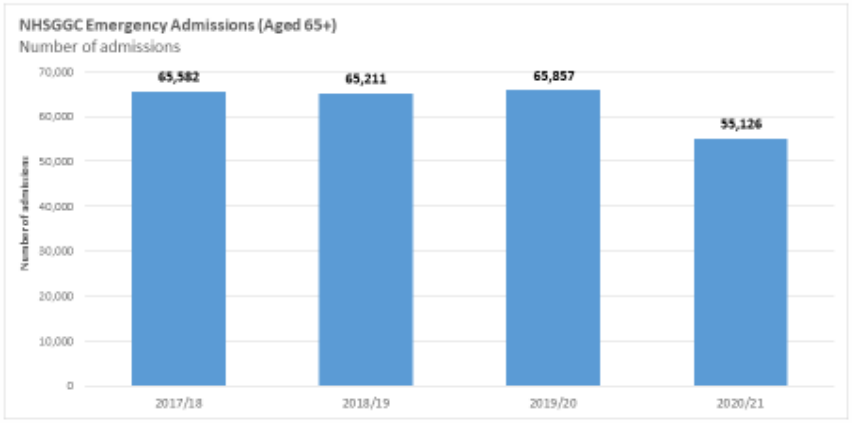
Population Projections
Change from 2018 (aged 65+)



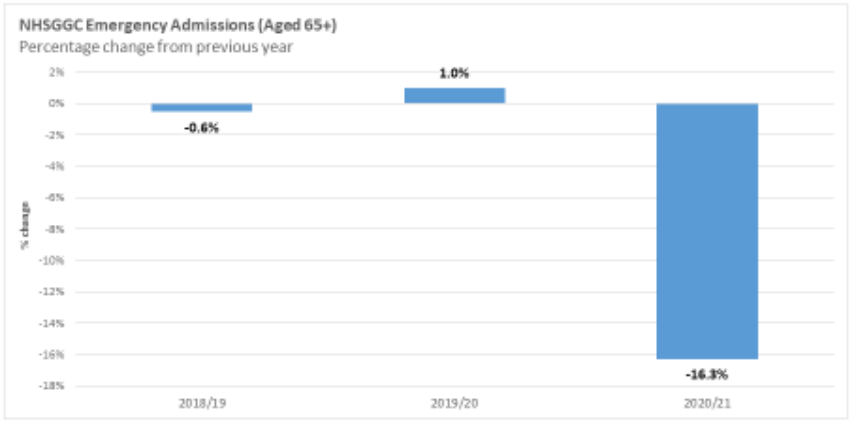
Emergency Admissions (Ages 65+)
Number of admissions



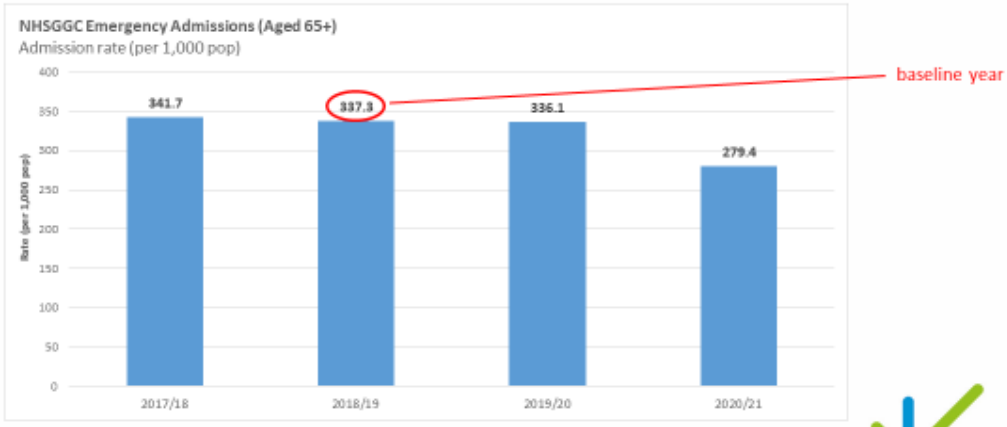
Emergency Admissions Ages 65+
Number of admissions



Emergency Admissions Ages 65+
% change from previous year



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



Emergency Admissions Ages 65+
Projection Scenarios

Scenario 1

No implementation ⇨ No reduction in 2018/19 baseline rate

Scenario 2

Partial implementation ⇨ 5% reduction

Scenario 3

Full implementation ⇨ 10% reduction

RMP3 is a 14.2% reduction

⇨ While factoring in RMP3 targets for 2021/22

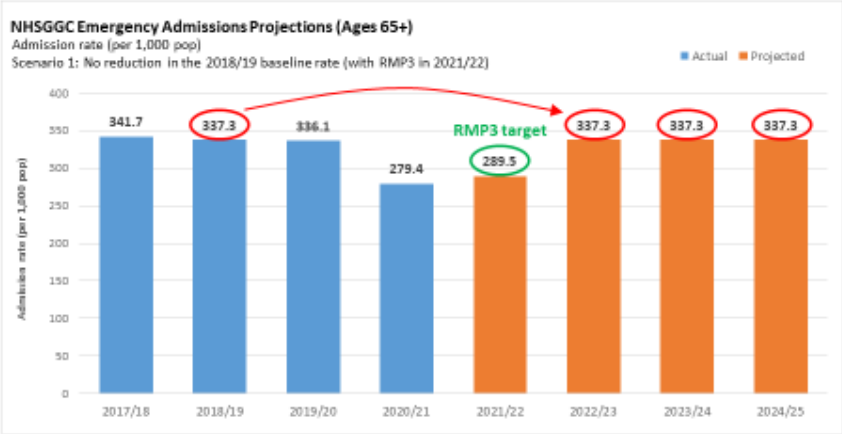
RMP3 target 2021/22:
138,594 (All ages)

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

Ratio of EAs:
Age 65+ / All ages

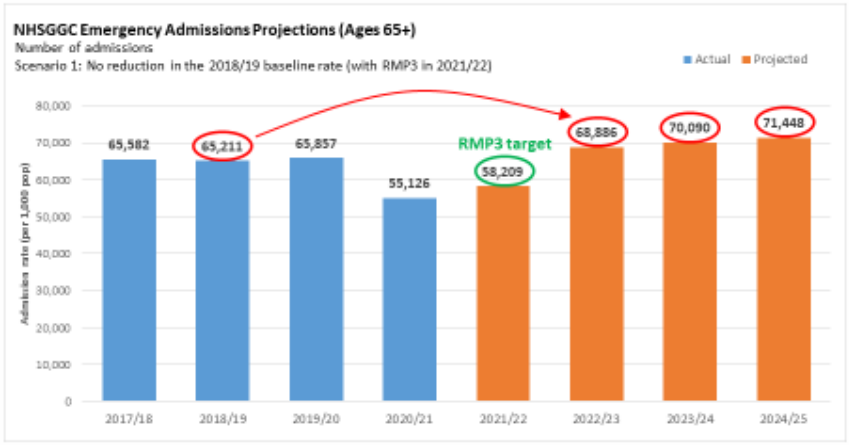
Scenario 1: No reduction in 2018/19 baseline (no implementation)

Admission rates (per 1,000 population)



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

Number of Admissions

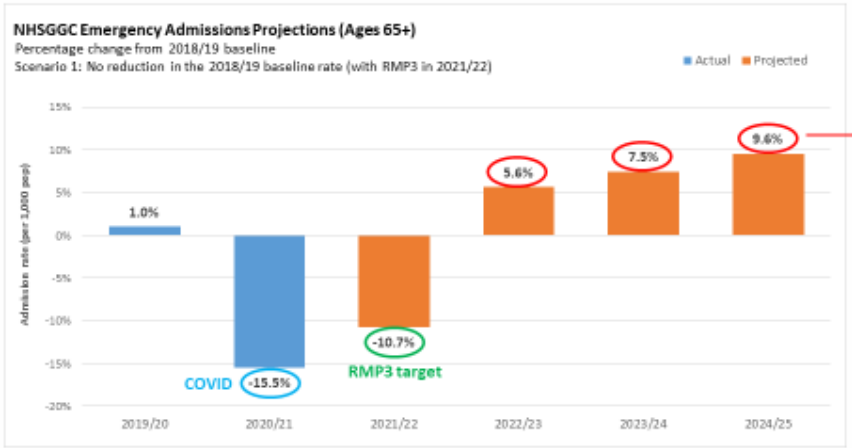


RMP3 target 2021/22:
138,594 (All ages)

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

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

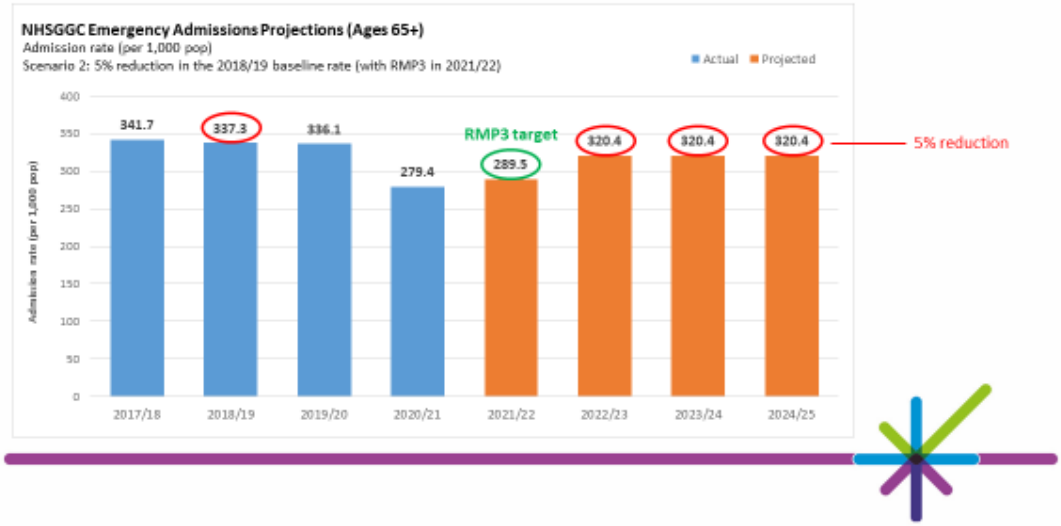
Percentage change from 2018/19 baseline



Increase solely due to the 65+ projected population increase

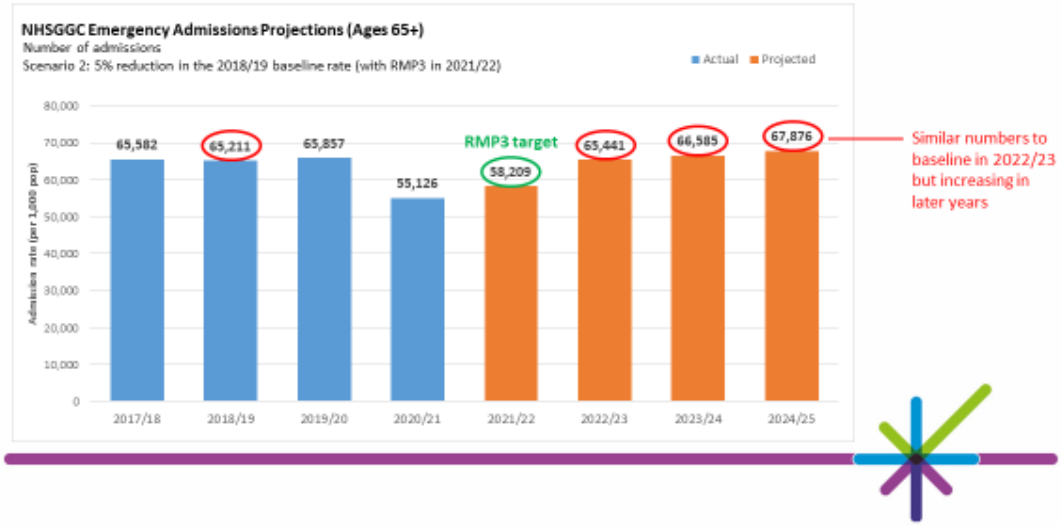
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Admission rates (per 1,000 population)



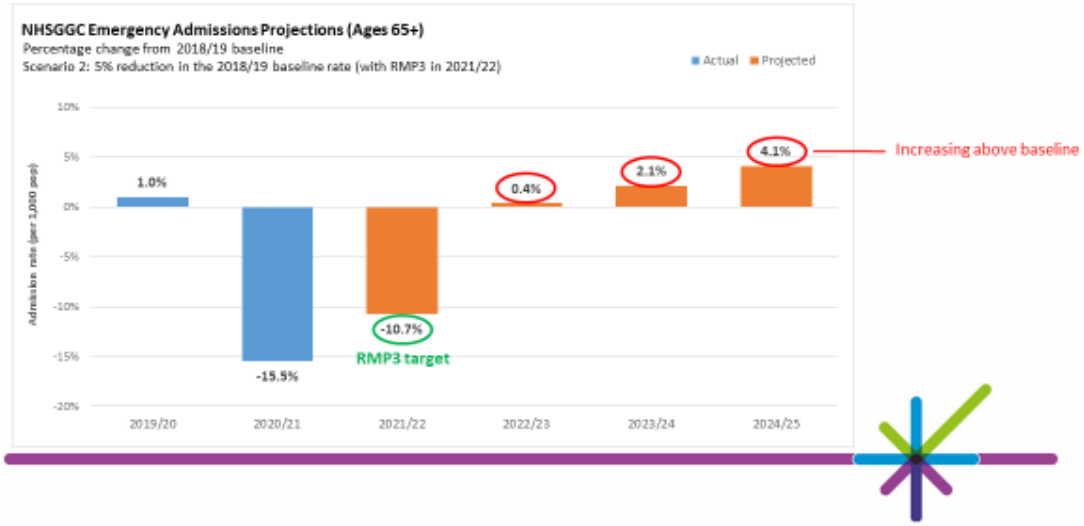
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Number of Admissions



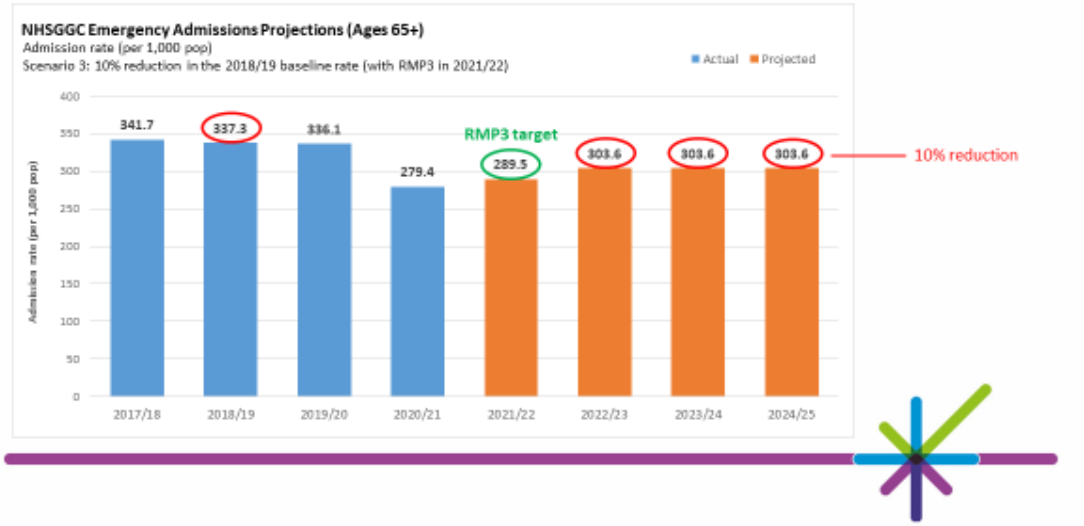
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Percentage change from 2018/19 baseline



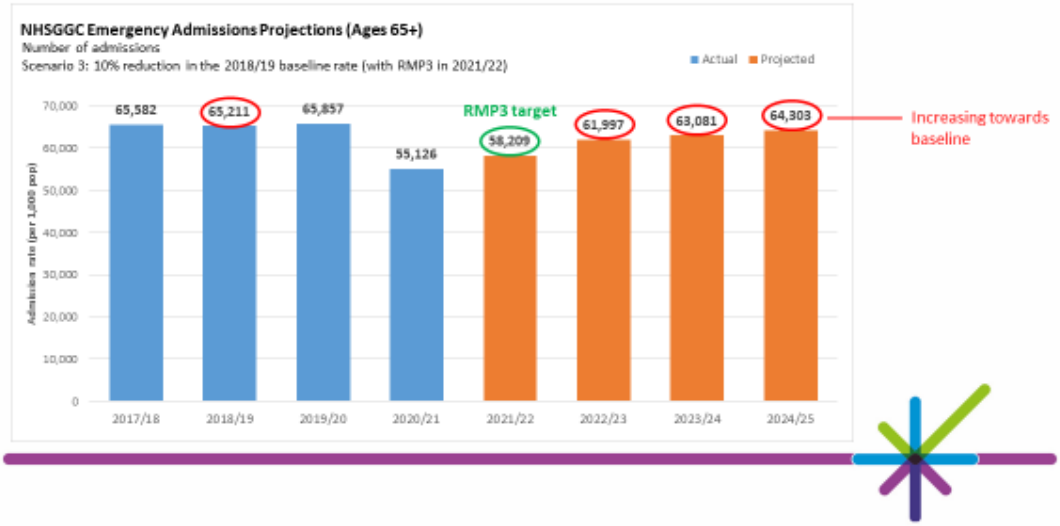
Scenario 3: 10% reduction in 2018/19 baseline (full impl.)

Admission rates (per 1,000 population)



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

Number of Admissions



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

Percentage change from 2018/19 baseline