



NHS GREATER GLASGOW & CLYDE

UNSCHEDULED CARE JOINT COMMISSIONING PLAN

DESIGN & DELIVERY PLAN 2021/22-2023/24

DRAFT

August 2021

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

CONTENTS

	Page
Purpose	5
Introduction	5
1. UNSCHEDULED CARE JOINT COMMISSIONING PLAN 2020	7
2. IMPACT OF THE PANDEMIC	9
3. DESIGN AND DELIVERY	12
4. ENGAGEMENT	21
5. FINANCIAL FRAMEWORK	23
6. PERFORMANCE FRAMEWORK	25
7. GOVERNANCE ARRANGEMENTS	32
8. PROGRESS REPORTING	34
9. NEXT STEPS	35

1. PURPOSE

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

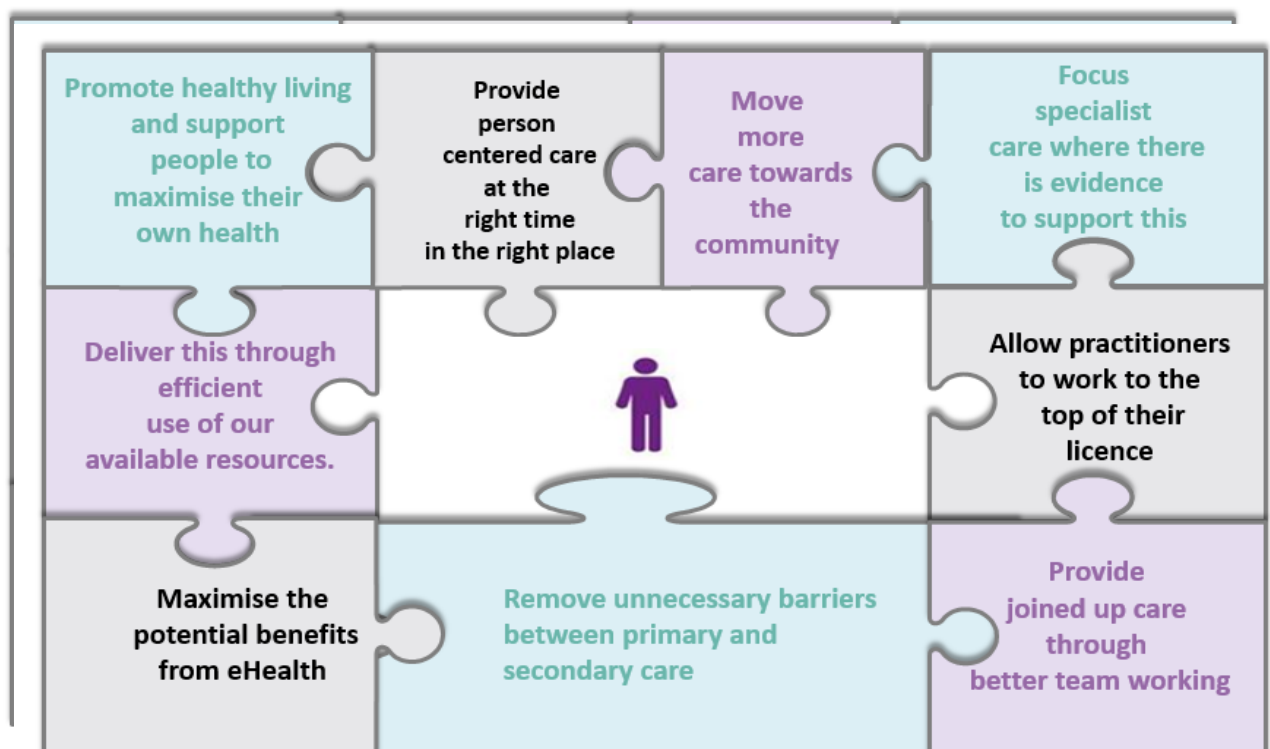
2. INTRODUCTION

- 2.1 This plan builds on the draft Joint Strategic Commissioning Plan approved by Integration Joint Boards (IJBs) [\(insert web link\)](#), updates the programme to take account of the impact of the Coronavirus pandemic, and the delivery of key improvements introduced in 2020.
- 2.2 This Board-wide programme was developed by all six Health and Social Care Partnerships (HSCPs) jointly with the Acute Services Division and the NHS Board in response to an unprecedented level of demand on unscheduled care services, and as a first step towards delegated budgets and to developing set aside arrangements for Greater Glasgow and Clyde. While NHSGGC performs well compared to other health and social care systems nationally, and the system is relatively efficient in managing significantly higher levels of demand than in other Boards, we struggled to meet key performance targets. In particular we have struggled to deliver the four hour standard of 95% on a consistent basis and in 2019/20 we reported performance at 85.7%.
- 2.3 The COVID-19 pandemic has brought a series of new challenges, some of which will be explored further in this plan. And because of this it is difficult to make activity and performance comparisons with previous years. At the time of writing NHSGGC was at Level 2 escalation for performance in recognition of the Board's performance during the pandemic, and evidence of whole system step change and improvement. The combination of reduced demand as a result of COVID-19 and new or redesigned services has resulted in an improvement in performance against the four hour standard reporting 92.0% for 2020/21. Section 4 and annexes B and C details performance pre, during and post pandemic and illustrates that although demand reduced during COVID-19 there is evidence that demand is on a rapid trajectory towards pre pandemic levels in the first quarter of 2021/22.
- 2.4 The 2020 draft plan outlined a major change programme to meet the challenge of what was then considered to be a continual year on year increase in urgent care demand. The aim of the programme was and remains to change the system so that patients are seen by the right person at the right time and in the right place, and in this way be more responsive to patients' needs. The emphasis continues to be on seeing more people at home or in other community settings when it is

safe and appropriate to do so and this has been further substantiated through a national programme of service redesign.

2.5 This direction of travel outlined in the Board-wide *Moving Forward Together* strategy continues to be the overarching ambition of our collective improvement efforts ([insert web link](#)) and as illustrated in figure 1 below.

Figure 1 – Moving Forward Together



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

2.7 During this period NHSGGC introduced emergency governance arrangements to reflect the situation and established a series of Tactical Groups (HSCP, Acute and Recovery) to support the Strategic Executive Group to deliver timely decision making. In addition the Scottish Government have introduced Remobilisation Planning and our collective progress and next steps towards recovery are also evidenced in Remobilisation Plan 3 (RMP3) [\(insert link\)](#).

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

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

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

3. UNSCHEDULED CARE JOINT COMMISSIONING PLAN 2020

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

and local targets (e.g. A&E four hour standard and delayed discharges). The conclusion was that to meet this challenge we needed to improve priority areas across the unscheduled care delivery system so that we could better meet current and future demand, and provide improved outcomes for patients.

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

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

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

3.4 Key achievements over the past 12 months have been:

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

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

4. IMPACT OF THE PANDEMIC

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

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

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

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

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

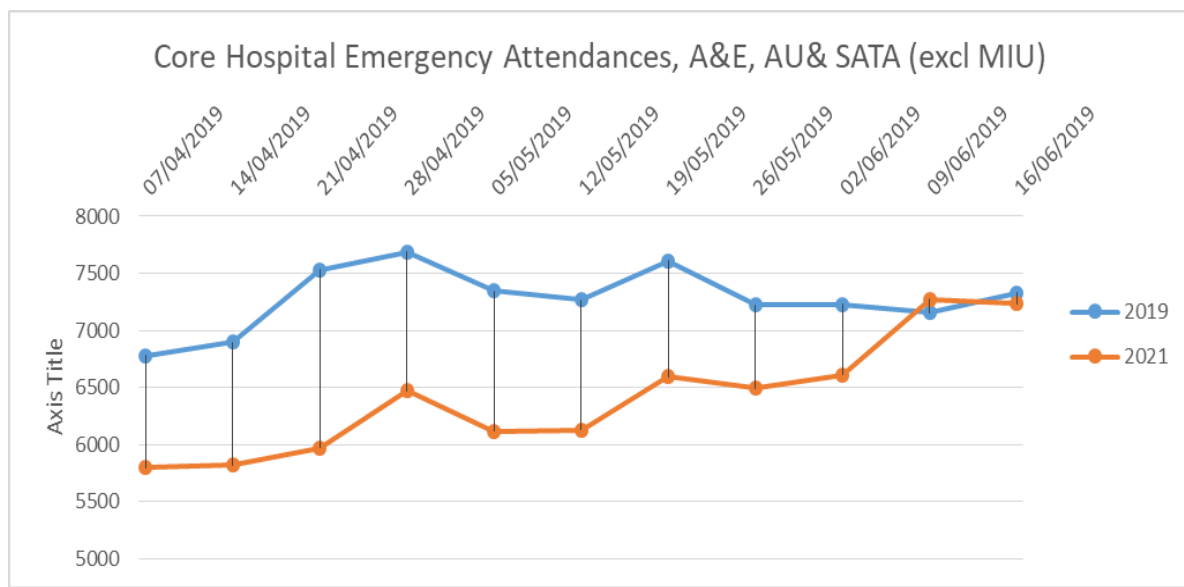
4.4 The demand profile for unscheduled care has however changed over recent months, and the Board is now experiencing a step change in demand in line with the success of the vaccination programme and easing of restrictions. At the time

of writing an activity review for urgent care services was completed at 11 weeks into the 2021/22 year (the full review paper is provided at annex C, and includes comparisons with activity pre-Covid).

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

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

Figure 2 - Core Hospital Emergency Attendances Chart



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

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

4.8 These changes will continue to evolve as we deliver further opportunities for service design as the programme progresses. The changing profile of demand,

and evidence from the pandemic recovery phase, means we will need to continually assess the impact of the pandemic on services as we go forward.

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

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

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

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

5 DESIGN AND DELIVERY PLAN

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

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

Phase 1 – 2020/21

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

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

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

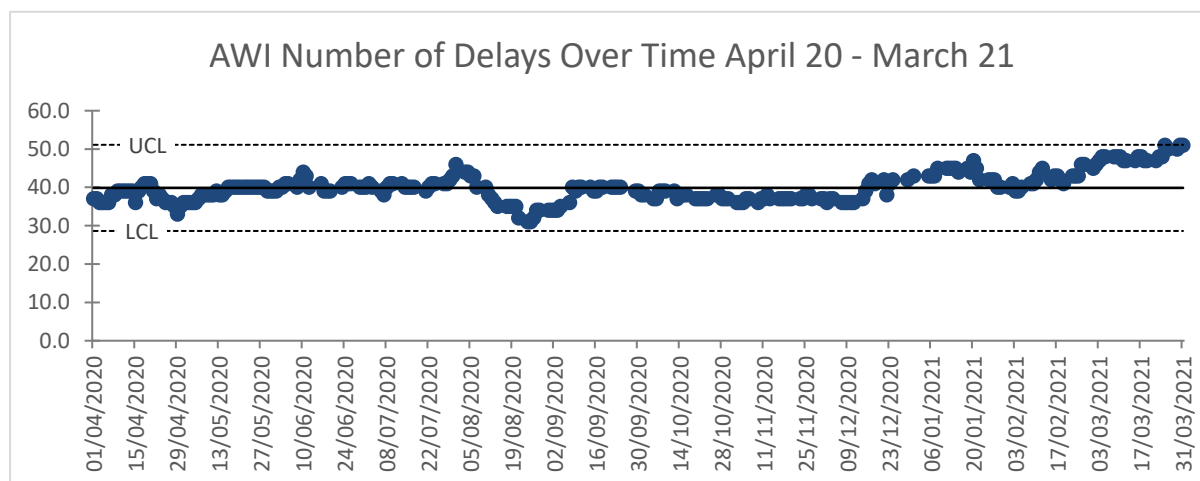
- 5.5 In the first six months of operation the FNC has completed virtual consultations for 7,000 patients with 32% of those being seen, treated and discharged without the need for further assessment.
- 5.6 **Signposting and Redirection Policy** - our signposting and redirection policy for Emergency Departments within NHS Greater Glasgow & Clyde was approved October 2020. Implementation of this policy and supporting standard operating procedures aim to ensure Emergency Department attendees are appropriately reviewed in line with their presentation. The purpose of the policy is not to turn attendees away from the ED, but to direct patients to another appropriate service where their healthcare need can be met, and minimising the risk to themselves and others in overcrowded EDs. These processes also reduce the potential for crowding in the ED by maximising use of safe alternatives for attendees to access care.
- 5.7 It is recognised that ED signposting and redirection form part of a broader aim across the health and social care environment to ensure patients receive the right care, at the right time and in the right place. NHSGGC have contributed to the development of national policy and guidance on this and we anticipate this will be released later in 2021.
- 5.8 **Primary Care Interface: alternatives to admission** has been extended to multiple specialties across NHSGGC. Professional to Professional Advice services through telephone and app technology are in place and working well. Surgical hot clinics and rapid access to frail elderly clinics are in place as well as the ability for GPs to request advice about patients rather than a direct referral. A pathway to provide access to the Assessment Unit (AU) for patients with DVT and cellulitis has also been implemented.
- 5.9 Across NHSGGC 212 GP practices have accessed advice via a telecoms application and the number of professional to professional calls made continues to increase month on month. The successful launch of Medical Paediatric Triage Referral Service in March 2020 has contributed to an overall rise since July 2020 and this service continues to receive the highest number of calls relative to other specialties. In addition from June 2021 the Mental Health Assessment Units have implemented the professional to professional advice service complimented by a new SCI Gateway referral process and uptake has been strong.
- 5.10 **Mental Health Assessment Units (MHAUs)** our two MHAUs were established last year in response to the COVID-19 pandemic and consolidated through the winter period with a full redesign of the urgent care pathways and access routes. These units have continued to reduce demand on secondary care services by reducing footfall through Emergency Departments. The referral pathway provides an immediate route out of ED for those who present directly, with vulnerable patients largely being managed away from the stressful ED

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

- 5.11 **COVID-19 Community Assessment Centres (CACs)** – these centres were also developed in response to the COVID-19 pandemic, and directed symptomatic patients who are potentially COVID-19 positive to separate facilities for assessment away from primary care and acute hospital services. Access to CACs is via NHS24. At the peak week in January 2021 there were a total of 566 attendances with 74% of these being maintained within the community with no hospital follow up required.
- 5.12 **Restructuring of GP Out of Hours (GPOOH)** - a new operating model introduced an appointments based service with access via NHS24 offering telephone triage. Those requiring a 4 hour response receive an initial telephone consultation by Advances Nurse Practitioners or GPs working in the service, including the use of 'Near me' consultation. This reduced the need for in person attendances by 60% freeing capacity to deal flexibly with other competing demands.
- 5.13 **Urgent Care Resource Hub Model** - HSCPs launched their Urgent Care Resource Hub models in January 2021. This model was established to bring together OOHs services in the community, enhancing integration and the co-ordination of care. The hub provides direct professional to professional access across the health and social care OOHs system and delivers a whole system approach to unscheduled and/ or emergency care via NHS 24.
- 5.14 **Delayed Discharge** we developed a response to delays that has seen a reduction in our non AWI delays in hospital across all of our sites. HSCPs adopted daily huddle approaches to problem solve and remove roadblocks to delays. Additionally we adopted process changes to the discharge process leading to the development and implementation of a new Discharge to Assess Policy as part of the overall discharge process. Joint working led to agreement with all six HSCPs and Acute on a standard operating procedure to improve effectiveness and reduce the risk of potential delays. This response builds on our 'Home First', if not home, why not ethos. A suite of patient communication materials have been developed and distributed to key areas within the acute setting launching the Home First branding and outlining the benefits of being cared for at home or in a homely setting, once medical care is no longer required.
- 5.15 **AWI delays** have been a particular challenge during 2020/21 as shown in figure 3. Since the Equality and Human Rights Commission ruling we have not been able to discharge patients to off-site beds with the consequence that the

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

Figure 3 – AWI delays 2020/21 Glasgow City HSCP



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

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

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

- 5.18 During the pandemic **West Dunbartonshire** HSCP district nursing staff continued to provide training and support to staff in care homes with a programme of bite size modules on various subjects including infection control, UTI, recognising sepsis etc. This helped care home staff to recognise the early signs of infection and with earlier intervention helped to prevent admissions to hospital. The Older Adult Community Psychiatric Liaison Nurse has provided training on stress/distress behaviour, which enables staff to identify and support residents within the care home, avoiding admissions to hospital from the mental health team. The care home residents have average fluid intake recorded. This is calculated and indicates whether residents' hydration has increased or decreased enabling care staff to review residents' health and wellbeing and identify if infection is fluid related. West Dunbartonshire care homes introduced refreshment trollies which are decorated to look like an old "Ice Cream Van", and this is to create an interest around fluid. There are a variety of flavoured drinks. This has assisted to increase fluid intake and therefore minimise dehydration and also made this a meaningful interaction.
- 5.19 **Renfrewshire** HSCP has implemented Alcohol Outreach Nurse Posts at the Royal Alexandra Hospital. These nurses are also called Alcohol and Liver Frequent Attenders (ALFA) Nurses. These posts were created following analysis of the HSCP Emergency Department Frequent Attendee list. This work highlighted a group of alcohol addicted patients who only used ED as the source of medical care, rarely attending their GP and never attending outpatient alcohol appointments. The nurses are based in the RAH and mainly clinically managed by the Liver Consultant, but are part of the Addictions team based at Back Sneddon St and employed by the HSCP. The nurses will identify alcohol related frequent attenders and then contact them proactively to try and help sort out their problems and reduce their alcohol intake and ED attendances and RAH admittances.
- 5.20 Renfrewshire HSCP has also established the District Nursing ANP role within all care homes across Renfrewshire. ANPs within the service are aligned to, and work closely with, the Care Home teams; collaborating as necessary with local GPs and acute care. They use focused MDT meetings with care home teams, RES, MH and dieticians. They assist greatly with the proactive and reactive response to care homes as well as the provision of the right professional to meet that person's needs. The service allows for care to be completed within the service, promoting person centred care and prevention of admission. In March 2021 there were 222 patients reviewed by the ANPs.

- 5.21 **Inverclyde** HSCP continued to maintain its focus on Home 1st and Getting it Right 1st Time managing to maintain performance except at times of lower capacity in care@home services. When the care@home service was impacted during the initial months of the pandemic the HSCP admitted over 50 services users on an interim basis to Care Homes of their choice to facilitate discharge from hospital or avoid hospital admission. After an average stay of 8 weeks the service users were able to return home with the care @ home service they required in place to support their needs.
- 5.22 Inverclyde also utilised available capacity around day service transport to support discharge to home or care home, the team also provided a meals service to older people in the community. The day service team and community connectors kept in contact with a number of service users by telephone, this helped to reduce the impact of isolation and anxiety which are key factors in preventing admission to hospital.
- 5.23 Overall the HSCP relied on existing Home 1st protocol and processes that effectively supported the teams through the pressures of the pandemic. These measures identified are on-going and are part of the contingency in Inverclyde's Unscheduled Care; Home 1st plan.
- 5.24 In **Glasgow City** the Community Respiratory Response Team (CRRT) was set up as an emergency interim measure to allow services to cope with the Covid Pandemic. The service was created to provide a safe alternative to hospital admission for our chronic lung disease population with the awareness of nosocomial inpatient spread and potential poor outcomes for those with severe lung disease. Initial evaluation suggests that the rapid amalgamation of several teams across community and acute has been a success in responding to the crisis. ED attendance with respiratory diagnosis was down by approximately four fold compared to 2018/19 – significantly more so than the rest of Scotland.
- 5.25 Also in Glasgow a Crisis Outreach Service was established to meet the needs of people who experience non-fatal overdose, in order to prevent further fatal overdose. This new service was designed to provide assertive follow up of patients who had attended hospital having experienced a non-fatal overdose. Non-fatal overdose is a strong predictor of future fatal overdose, so an immediate response and assertive outreach to individuals was considered essential in an attempt to reduce drug related deaths, including out of hours. The team provides assertive outreach to referrals from Police Scotland and SAS and works closely with third sector organisations to provide follow up and support. There is close liaison with Emergency Departments to develop pathways and ensure follow up with locality teams.

5.26 Development of the HSCP Unscheduled Care Delivery Group, HSCP

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

Phase 2 - 2021 -2023

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

Figure 4 - Phase 2 Unscheduled Care Improvement Programme Core Projects

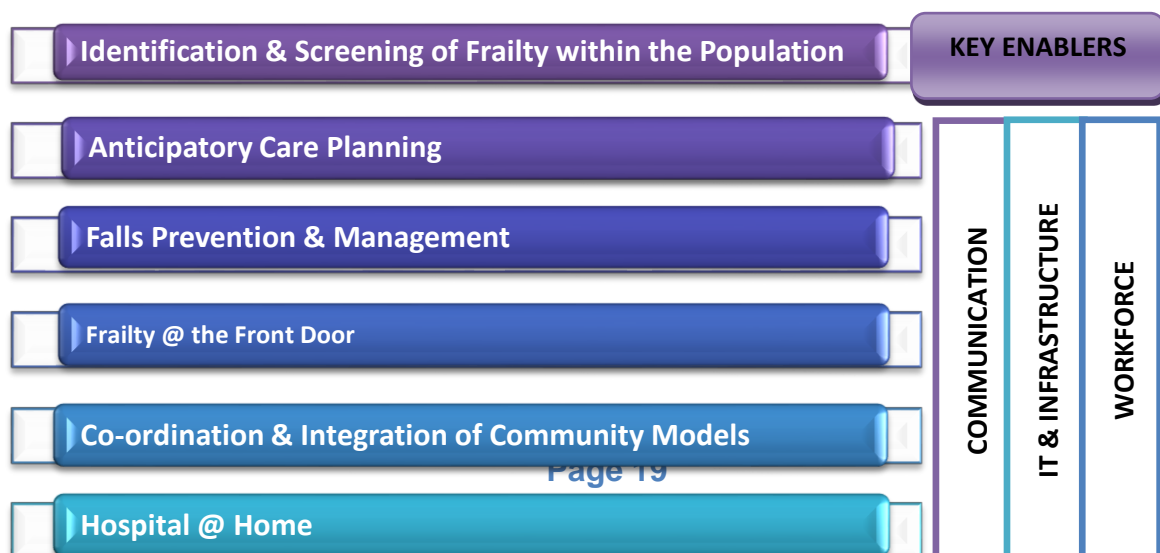
Patient Flow & Flow Navigation Centre Processes	Optimising Discharge and Reducing Delays	Prof to Prof	MSK	Falls & Frailty
<ul style="list-style-type: none"> ED Processes 4 hour standard Demand Prediction & Capacity Mgmt FNC Process Optimisation (workflow) 	<ul style="list-style-type: none"> 'Home First' application of Discharge to Assess Development of 'Hospital in Reach' processes AWI Peer Review 	<ul style="list-style-type: none"> Scheduling urgent care to Medical and Surgical AU's Community Pharmacy integration with GP in/out of hours and the FNC SAS – access to FNC and Community Services prof to prof (falls, care homes, COPD) Whole System Redirection (mutual aid FNC/GPOOH's/ OOHUCRH etc) 	<ul style="list-style-type: none"> Develop MSK local FNH/onward community referral pathways and outflow services to reduce hospital and primary care based services Development of NHS24 Physio resource to deliver National 111 MSK service 	<ul style="list-style-type: none"> Frailty Screening Tools Anticipatory Care Planning Falls Prevention & Management Frailty at the Front door Coordination & Integration of Community Models Hospital at Home - Glasgow City Test of Change

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

- **Primary Care/Acute Interface** – we will continue to develop pathways to convert unplanned to planned care with particular focus on scheduling urgent care within Assessment Units. Pathways under review/Development include: Care Homes (Falls), Head Injury, Acute and Surgical (Nat No 2)
- **MSK** – development of NHS24 Physio resource and local Flow Navigation Centre (FNC)/onward community referral pathways to reduce hospital and primary care based services (Nat No.5)
- **Community Pharmacy** – integration with GP in/out of hours and the FNC and to include signposting and direction from MIU/ED for minor illness (Nat No.1)
- **SAS** – development of Community Services and FNC prof to prof to access out of hospital/GP referral pathways e.g. COPD, Falls, Care Homes (Nat No.4)
- **Mental Health** - pathway development to include referrals from GP in/out of hours and the Flow Navigation Centre through prof to prof and scheduled virtual assessments (Nat No.3). This will build on the MHAU pathway fully embedded during 2020.

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

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



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

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

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

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

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

- **IT & Infrastructure eHealth Digital Solutions** – on-going challenges exist regarding interfaces between core systems and shared access to electronic patient information to deliver care closer to home. In the absence of shared systems across community teams, acute, primary care etc. we continue to develop processes with numerous work arounds that are not 'lean' and create barriers to sharing key patient information.
- **Workforce** – we face a significant challenge around workforce, in particular access to clinicians with advanced clinical assessment and management skills, whether this is ANPs or Advanced Allied Health Professionals. This has been evident across the Primary Care Improvement Plan and the Memorandum of Understanding resulting in 'in=post' training and mentoring taking place to develop the skills required.

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

Phase 3 - 2022/23 and onwards

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

6 ENGAGEMENT

Patient Engagement

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

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

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

Staff Engagement

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

Clinical Engagement

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

Primary Care

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

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

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

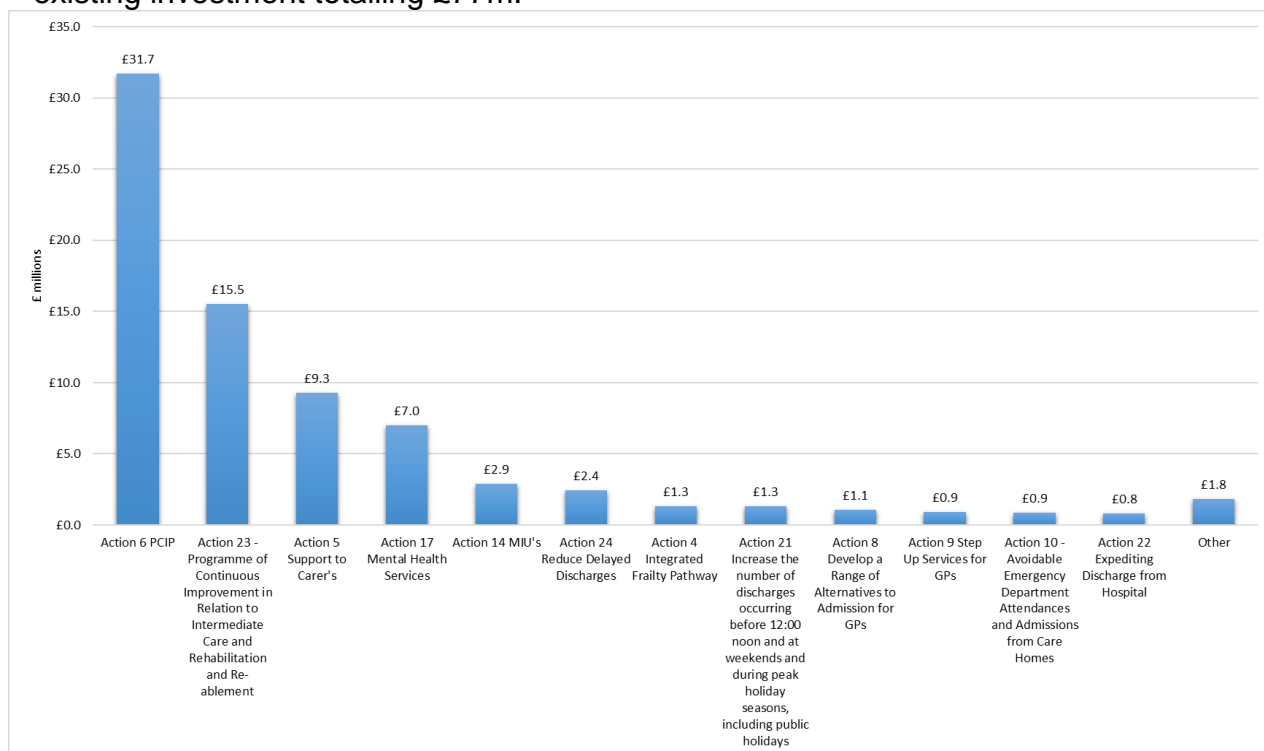
6.7 A key take away message from the engagement with GPs was that the unscheduled care programme needed to specifically recognise and include the contribution of PCIP to this agenda. The PCIP and unscheduled care programme direction of travel are closely aligned and are essentially about patients being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

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

7. FINANCIAL FRAMEWORK

- 7.1 In this section we outline the financial framework to support delivery of the plan. A number of the proposals in this plan are already funded in HSCPs or the Acute Services Division. Others will need additional or a shift in resources to support implementation.
- 7.2 This Joint Commissioning Plan represents the first step in moving towards delegated hospital budgets and set aside arrangements within GG&C. In 2019/20 unscheduled care was estimated to cost GG&C £444.3m. With a budget of £415.1m identified by GG&C Health Board. This is a shortfall in funding of £29.2m and represents a significant financial risk to GG&C Health Board and the six IJBs with strategic responsibility for this area.
- 7.3 This budget shortfall impacts on the IJBs' ability to strategically plan for unscheduled care. Nationally there is an expectation that IJBs, through commissioning plans, can improve outcomes and performance in relation to unscheduled care, which in turn will support the release of resources to support investment in primary care and community services. This was reiterated in the Scottish Government's Medium Term Financial Plan which assumes that 50% of savings released from the hospital sector will be redirected to investment in primary, community and social care service provision.

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



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

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

7.7 The recurring funding gap for Phase 1 and the investment required to deliver Phase 2 has been fully costed and the investment required is attached in annex F. It should be noted that this has been completed on a 2021/22 cost base. This highlights the need for £8.862m of investment, of which £7.337m is required on a recurring basis and £1.525m is required non-recurrently. Full funding for the non-recurring investment has been found with partner bodies utilising reserve balances or managing within existing budgets to deliver the funding required.

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

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

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

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

8 PERFORMANCE FRAMEWORK

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

8.2 It is essential that we develop a performance framework to support all levels of data and information required including high level management reporting at both GGC and HSCP levels; operational management data to support local planning

and monitoring and wider data to support targeted review and improvement activity at HSCP and locality/community levels.

- 8.3 It is the aspiration of the HSCP UC Delivery Group to have a single repository hosting the key data sets to support the framework. This will build on the HSCP dashboards currently developed. This will be similar to the Command Centre used by the acute sector.
- 8.4 A Data, Information & Knowledge work stream has been developed with key stakeholders to develop the framework and build the requirements for the single repository to be used across HSCPs. The work stream has developed the key indicators we propose to use to measure the impact of our programme as outlined in annex G. Figure 6 provides a pictorial example of the levels of data within the performance framework, with the high level data required to evidence impact example presented

Figure 6 – Performance Management Framework



- 8.5 In a large and complex system such as NHS GGC with many moving parts estimating and forecasting the impact of specific interventions is never an exact science. As we have seen in 2020 there are many factors that can influence the impact of any given intervention – many of which are not in our direct control e.g. changes in the economy. Forecasting or estimating the potential impact of such a wide ranging programme as described in this plan on Scotland's largest health

and social care system is even more difficult when looking into future years, and beyond Covid.

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

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

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

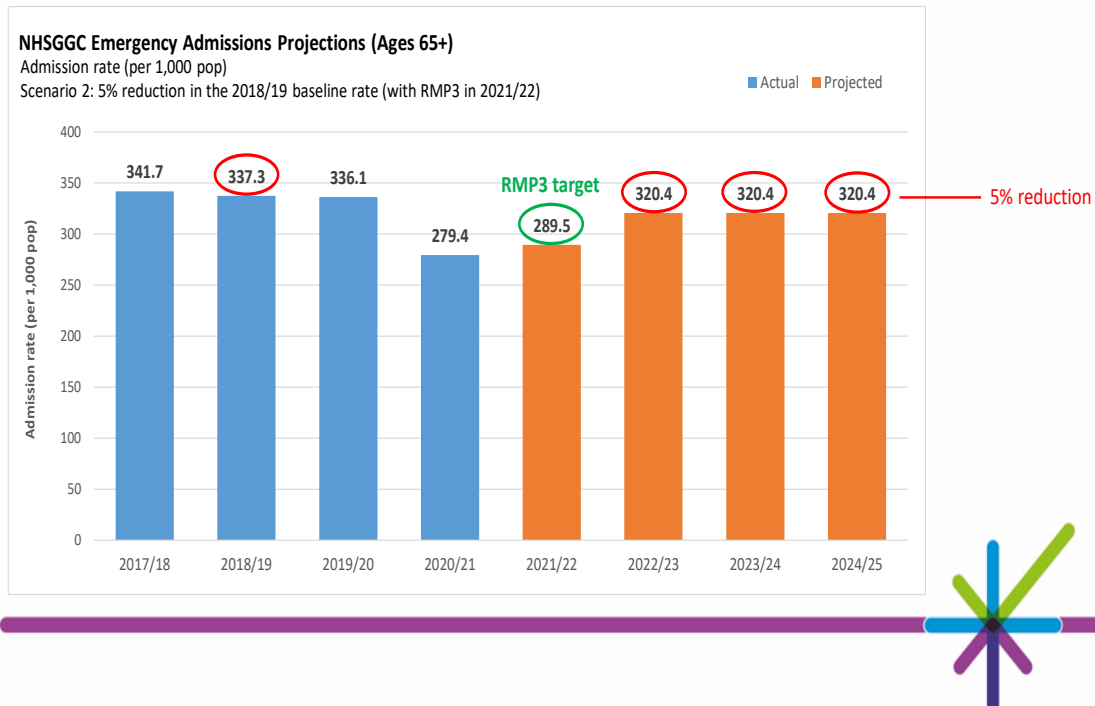
- a do nothing scenario with no implementation of the programme showing the impact demographic changes might have on current rates;
- a partial implementation of the programme taking into account that significant parts of the programme are funded non-recurrently; and,
- full implementation showing what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

8.9 Below we show the partial implementation scenario (see annex H for the detail) that illustrates the impact of the programme could (with all the caveats outlined above) result in a reduction in the rate of emergency admissions for over 65s from 337.3 in 2018/19 (the last pre-Covid year) to 320.4 in 2022/23 – a reduction of 5%. This estimate takes into account the demographic changes forecast in NHSGGC over this period (see also annex H), and also current projections for 2021/22 included in RMP3.

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

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

Admission rates (per 1,000 population)



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

9 GOVERNANCE ARRANGEMENTS

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

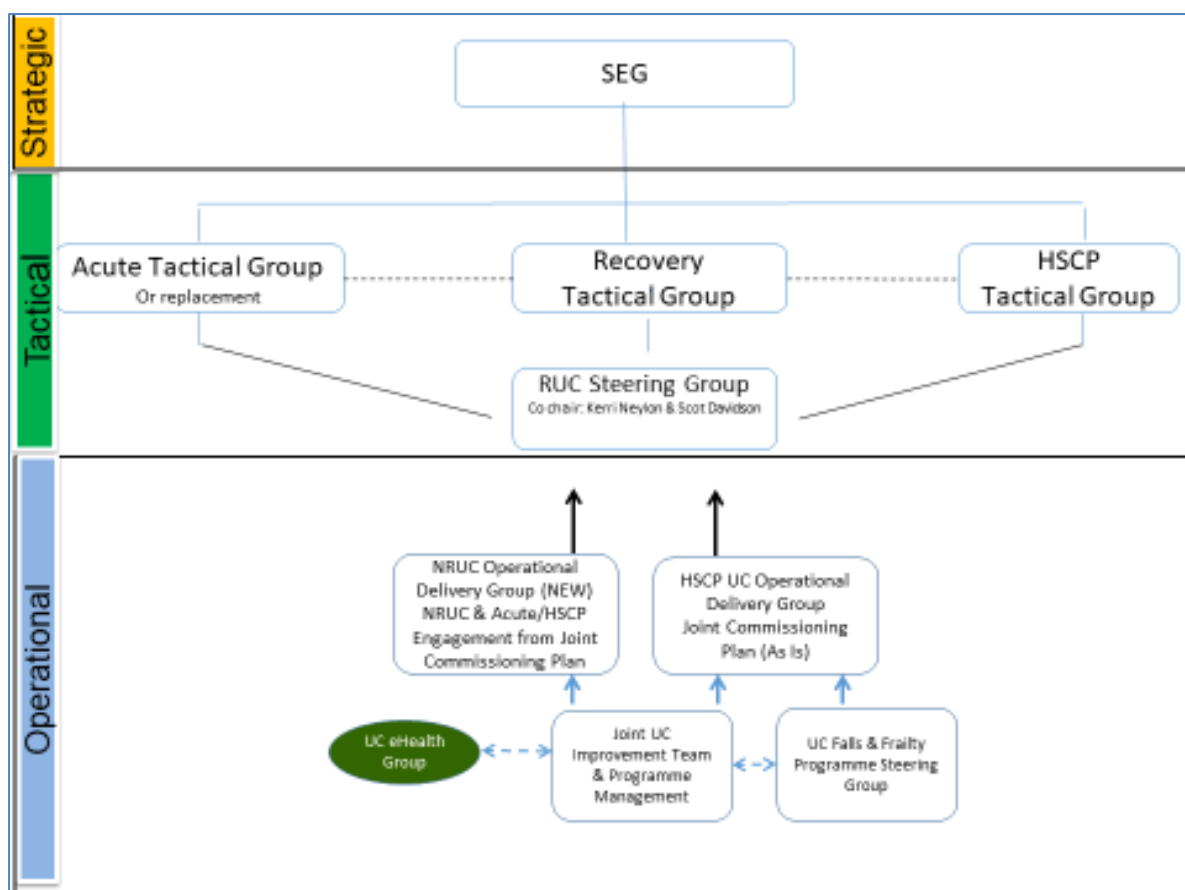
- facilitate strategic direction and operational leadership of UC;
- provide accountability for developing strategy and design via the Steering Group;
- demonstrate responsibility for implementation via Delivery Groups;
- embed the Programme Management approach to provide assurance that the programme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

9.2 At a strategic level the overall programme will report to the Strategic Executive Group (SEG) to provide oversight and overall governance assurance. As deemed appropriate there will be escalation to Corporate Management Team (CMT).

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

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

Figure 8 – Unscheduled Care Governance Arrangements



10 PROGRESS REPORTING

- 10.1 Progress on implementation of each action in the phases outlined above will be reported routinely firstly to the HSCP Delivery Group and then quarterly to the RUC Steering Group, Tactical Groups and onto SEG. Annual updates will also be provided to IJBs and the Health Board.
- 10.2 Where appropriate escalation of issues or areas of concern will be reported timeously.
- 10.3 Performance reports on the KPIs in annex G will be submitted monthly in line with existing performance reporting for delays, the four hour target, A&E attendances and other key measures.
- 10.4 The Data, Information & Knowledge work stream will develop a Standard Operating Procedure providing guidance to support reporting across all levels via appropriate governance routes.

11 NEXT STEPS

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

11.2 This revised plan has:

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

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