

A meeting of the Health & Social Care Committee will be held on Thursday 21 October 2021 at 3pm within the Municipal Buildings, Greenock.

Members may attend the meeting in person or access the meeting by remote online access. Webex joining details will be sent to Members and Officers prior to the meeting. Members are requested to notify Committee Section by 12 noon on Wednesday 20 October 2021 how they intend to access the meeting.

In the event of connectivity issues, Members joining remotely are asked to use the *join by phone* number in the Webex invitation and as noted above.

Information relating to the recording of meetings can be found at the end of this notice.

ANNE SINCLAIR
Interim Head of Legal Services

BUSINESS

1. Apologies, Substitutions and Declarations of Interest	Page
PERFORMANCE MANAGEMENT	
2. Revenue & Capital Budget Report – Position as at 31 August 2021 Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership and Head of Finance, Planning and Resources, Inverclyde Health & Social Care Partnership	p
NEW BUSINESS	
3. Drug Related Deaths 2020 and ADP Update Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	p
4. Inverclyde ADRS – Conclusion of Service Redesign Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	p
5. Action for Children Inverclyde Wellbeing Service Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	p
6. Chief Officer’s Report Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	p

The documentation relative to the following items has been treated as exempt information in terms of the Local Government (Scotland) Act 1973 as amended, the nature of the exempt information being that set out in the paragraphs of Part I of Schedule 7(A) of the Act as are set out opposite the heading to each item.

NEW BUSINESS		
7.	Homeless Service – Development of Rapid Rehousing Support Provision September 2021 Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership requesting the Committee note proposed changes to the Homeless Service and the creation of a Rapid Rehousing Support Service.	Paras 1, 6 & 9 p
8.	Direct Award for Accommodation Based Services Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership requesting the Committee to agree to the award of contracts to a number of organisations.	Paras 6, 8 & 9 p
9.	Direct Award for Good Shepherd Centre for the Provision of a Children’s Residential Care with Education Service for Children and Young People Placed by Inverclyde Council Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership requesting the Committee to agree to the award of a contract to the Good Shepherd Centre.	Paras 3, 6, 8 & 9 p
PERFORMANCE MANAGEMENT		
10.	Reporting by Exception – Governance of HSCP Commissioned External Organisations Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on matters relating to the HSCP governance process for externally commissioned Social Care Services.	Paras 6 & 9 p
<p>The reports are available publicly on the Council’s website and the minute of the meeting will be submitted to the next standing meeting of the Inverclyde Council. The agenda for the meeting of the Inverclyde Council will be available publicly on the Council’s website.</p> <p>Please note that the meeting will be recorded for publishing on the Council’s website. The Council is a Data Controller under UK GDPR and the Data Protection Act 2018 and data collected during any recording will be retained in accordance with the Council’s Data Protection policy, including, but not limited to, for the purpose of keeping historical records and making those records available.</p> <p>By entering the online recording or attending the Chambers in person, please acknowledge that you may be filmed and that any information pertaining to you contained in the video and oral recording of the meeting will be used for the purpose of making the recording available to the public.</p>		

Enquiries to – **Diane Sweeney** - Tel 01475 712147

Report:	Inverclyde Health & Social Care Committee	Date:	21 October 2021
Report By:	Allen Stevenson Interim Chief Officer Inverclyde Health & Social Care Partnership	Report No:	SW/30/2021/CG
	Craig Given Head of Finance, Planning & Resources Inverclyde Health & Social Care Partnership		
Contact Officer:	Samantha White	Contact No:	01475 712652
Subject:	REVENUE & CAPITAL BUDGET REPORT – POSITION AS AT 31 AUGUST 2021		

1.0 Purpose

- 1.1 The purpose of this report is to advise the Committee of the projected out turn on revenue and capital budgets for 2021/22 as at 31 August 2021.

2.0 Summary

- 2.1 The projected Revenue Out Turn for Social Work as at 31 August 2021 is an overspend of £522,000 which is a reduction in costs of £22,000 since Period 3.

In order to get to this projected out turn position, Inverclyde Health and Social Care Partnership needs to use £810,000 of its smoothing reserves.

Main areas of overspend are:

- A projected overspend of £706,000 in Children's Residential Placements, Foster, Adoption and Kinship after full utilisation of the smoothing Earmarked Reserve.
- Within Criminal Justice a £256,000 projected overspend as a result of shared client package costs with Learning Disabilities.
- A projected overspend of £184,000 within Residential and Nursing Care other client commitments, which reflects an anticipated overspend against direct payments and assumes that respite will return to pre-Covid levels.
- A projected overspend of £51,000 against CM2000, the homecare monitoring and scheduling system.

Main areas of underspend are:

- A £387,000 projected net underspend within External Homecare based on the invoices received together with an anticipated reduction in hours to be delivered.
- Additional turnover savings being projected across services of £248,000.
- A projected underspend of £106,000 Residential and Nursing Care client commitments following the allocation of pressure funding from the new monies received in 2021-22.

- 2.2 The Social Work 2021/22 capital revised estimate is £1,728,000, with spend to date of £80,000, equating to 4.63% of the revised estimate. No slippage is anticipated with the advancement of the capital programme in 2021/22.
- 2.3 The balance on the Integration Joint Board (IJB) reserves at 31 March 2021 was £14.932 million. The reserves reported in this report are those delegated to the Council for spend in 2021/22. The opening balance on these is £2.393 million with an additional £0.730 million received for 2021/22, totalling £3.123 million at period 5. Projected spend for 2021/22 is £1.263 million, expenditure is currently 12% ahead of the phased budget.
- 2.4 It should be noted that the reserves reported exclude those earmarked reserves that relate to budget smoothing, namely:
- Children's Residential Care, Adoption, Fostering & Kinship
 - Continuing Care
 - Residential & Nursing Accommodation
 - Learning Disability (LD) Redesign
 - LD Client Commitments
 - Advice Services

3.0 Recommendations

- 3.1 That the Committee notes the projected current year revenue out turn of an overspend of £522,000 at 31 August 2021. This position is after the use of £810,000 smoothing reserves. Similar to previous years, the position continues to be reviewed with the aim of reducing the overspend by year-end.
- 3.2 That the Committee notes the current projected capital position.
- 3.3 That the Committee notes the current earmarked reserves position.
- 3.4 That the Committee approves the virement listed in Appendix 6.

Allen Stevenson
Interim Chief Officer
Inverclyde Health & Social Care
Partnership

Craig Given
Head of Finance, Planning & Resources
Inverclyde Health & Social Care
Partnership

4.0 Background

- 4.1 The purpose of the report is to advise the Committee of the current position of the 2021/22 Social Work revenue and capital budgets and to highlight the main issues contributing to the projected £522,000 overspend.

5.0 2021/22 Current Revenue Position: Projected £522,000 overspend (0.95%)

The table below provides a summary of this position, including the impact on the earmarked reserves.

2020/21 Actual £000		Approved Budget £000	Revised Budget £000	Projected Outturn £000	Projected (Under) / Overspend £000	Variance to Budget %
59,591	Delegated Social Work Budget	54,652	54,714	55,236	522	0.95
(6,295)	Contribution from IJB	0	0	0	0	
518	Transfer to EMR	0	0	0	0	
53,814	Social Work Net Expenditure	54,652	54,714	55,236	522	0.95
2020/21 Actual £000	Earmarked Reserves	Approved Reserves £000	Revised Reserves £000	2021/22 Budget £000	Projected Spend £000	Projected Carry Forward £000
14,932	Earmarked Reserves	14,932	15,662	3,122	7,735	7,927
0	CFCR	0	0	0	0	0
14,932	Social Work Total	14,932	15,662	3,122	7,735	7,927

Appendix 1 provides details of the movement in the budget and Appendix 2 contains details of the out turn position. The material variances are identified by service below and detailed in Appendix 3.

5.1 Children & Families: Projected £823,000 (7.84%) overspend

The increase in the projected overspend of £178,000 primarily relates to:

- A projected overspend of £415,000 against external residential placements, an increase of £44,000 from period 3, due to an additional child needing to be in a residential placement along with some changes to other packages. Included the projected out turn, there are currently 13 children being looked after in a mix of residential accommodation, secure accommodation and at home to prevent residential placements.
- A projected overspend of £291,000 within fostering, adoption and kinship, an increase of £87,000 since period 3. The increase relates to an additional adoption and 2 external fostering placements from those reported at period 3.
- A projected overspend of £66,000 within employee costs, an increase of £37,000 from period 3, in the main within residential to reflect additional hours and overtime being required for holiday cover.

Where possible any over/underspends on adoption, fostering, kinship and children's external residential accommodation and continuing care are transferred from/to the earmarked reserves at the end of the year. These costs are not included in the above figures.

Movement in Earmarked Reserve:

- The opening balance on the childrens external residential accommodation, adoption, fostering and kinship reserve is £350,000. At period 5 there is a projected net overspend of £1,056,000 of which £350,000 would be funded from the earmarked reserve at the end of

the year it if continues, leaving an overspend against Core of £706,000 across these services.

- The opening balance on the continuing care reserve is £425,000. At period 5 there is a projected net overspend of £110,000 which would be funded from the earmarked reserve at the end of the year.

5.2 Criminal Justice: Projected £254,000 (12.63%) overspend

The projected overspend is showing a minor increase of £2,000 since period 3.

5.3 Older People: Projected £41,000 (0.18%) overspend

The reduction in the projected overspend of £135,000 mainly comprises:

- A projected net underspend of £387,000 within External Homecare, a reduction in costs of £197,000, which reflects the anticipated reduction in hours to be delivered. This is offset by an increased overspend against staffing costs detailed below, required to maintain service delivery.
- A projected net overspend of £251,000 on Employee Costs within Homecare, an increase of £101,000. This relates to additional sessional, overtime and travel costs of £97,000 and £126,000 for the planned recruitment to 24 temporary new posts required to maintain service delivery, given the anticipated reduction in external hours.
- A projected overspend of £51,000 against CM2000, the homecare monitoring and scheduling system, due to external costs and increased data access charges for the new App.
- A projected underspend of £106,000 Residential and Nursing Care client commitments as following the allocation of pressure funding from the new monies received in 2021-22. The projection is based on 551 beds (540 at period 3).

Any over / underspends on residential & nursing accommodation are transferred to the earmarked reserve at the end of the year. The opening balance on the residential & nursing accommodation reserve is £617,000. At period 5 there is a projected underspend of £106,000. However, as at period 5, Officers are not showing any transfer of the residential & nursing underspend to the earmarked reserve.

5.4 Learning Disabilities: Projected £219,000 (2.61%) underspend

The increase in the projected underspend of £54,000 since period 3 is largely within Day Services, pending the completion of the new Learning Disability Hub.

Any over / underspends on Learning Disability client commitments are transferred to the earmarked reserve at the end of the year. The opening balance on the Learning Disability client commitments reserve is £350,000. At period 5 there is a projected net overspend of £368,000 of which £350,000 would be funded from the earmarked reserve at the end of the year it if continues, leaving an overspend against Core of £18,000 across these services.

5.5 Physical Disabilities: Projected £22,000 (0.89%) overspend

The projected overspend is in the main within client commitments and reflects the impact of the 8% increase to Care at Home providers for this client group.

5.6 Assessment and Care Management: Projected £55,000 (2.43%) underspend

The projected underspend has increased slightly by £8,000 since period 3.

5.7 Mental Health: Projected £79,000 (8.41%) underspend

The increase in the projected underspend of £30,000 since period 3 is within employee costs due to an additional vacancy and further slippage in filling posts.

5.8 Alcohol & Drugs Recovery Service: Projected £134,000 (15.37%) underspend

The projected underspend is reflecting a minor increase in costs of £5,000 since period 3.

5.9 Business Support: Projected £112,000 (3.45%) underspend

The projected underspend of £112,000 relates to against employee costs and has increased by £39,000 since period 3 due to additional vacancies and slippage in filling posts.

6.0 2021/22 Current Capital Position

6.1 The Social Work capital budget is £10,829,000 over the life of the projects with £1,728,000 projected to be spent in 2021/22. No slippage is currently being reported with advancement of £499,000 in connection with the virement of covid contingency from the Environment & Regeneration capital programme in connection with the completion works for the new Crosshill Children's Home and based on the current programme to completion. Expenditure on all capital projects to 31 August 2021 is £80,000 (6.51% of approved budget, 4.63% of revised estimate). Appendix 4 details capital budgets.

6.2 Crosshill Children's Home:

- The former Neil Street Children's Home is in use as temporary decant accommodation for the Crosshill residents.
- The demolition of the original Crosshill building was completed in Autumn 2018. Main contract works commenced on site in October 2018 and had been behind programme when the Main Contractor (J.B. Bennett) ceased work on site on 25th February 2020 and subsequently entered administration. The Administrators confirmed that the Council would require to progress a separate completion works contract to address the outstanding works and a contract termination notice was issued for the original contract.
- The COVID-19 situation impacted the progression of the completion works tender which was issued in late December 2020 and returned mid-February 2021. Approval to accept the lowest acceptable tender was granted through emergency powers in March 2021. The completion work recommenced on 4 May 2021 with a contractual completion date in early November 2021.
- Works are progressing on site with external render repairs in progress and with roof tile repairs to follow. Photovoltaic roof panels have been installed. The replacement of the foul drainage system will commence when the scaffolding has been removed. Internally the electrical works are in progress with internal wall lining installation to follow.
- The contractor is currently projecting completion at the end of November.

6.3 The project involves the development of a new Inverclyde Community Learning Disability Hub. The new hub will support and consolidate development of the new service model and integration of learning disability services with the wider Inverclyde Community in line with national and local policy. The February 2020 Health & Social Care Committee approved the business case, preferred site (former Hector McNeil Baths) and funding support for the project with allocation of resources approved by the Inverclyde Council on 12th March 2020. The COVID-19 situation has impacted the progression of the project. The progress to date is summarised below:

- As previously reported the initial site information and survey work has been completed including flood risk assessments of the site. Supplementary site surveys are currently being progressed to provide more detail on the shallow rock substrate across the site to inform the design for drainage.
- Space planning and accommodation schedule interrogation work has been progressed through Property Services and the Client Service to inform the developing design with the Design Team focus on concluding the concept design to Architectural Stage 2. As part of the Stage 2 works an energy model of the proposed building has been developed including

a design based on current building standards and options for consideration (subject to funding / budget constraints) that align with the impending zero carbon building standards.

- Consultation with service users, families, carers and learning disability staff continues supported by the Advisory Group.

6.4 Swift Upgrade:

The project involves the replacement of the current Swift system. The March Policy & Resources Committee approved spend of £600,000. There has been a delay going back out to tender because of Covid. An update report will be brought to the Committee later in 2021/22.

7.0 Earmarked Reserves

7.1 The balance on the IJB reserves at 31 March 2021 was £14,932,000. The reserves reported in this report are those delegated to the Council for spend in 2021/22. The opening balance on these is £2.393 million with an additional £0.730 million received for 2021/22, totalling £3.123 million at period 5. Projected spend for 2021/22 is £1.263 million. There is spend to date of £269,000 which is 12% ahead of the phased budget. Appendix 5 details the Earmarked Reserves.

7.2 It should be noted that the reserves reported exclude those earmarked reserves that relate to budget smoothing, namely:

- Children's Residential Care, Adoption, Fostering & Kinship,
- Residential & Nursing Accommodation,
- Continuing Care,
- LD Redesign,
- LD Client Commitments
- Advice Services

8.0 Implications

Finance

8.1 All financial implications are discussed in detail within the report above.

Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

Legal

8.2 YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.

NO

Human Resources

8.3 There are no specific human resources implications arising from this report.

Equalities

8.4 Has an Equality Impact Assessment been carried out?

Yes See attached appendix

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

Repopulation

8.5 There are no repopulation issues within this report.

9.0 Consultations

9.1 This report has been jointly prepared by the Interim Corporate Director (Chief Officer), Inverclyde Community Health & Care Partnership and the Head of Finance, Planning and Resources, Inverclyde Community Health & Care Partnership.

10.0 List of Background Papers

10.1 There are no background papers for this report.

Social Work

Budget Movement - 2021/22

Period 5 1 April 2021 - 31 August 2021

Service	Approved Budget £000	Movements				Amended Budget £000	IJB Funding Income £000	Revised Budget £000
		Inflation £000	Virement £000	Supplementary Budgets £000	IJB Funding £000			
Children & Families	10,494	0	0	0	0	10,494	0	10,494
Criminal Justice	75	43	0	0	0	118	0	118
Older Persons	22,548	414	0	0	0	22,962	0	22,962
Learning Disabilities	8,435	0	0	0	0	8,435	0	8,435
Physical & Sensory	2,461	0	0	0	0	2,461	0	2,461
Assessment & Care Management	2,716	(454)	0	0	0	2,262	0	2,262
Mental Health	939	0	0	0	0	939	0	939
Alcohol & Drugs Recovery Service	960	0	(89)	0	0	871	0	871
Homelessness	1,218	0	0	0	0	1,218	0	1,218
Planning, Health Improvement & Commissioning	1,649	26	0	0	0	1,675	0	1,675
Business Support	3,157	372	(250)	0	0	3,279	0	3,279
Totals	54,652	401	(339)	0	0	54,714	0	54,714

Budget Movements Detail

<i>Inflation</i>	<u>£000</u>
Care at Home	108
National Care Home Contract	293
	<u>401</u>
<i>Virements</i>	
ADRS to Community Learning & Development (CLD)	(89)
Corp Dir (SIMD Deprivation)	(250)
	<u>(339)</u>

Social Work

Revenue Budget Projected Outturn - 2021/22

Period 5 1 April 2021 - 31 August 2021

2020/21 Actual Subjective Analysis £000	Approved Budget £000	Revised Budget £000	Projected Outturn £000	Projected Over / (Under) Spend £000	Budget Variance %
32,503 Employee costs	29,677	31,860	31,612	(248)	(0.78)
1,437 Property costs	997	996	969	(27)	(2.71)
1,689 Supplies & services	805	853	897	44	5.16
254 Transport & plant	378	350	339	(11)	(3.14)
840 Administration costs	723	767	795	28	3.65
47,812 Payments to other bodies	42,904	42,726	43,658	932	2.18
(19,076) Income	(20,832)	(22,838)	(23,034)	(196)	0.86
65,459	54,652	54,714	55,236	522	0.95
(6,295) Contribution from IJB	0	0	0	0	0
518 Transfer to Earmarked Reserves	0	0	0	0	0
(6,038) Scottish Government Covid Funding	0	0	0	0	0
53,644 Social Work Net Expenditure	54,652	54,714	55,236	522	0.95

2020/21 Actual Objective Analysis £000	Approved Budget £000	Revised Budget £000	Projected Outturn £000	Projected Over / (Under) Spend £000	Budget Variance %
11,583 Children & Families	10,494	10,493	11,316	823	7.84
182 Criminal Justice	75	118	372	254	12.63
26,246 Older Persons	22,548	22,962	23,003	41	0.18
8,206 Learning Disabilities	8,435	8,435	8,216	(219)	(2.61)
2,812 Physical & Sensory	2,461	2,461	2,483	22	0.89
1,812 Assessment & Care Management	2,716	2,262	2,207	(55)	(2.43)
1,538 Mental Health	939	939	860	(79)	(8.41)
706 Alcohol & Drugs Recovery Service	960	872	738	(134)	(15.37)
1,189 Homelessness	1,218	1,218	1,209	(9)	(0.74)
Planning, Health Improvement & Commissioning	1,649	1,675	1,665	(10)	(0.60)
3,566 Business Support	3,157	3,279	3,167	(112)	(3.45)
6,038 Covid-19	0	0	0	0	0.00
65,629	54,652	54,714	55,236	522	0.96
(6,295) Contribution from IJB	0	0	0	0	0
518 Transfer to Earmarked Reserves	0	0	0	0	0
0 Use of Reserves	0	0	0	0	0
(6,038) Scottish Government Covid Funding	0	0	0	0	0
53,814 Social Work Net Expenditure	54,652	54,714	55,236	522	0.95

Social Work

Material Variances - 2021/22

Period 5 1 April 2021 - 31 August 2021

2020/21 Actual	Budget Heading	Revised Budget	Proportion of budget	Actual to 31/08/2021	Projected Outturn	Projected Over/(Under) Spend	Percentage Variance
£000		£000	£000	£000	£000	£000	%
	Employee Costs						
6,712	Children & Families	6,344	1,460	2,707	6,410	66	1.04
11,028	Older Persons	10,666	2,455	4,342	10,973	307	2.88
2,445	Learning Disabilities	2,645	609	933	2,439	(206)	(7.79)
2,039	Assessment & Care Management	2,165	498	788	2,118	(47)	(2.17)
1,087	Mental Health	1,263	291	419	1,171	(92)	(7.28)
1,057	Alcohol & Drugs Recovery Service	1,144	263	391	1,011	(133)	(11.63)
929	Homelessness	1,059	244	402	1,035	(24)	(2.27)
1,673	Business Support	1,549	356	567	1,475	(74)	(4.78)
234	Finance Services	522	120	186	475	(47)	(9.00)
30,802		27,357	6,296	10,735	27,107	(250)	(0.91)
2,079	Children & Families - Residential Childcare	1,982	826	1,033	2,397	415	20.94
1,922	Children & Families - Adoption, Fostering and Kinship	1,744	782	938	2,035	291	16.69
13,676	Older People - Residential & Nursing	14,594	6,081	5,461	14,488	(106)	(0.73)
388	Older People - Residential Nursing - other client commitments	434	181	56	618	184	42.40
147	Criminal Justice package costs	0	0	0	256	256	n/a
3,369	Older People - External Homecare Payments	4,304	1,324	1,055	3,917	(387)	(8.99)
166	Older People - Homecare CM2000 system	99	41	24	150	51	51.52
1,607	Physical Disabilities - Client Commitments	1,636	682	611	1,669	33	2.02
23,354		24,793	9,916	9,178	25,530	737	2.97
54,156	Total Material Variances	52,150	16,212	19,913	52,637	487	0.93

Social Work
Capital Budget 2021/22

Period 5 1 April 2021 - 31 August 2021

Project Name	Est Total Cost £000	Actual to 31/03/21 £000	Approved Budget £000	Revised Estimate £000	Actual to 31/08/21 £000	Estimate 2022/23 £000	Estimate 2023/24 £000	Future Years £000
Social Work								
Crosshill Childrens Home Replacement	2,315	1,489	221	720	74	106	0	0
New Learning Disability Facility	7,400	67	406	406	6	6,292	635	0
Swift Upgrade	1,101	0	600	600		501	0	0
Complete on Site	13	0	2	2		11	0	0
Social Work Total	10,829	1,556	1,229	1,728	80	6,910	635	0

Social Work

Earmarked Reserves - 2021/22

Period 5 1 April 2021 - 31 August 2021

Project	Lead Officer / Responsible Manager	Total Funding 2021/22 £000	Phased Budget To Period 5 2021/22 £000	Actual To Period 5 2021/22 £000	Projected Spend 2021/22 £000	Amount to be Earmarked for 2022/23 & Beyond £000	Lead Officer Update
Covid Recovery - Establish Inverclydes Board and Memorial	Allen Stevenson	40	0	0	40	0	Approved P&R 25/05/21 - Covid Recovery Plans
Covid Recovery - Provide Passes for leisure access for physical activity	Allen Stevenson	50	0	0	50	0	Approved P&R 25/05/21 - Covid Recovery Plans
Covid Recovery - Support participation in groups and to re engage with Communities	Allen Stevenson	60	0	0	60	0	Approved P&R 25/05/21 - Covid Recovery Plans
Covid Recovery - Develop Food to Fork project to promote growing strategy	Allen Stevenson	30	0	0	30	0	Approved P&R 25/05/21 - Covid Recovery Plans
Covid Recovery - Develop Wellbeing Campaign	Allen Stevenson	35	0	0	35	0	Approved P&R 25/05/21 - Covid Recovery Plans
Community Justice	Sharon McAlees	88	0	0	13	75	Funding community justice Third sector work, £13k along with funding shortfall in prison income and shortfall of turnover savings against core grant in 21/22
Tier 2 School Counselling	Sharon McAlees	375	0	0	41	334	EMR covers the contract term - potentially to 31 July 2024. Contract commenced 1 August 2020. Projected spend in 2021-22 of £41k reflects shortfall in SG grant against contract.

Social Work

Earmarked Reserves - 2021/22

Period 5 1 April 2021 - 31 August 2021

Project	Lead Officer / Responsible Manager	Total Funding 2021/22 £000	Phased Budget To Period 5 2021/22 £000	Actual To Period 5 2021/22 £000	Projected Spend 2021/22 £000	Amount to be Earmarked for 2022/23 & Beyond £000	Lead Officer Update
C&YP Mental Health & Wellbeing	Sharon McAlees	202	0	7	202	0	Plan and implement a programme aimed at supporting children and young people whose life chances are negatively impacted through community mental health based issues. Expenditure will be on staffing: two FTE staff from Action for Children, two FTE staff from Barnardo's, one FTE research assistant based in Educational Psychology and 0.2 Educational Psychologist to act as development Officer with backfill.
C&YP Winter Planning	Sharon McAlees	187	94	131	187	0	The winter pressure Fund funding has been allocated to a number of projects, direct awards to families and enhanced family support, additional staff to meet demands of additional workload associated with outstanding referrals, deferred children's hearing orders etc. This will be spent in full in 21/22
Refugees	Sharon McAlees	737	0	0	50	687	Funding to support Refugees placed in Inverclyde. Funding extends over a 5 year support programme.
Autism Friendly	Alan Best	164	0	0	0	164	Plans currently being developed.
Integrated Care Fund	Alan Best	109	0	0	0	109	The Integrated Care Fund funding has been allocated to a number of projects, including reablement, housing and third sector & community capacity projects.
Delayed Discharge	Alan Best	422	175	160	414	8	Delayed Discharge funding has been allocated to specific projects, including overnight home support and out of hours support. Spend of £414k is expected for 2021-22.
Self Directed Support	Alan Brown	43	0	0	43	0	This supports the continuing promotion of SDS.

Social Work

Earmarked Reserves - 2021/22

Period 5 1 April 2021 - 31 August 2021

Project	Lead Officer / Responsible Manager	Total Funding 2021/22 £000	Phased Budget To Period 5 2021/22 £000	Actual To Period 5 2021/22 £000	Projected Spend 2021/22 £000	Amount to be Earmarked for 2022/23 & Beyond £000	Lead Officer Update
Wifi	Alan Best	7	0	0	7	0	Work has been carried out with balance looking to be fully spent this year.
Dementia Friendly	Anne Malarky	100	0	0	30	70	Now linked to the test of change activity associated with the new care co-ordination work. Proposals for spend of circa £90k over 18 months, to fund a Development Worker post and a Training Co-Ordinator post. This will continue to be reviewed at the Steering Group.
RRTP	Gail Kilbane	136	0	2	60	76	RRTP funding- progression of Housing First approach and the RRTP partnership officer to be employed. Full spend is reflected in 5 year RRTP
Growth Fund - Loan Default Write-off	Craig Given	24	0	0	1	23	Loans administered on behalf of DWP by the credit union and the Council has responsibility for paying any unpaid debt. This requires to be kept until all loans are repaid and no debts exist. Minimal use anticipated in 2020/21.
Welfare - IDEAS Projects	Craig Given	297	0	0	0	297	Plans currently being developed.
Anti Poverty - Community Support Fund	Craig Given	17	0	0	0	17	£7k NDR relief Tail O The Bank, £10k HSCP Digital Devices
Total		3,123	269	300	1,263	1,860	

Social Work

Virement Requests 2021/22

Period 5 1 April 2021 - 31 August 2021

Budget Head	Increase Budget £000	Decrease budget £000
1. Corporate Director - Payment to Other Bodies Policy & Resources Committee - Miscellaneous	250	(250)
2. ADRS - Employee Costs		(81)
ADRS - Administration Costs		(2)
ADRS - Payments to Other Bodies		(5)
CLD - Employee Costs	81	
CLD - Administration Costs	2	
CLD - Payments to Other Bodies	5	
	338	(338)

Notes:

1. Budget reallocation of £250,000 SIMD Deprivation funding within HSCP to a Council-wide Fund.
2. Budget transfer from ADRS to CLD.

Report To:	Inverclyde Health & Social Care Committee	Date: 21 October 2021
Report By:	Allen Stevenson Interim Chief Officer Inverclyde Health and Social Care Partnership (HSCP)	Report No: SW/28/2021/AM
Contact Officer:	Anne Malarkey Head of Service Mental Health, ADRS and Homelessness	Contact No: 715284
Subject:	DRUG RELATED DEATHS 2020 AND ADP UPDATE	

1.0 PURPOSE

- 1.1 The purpose of this report is to present to the Health and Social Care Committee the details from the recently published Drug Related Deaths in Scotland in 2020, published by the National Records of Scotland. An update on the Inverclyde Alcohol and Drug Partnership will also be presented.

2.0 SUMMARY

- 2.1 While this report has a particular focus on presenting data; it is important to recognise that behind every piece of data presented are people who have sadly lost their lives, who have left behind family and friends and who were part of our local communities.
- 2.2 Data in the report is presented at a Scotland wide level (with additional detail provided at this level) and then at Health Board Level and finally there is more limited information available at a Local Authority level.
- 2.3 In 2020, there were 1,339 drug-related deaths registered in Scotland. This was 5% more than in 2019 and the largest number since records began in 1996. In NHS Greater Glasgow and Clyde there were 444 drug-related deaths, an increase of 9.9% on 2019. In Inverclyde there were 33 drug-related deaths, no change from 2019.
- 2.4 In 2020, males were 2.7 times as likely to have a drug-related death as females, after adjusting for age in Scotland. This picture is reflected across NHS GG&C where there were 321 male deaths compared to 123 females, however, of note is the rate of increase over the last 10 years in female deaths, rising from 35 in 2010, an increase of 251.4%. In Inverclyde there were 28 male deaths and 5 female deaths in 2020. This compares to 13 male deaths in 2010 and 4 female deaths in the same year.
- 2.5 63% of all drug-related deaths were of people aged between 35-54 years of age in Scotland, with the average being 42.6. This was a similar picture in NHS GG&C indicating that those aged 35-44 have the highest 5 year average drug-related deaths

per 100,000 population at an average of 81.9. Likewise, Inverclyde has an average rate of 113.3 for those aged 35-44.

- 2.6 In 2020, after adjusting for age, people in the most deprived areas were 18 times as likely to have a drug-related death as those in the least deprived areas. That ratio has almost doubled in 20 years, from around 10 times in the early 2000s.
- 2.7 Using age standardised death rate in relation to drug related deaths, the Scotland wide rate average from 2016-2020 is 21.2 per 100,000 population. NHS GG&C has the highest age-standardised drug-related death rate of all health board areas at 30.8. Inverclyde has the third highest rate at a Local Authority level with a rate of 36.7. This compares to Dundee at 43.1 and Glasgow City at 39.8.
- 2.8 In 93% of all drug-related deaths, more than one drug was found to be present in the body.
- 2.9 The table below provides an outline of the overall substances implicated:

Substances	Scotland	NHS GG&C	Inverclyde
opiates/opioids (such as heroin/morphine and methadone)	89%	86.7%	87.88%
benzodiazepines (such as diazepam and etizolam)	73%	72.97%	75.76%
gabapentin and / or pregabalin	37%	32.88%	24.24%
cocaine	34%	33.56%	69.7%

- 2.10 With regards to the underlying cause of death there is a very similar picture with 92.76% of drug-related deaths in Scotland being classified as accidental poisoning and this being 95.05% in NHS GG&C and 93.94% respectively in Inverclyde.
- 2.11 Scotland's drug-death rate was over 3½ times that for the UK as a whole, and higher than that of any European country.
- 2.12 Following the publication of the 2019 Drug-Related Deaths in Scotland Report, Scottish Government has outlined the National Drugs Mission and associated funding to address drug related deaths.
- 2.13 Inverclyde Alcohol and Drug Partnership's Drug Death Prevention Action Plan focuses on actions related to the national Drug Death Taskforce priorities:
- Targeted distribution of naloxone;
 - Immediate response pathway for non-fatal overdose;
 - Medication-Assisted Treatment;
 - Targeting the people most at risk;
 - Public Health Surveillance;
 - Equity of Support for People in the Criminal Justice System

3.0 RECOMMENDATIONS

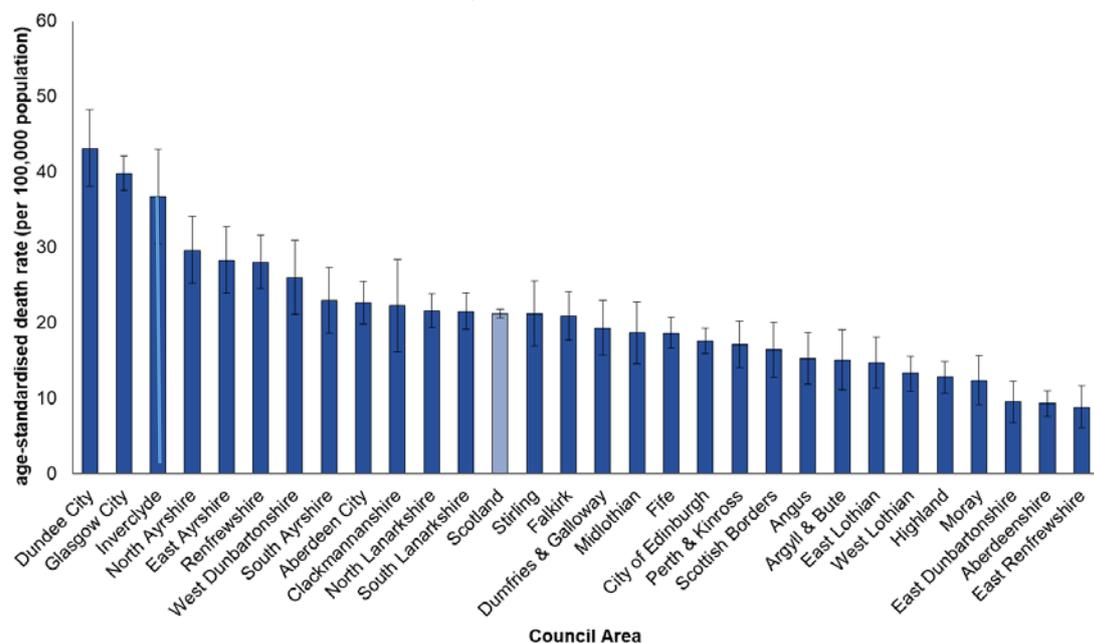
- 3.1 It is recommended that the Health and Social Care Committee:
- a. Note and give comment on the Drug Related Deaths in Scotland in 2020 Report.
 - b. Approve the work being driven through the Inverclyde Alcohol and Drug Partnership in relation to drug death prevention.

Allen Stevenson
Interim Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

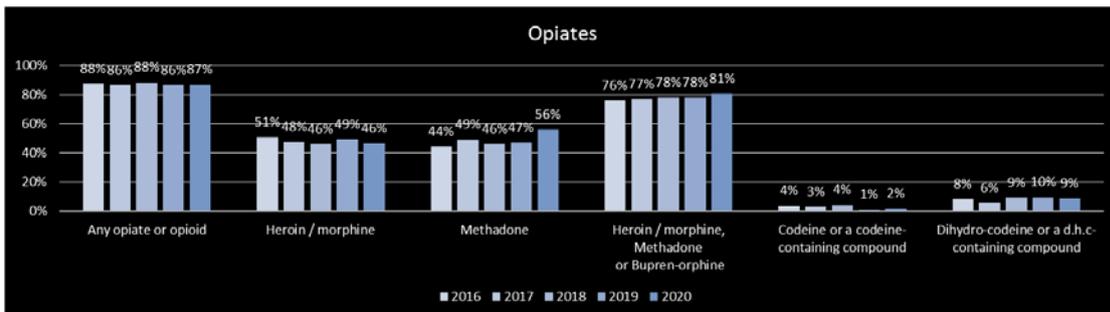
- 4.1 The “Drug Related Deaths in Scotland in 2020” was published on 30 July 2021, by the National Records of Scotland. This continues to be the long standing drug related death reporting framework of those individuals who sadly lose their lives to controlled drugs within the previous year.
- 4.2 In 2020 there were 1,339 drug-related deaths in Scotland. This is a 5% increase since 2019, with the age standardised rate per 100,000 population being 25.2 in Scotland.
- 4.3 Deaths have increased substantially over the last 20 years – there were 4.6 times as many deaths in 2020 compared with 2000.
- 4.4 Age-standardised mortality rates take account of the size of the population and its age structure, in order to provide more reliable comparisons of mortality over time and/or between areas or between sub-groups of the population. For example, as the probability of death tends to increase with age, changes in the age distribution of the population could have an effect on any apparent trend shown by the numbers of deaths. Similarly, if the populations of two areas or sub-groups have different age distributions, using age-standardised rates will remove the effect of those differences and show which area or sub-group has the higher underlying mortality rate. Therefore age-standardised rates are more reliable for comparing mortality over time and between different areas
- 4.5 In NHS GG&C there were 444 drug-related deaths, an increase of 9.9% on 2019, the highest ever recorded. Here the 2016-2020 average deaths per 100,000 is 30.3, with Glasgow City being 38.6 and Inverclyde being 34.5.
- 4.6 While Inverclyde has seen no rise in the number of drug-related deaths from 2019, remaining at 33; as outlined by the 5 year average rate outlined above; Inverclyde remains the third highest rate only compared to Glasgow at 38.6 and Dundee at 43.1. This is illustrated in the graph below:

Figure 6A: Drug-related deaths for selected council areas, age-standardised death rates, Scotland 2016-2020

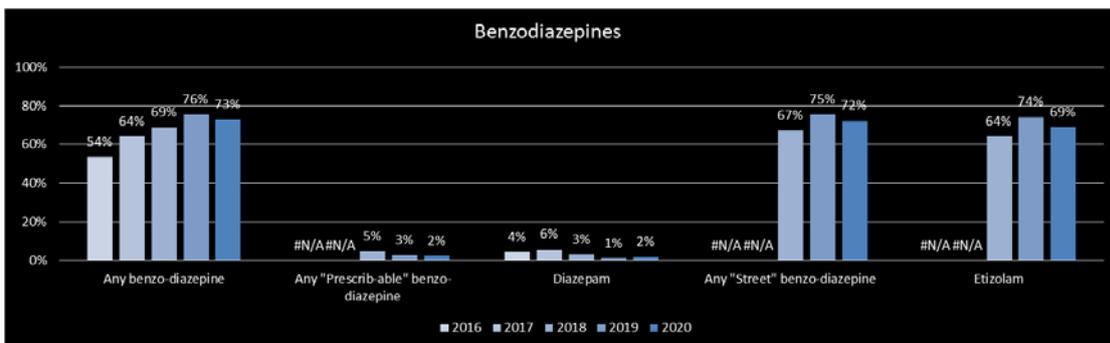


- 4.7 The average age of drug-related deaths has increased over the last 20 years, with the average age being 32 years in 2000, whereas this has increased over time to 43 years in 2020. There may be several factors that are influencing this pattern including, for example, having a long history of drug use and the physical impact of this; as well as the significant increase in poly-drug use and the range of drugs implicated as well as the volume taken.
- 4.8 In Inverclyde the annual average for 2016-2020 per 100,000 was 16.3 who were 15-24 years of age. This is the third highest rate for this age-group next to Renfrewshire at 17.0 and Midlothian with 18.6. A further deep dive to understand this data more will be undertaken.
- 4.9 The largest rate in relation to age-group in Inverclyde is the 35-44 age band in Inverclyde with a 5 year average rate per 100,000 of 113.3. Work is underway by services across the ADP to target this age-group, particularly those who are also experiencing severe and multiple disadvantages such as homelessness, involvement in the justice system and / or mental health issues.
- 4.10 Poly-drug use is a critical factor with 93% of drug-related deaths in Scotland evidencing more than one substance from the toxicology reports. The following graphs illustrate the range of substances and illustrate the changing drug trends across NHS GG&C, however, these very much reflect a similar picture in Scotland and in Inverclyde.

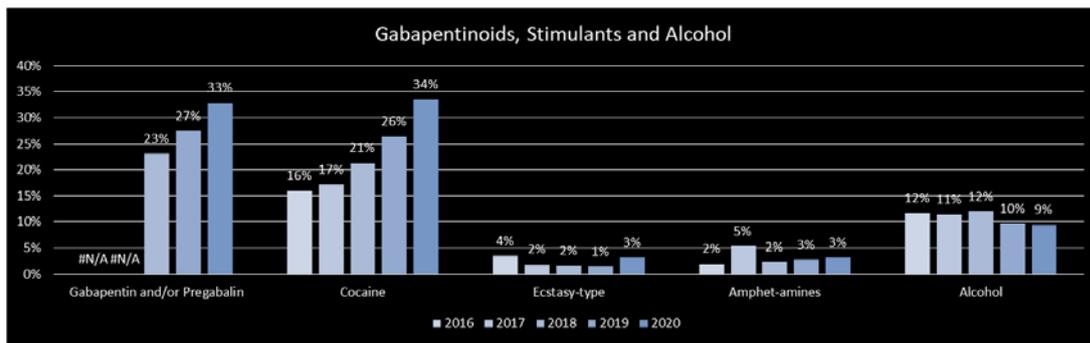
Opiates Implied in the Cause of Death



Benzodiazepines Implied in the Cause of Death



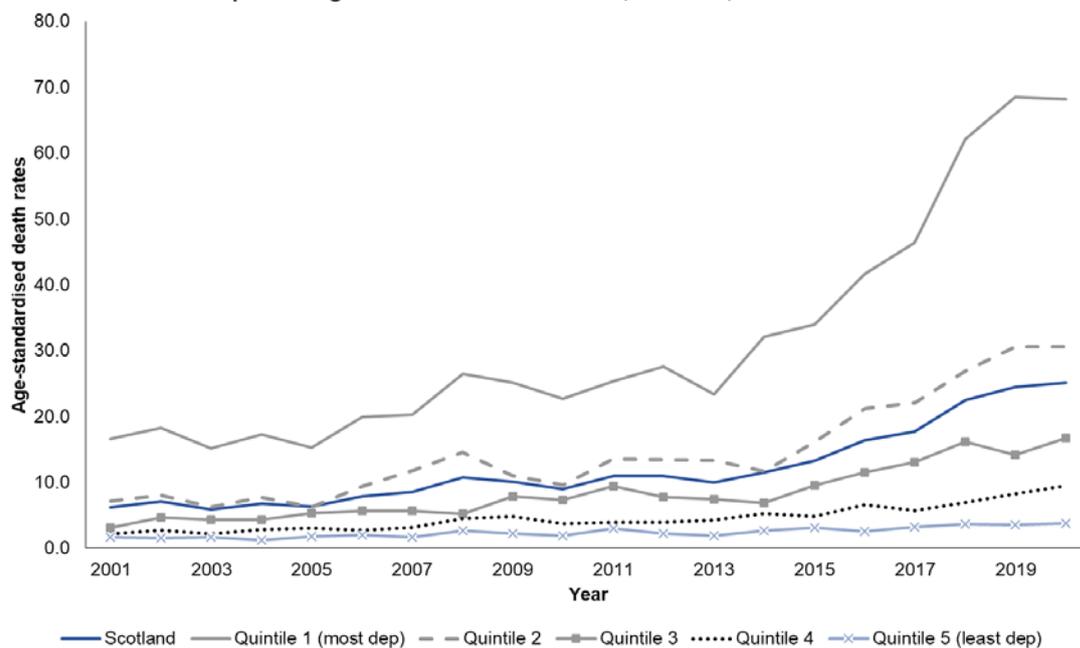
Gabapentinoids, Stimulants & Alcohol Implied in the Cause of Death



Of particular note where there is a clear distinction in Inverclyde is that 69.7% of drug-related deaths implicated cocaine use, compared to the NHS GG&C figure of 33.56% and the Scotland wide figure of 34%. This would suggest that cocaine is possibly easier to access in Inverclyde.

- 4.11 In 2020, after adjusting for age, people in the most deprived areas were 18 times as likely to have a drug-related death as those in the least deprived areas (68.2 per 100,000 population compared with 3.7) This ratio has almost doubled in 20 years where those in the most deprived areas were around 10 times as likely to have a drug-related death as those in the least deprived. This stark factor is illustrated in the graph below:

Figure 4: Drug-related deaths by Scottish Index of Multiple Deprivation (SIMD) quintile: age-standardised death rates, Scotland, 2001 to 2020



- 4.12 A key priority in Inverclyde's Anti-Poverty Strategy is to use funding to undertake an employability pilot, targeting a cohort of 20-30 year old males who are unemployed with alcohol or drug dependencies. This pilot will initially target Greenock Town Centre followed by a second phase targeting Port Glasgow. This pilot recognises the challenges to be overcome in relation to reducing poverty and increasing employment opportunities while tackling health inequalities.

4.13 In January 2021 the First Minister announced a new National Drugs Mission and a five year commitment of £250 million. The National Drugs Mission includes the following five key areas:

- Fast and appropriate access to treatment;
- Residential rehabilitation;
- The creation of a more joined-up approach that supports people living with drug addiction to address all the underlying challenges that they face and which ensures better support after near-fatal overdoses;
- The vital role of front-line, often third sector organisations;
- Exploring ways to overcome the barriers to introducing overdose prevention facilities.

4.14 As outlined in a letter to ADP Chair's in June 2021; Inverclyde ADP has been allocated an additional funding for 2021-2022 of:

- £81,537 to support priorities of National Mission;
- £81,537 to support access to residential rehabilitation; and
- £57,076 to support implementation of a Whole Family Approach.

4.15 Inverclyde Alcohol and Drug Partnership's Drug Death Prevention Action Plan focuses on actions related to the national Drug Death Taskforce priorities:

- Targeted distribution of naloxone;
- Immediate response pathway for non-fatal overdose;
- Medication-Assisted Treatment;
- Targeting the people most at risk;
- Public Health Surveillance;
- Equity of Support for People in the Criminal Justice System

4.16 Over the last year good progress has been made in several key actions including:

- The inclusion of the 3rd sector to distribute Naloxone (through the Lord Advocate's decree during Covid).
- The development of the information sharing protocols with key partners to ensure assertive outreach within 48 hours to anyone who has had a non-fatal overdose.
- Work to support those most at risk into treatment and try to keep them established within treatment services.
- The reduction in waiting times into ADRS treatment services; the ongoing work to support service users onto appropriate doses of treatment; and the introduction of Buvidal (longer lasting injection) which may change prescribing practices.
- The review of all drug deaths on a multiagency basis to determine any learning and improvements in practice.
- The test of change of Care Navigators to work intensively with the most vulnerable service users known to Homelessness; ADRS and Criminal Justice.

4.17 Analysis from the 2019 drug-related deaths in Inverclyde indicated that 30.3% of people were in police custody in the six months prior to their death. Inverclyde ADP has secured funding from the national Drug Death Task Force to employ Peer Navigators in Greenock Police Custody as a means of early help. This is a test of change with the potential to influence practice across Scotland, targeting a group of people who are at an increased risk of a drug-related death.

4.18 Inverclyde ADP are in the process of refreshing the Drug Death Prevention Action Plan, taking the opportunity to capture the wide range of actions and additional funding. Partners recognise that these actions will take time before achieving the overall ambition of reducing the unacceptable number of drug related deaths in Inverclyde.

5.0 IMPLICATIONS

Finance

5.1 Inverclyde ADP has secured several various strands of additional funding where combined actions are aiming to over time, reduce drug-related deaths.

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
PA370	<i>ADP OT</i>	2021-2022	£31,300		1 WTE
PA520	<i>Senior Pharmacist</i>	2021-2022	£28,900		0.6 WTE
S1930	<i>Misc</i>	2021-2022	£9,740		Recovery Activity
PA800	<i>Admin clerical</i>	One-off cost	£587		Printing
S1305	<i>Equipment Purchase</i>	One-off cost	£10,000		Website Development

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

Legal

5.2 There are no specific legal implications in respect of this report.

Human Resources

5.3 There are no implications.

Equalities

5.4 Has an Equality Impact Assessment been carried out?

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

Repopulation

5.5 There are no specific repopulation issues.

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with statutory and third sector partners.

7.0 BACKGROUND PAPERS

7.1 Drug Related Deaths in Scotland in 2020, (2021), National Records of Scotland.

Report To:	Inverclyde Health & Social Care Committee	Date:	21 October 2021
Report By:	Allen Stevenson Interim Chief Officer Inverclyde HSCP	Report No:	SW/29/2021/AM
Contact Officer:	Anne Malarkey Interim Head of Mental Health, Alcohol and Drug Recovery and Homelessness Services	Contact No:	01475 715284
Subject:	INVERCLYDE ADRS – CONCLUSION OF SERVICE REDESIGN		

1.0 PURPOSE

- 1.1 The purpose of this report is to provide the Health & Social Care Committee with a final overview of the work progressed within the Inverclyde Alcohol and Drug Recovery Service to conclude service redesign.

2.0 SUMMARY

- 2.1 Inverclyde Alcohol and Drug Recovery Service (ADRS) has undergone a service review over the past 2-3 years. The final phase – the implementation plan of service redesign was put on hold at the start of the Covid-19 pandemic and recommenced again in September 2020. Four sub-groups have taken forward this work, reporting to a steering group.
- 2.2 We are in the final phase of the implementation plan, with all required elements of the workplan completed.
- 2.3 There is no longer a requirement for the continuation of the sub-groups therefore the role of the ADRS Steering Group has been fulfilled.
- 2.4 Ongoing service development will continue within a service operational plan, as national and board wide initiatives are developed and rolled out into practice.

3.0 RECOMMENDATIONS

- 3.1 The Health and Social Care Committee is asked to:
- note the level and activity undertaken as part of the service redesign as detailed in the attached report (Appendix 1);
 - agree to conclude the ADRS Steering Group and associated sub-groups; and
 - agree that future work will be delivered as part of the service operational plan and that future reports will be scheduled through the Alcohol and Drug Partnership.

**Allen Stevenson
Interim Chief Officer
Inverclyde HSCP**

4.0 BACKGROUND

4.1 The ADRS Steering Group has overseen the implementation plan, taken forward across a range of sub groups to develop the new service model.

4.2 *Workforce Subgroup*

Amendments to the staffing model, identified during the pandemic have been fully implemented. A number of posts are being recruited to in order to conclude this element of the workplan. Ongoing engagement and wellbeing events are held with staff to support them in the change.

4.3 *Care and Treatment Sub-group*

We have developed, implemented and adapted a range of standard operating procedures to ensure safe, effective governance of new interventions and practice. By working alongside Board-wide ADRS colleagues to support equity of access to emerging new treatments and ways of working against MAT Standards.

4.4 *Performance and Information Sub-group*

Implementation of DAISy reporting system is underway. The service will continue to review against other reporting arrangements in order to report on waiting times and provide service activity updates.

4.5 *Prevention and Education*

Moved out of ADRS as part of redesign to ensure wider community education.

5.0 PROPOSALS

5.1 This report seeks approval to conclude the ADRS Steering Group and associated workstreams. Ongoing service development will continue at operational level with regular reporting on activity via the Alcohol and Drug Partnership.

6.0 IMPLICATIONS

Finance

6.1

Financial Implications:

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

Legal

6.2 No implications

Human Resources

6.3 No implications

Equalities

6.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
X	NO -

Repopulation

6.5 No implications

7.0 CONSULTATIONS

7.1 None

8.0 LIST OF BACKGROUND PAPERS

8.1 Inverclyde ADRS Review – Implementation Plan

8.2 Inverclyde ADRS Care and Treatment Milestones

Inverclyde HSCP Alcohol and Drug Review Implementation Plan

As at 01/09/21

The review has identified three main strands of work which will be progressed as follows:

- Prevention- through the Alcohol and Drug Partnership (Action 1)
- Assessment, Treatment and Care -through the Alcohol and Drug Review Programme Board (Actions 2-17&19))
- Recovery- through a wider HSCP recovery development approach with mental health; supported self-care and commissioning. (Action 18)

Action No.	Link to Recommendation	Action required	Responsible Officer	Sub Group	Timescale	Progress (BRAG)
1	13,14	Develop a robust whole population cohesive approach to prevention and education within schools and the wider community	ADP Chair and Coordinator	Alcohol and Drug Partnership	January 2020	Green
2	1	Rebrand the current alcohol and drugs services into the Inverclyde HSCP Alcohol and Drug Recovery Service <ul style="list-style-type: none"> • Rebranding of the service has been undertaken to “Inverclyde Alcohol and Drug Recovery Service” (ADRS). All external and internal communications now incorporate the new name and work to redesign leaflets/social media etc. for the service, which are being co-produced with the Service User Reference Group at Your Voice, is ongoing. 	Service , HSCP Comms Group	Care & Treatment Sub Group	July 2019	COMPLETE
3	2,3	Phase 1-Develop a single point of access (SPOA); and one duty system for all service users requiring support with regard to their alcohol and drug issues. Phase 2-Integrate the SPOA into the HSCP Access 1st service	SM-A&H SM-ACM team leads	Care & Treatment Sub Group	Phase 2- ON HOLD	COMPLETE Appendix 1

4	15	<p>Agree Eligibility criteria and Access Criteria for access to the HSCP alcohol and drug services</p> <ul style="list-style-type: none"> • An eligibility criteria for the new model has been agreed • 3rd sector pathway and referral routes are in place. • Plan for sub group for coms and engagement <p> Access Criteria to ADRS version 1.0 Jun</p>	SM-A&H SM-ACM team leads	Care & Treatment Sub Group	August 2019 Meeting reconvened 24/2/21	COMPLETE
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5	3,6	<p>Develop one duty process; one allocations process and review process for implementation across the service</p> <ul style="list-style-type: none"> • A new integrated duty system has been developed with appropriate paperwork to capture both alcohol and drug information and updated to incorporate a validated screening tool. Guidelines from point of self-referral to allocation have been developed. <ul style="list-style-type: none">  Provision of duty SOP version 1.1.doc. • A single pathway has been agreed for individuals who do not attend (DNA) and criteria agreed for assertive outreach in line with Greater Glasgow & Clyde (GG&C) DNA <ul style="list-style-type: none">  DNA Pathway.rtf • Joint Multidisciplinary team meeting for drug and alcohol cases have been established. <ul style="list-style-type: none">  SOP Escalation of case to MDT clinical • Single point of access screening/allocations meeting established for all new referrals. <ul style="list-style-type: none">  Screening and Allocations SOP.doc 	Operational manager/ Team Leads	Care & Treatment Sub Group	September 2021 September 2021 August 2021 August 2021 August 2021	COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE
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6	3,6,	Implement a single pathway model based on Intake and Core provision with appropriate staffing. On hold for 12 months for service redesign to be fully implemented and embedded. Determine if intake and core is required in future.	SM and team leads	Care & Treatment Sub Group	Review operational model Sept 22	Red
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7		<p>As part of the CORRA plan, start to expand alcohol and drug liaison services within acute setting with increased focus on ED and repeat attenders</p> <ul style="list-style-type: none"> E.D Repeat presentations standard operating procedure has been established a multidisciplinary team meeting to support the board wide initiative and encourage better integration with ED. <p> Inverclyde Alcohol and Drug Repeat Pr.</p> <ul style="list-style-type: none"> Links with clinical lead and charge nurse within ED have been re-established. Pathway for referral reviewed and highlighted to ED staff. Standardised acute addiction training plan will be delivered commencing July 2021 with added sessions focusing on repeat attenders and NFOD with specific ED awareness sessions. New pathways for non-fatal over dose referrals have been agreed with the Scottish Ambulance Service and will be operationalised by the liaison nurse. Information sharing process is in place. <p> SOP Non fatal OD final.docx</p> <p> NFOD referral flowchart final.doc</p> <p> local ambulance pathway.doc</p> <p> 2020-11-06 Caldicott Letter Incic</p>	NHS Operational manager/ Team leads	CORRA Team Lead	Care & Treatment Sub Group	Commence October 2018 Meeting reconvened 24/2/21	COMPLETE
						18 th June 2021	COMPLETE
							COMPLETE

8	5	<p>As part of the CORRA plan, start to work with primary care colleagues to commence development alcohol and drug liaison within primary care liaison.</p> <ul style="list-style-type: none"> • CORRA lead has attended GP forum to agree new pathways into service, location of the test of change and service specification has been agreed • SOP complete • SOP and pathways to GPs 2nd March 2021 for feedback before roll out on the 5th March 2021. • Plan to go live 8th March 2021. <p>  Primary care SOP.docx  Primary care referral flowchart drug use.referral flow chart.d </p>	NHS Team leads and CORRA Team lead	Care & Treatment Sub Group	Meeting reconvened 24/2/21	COMPLETE
9	6,7	<p>Commence development of a test of change to determine need for extended hours/7 day service for services users requiring drug and alcohol treatment.</p> <p>Actively developing staff model to deliver extended service.</p> <p>Links to CORRA Imp Group</p>	CORRA team lead and team leads	Care & Treatment Sub Group	Commence October 2018 Meeting reconvened 24/2/21	Green
10	4,7	<p>Reshape the current alcohol day service into a Tier 4 service and extend availability to all clients with complex health issues.</p> <p>Extended to cover drug Dependency – DTTO, Benzodiazepine, Bupivital initiation/ Depot clinic</p>	NHS Team leads Consultants	Care & Treatment Sub Group	November 2019 Meeting reconvened 24/2/21	Green

11	7	<p>Commence the development of opportunities for alcohol home detox and develop appropriate risk processes and procedures.</p> <ul style="list-style-type: none"> • Staff are now trained in home detox procedures, • standard operating procedure has been developed • Final discussions with medic regarding implementation and commencement date.  <p>Guidance to Support Service Deli</p>	CORA Team lead	Care & Treatment Sub Group	Commence October 2018 Meeting reconvened 24/2/21	COMPLETE
12	6,11	Develop a Complex Needs Team to support most vulnerable clients	SM A&H and team leads alcohol drugs homeless and Criminal justice	Care & Treatment Sub Group	November 2019 Meeting reconvened 24/2/21	Red
13	9	Commission SFAAD (Scottish Families affected by Alcohol and Drugs) to review current range of family support and identify future provision	ADP Lead SM H&A	Family Support sub group	September 2019	COMPLETE
14	12	<p>Review of the current psychological therapies approaches within services to ensure appropriate access across all alcohol and drug service users.</p> <ul style="list-style-type: none"> • Meeting arranged with Dr Mooney to discuss training needs • Psychology post/structure update • 	SM A&H Lead Psychologist alcohol and drugs	Care & Treatment Sub Group	Meeting reconvened 24/2/21	On going GREEN
15	18	Review current pathways and develop specific protocols and seamless pathway for young people experiencing issues with alcohol and drugs.	SM A&H SM C&F	Young Peoples Sub group	September 2019	Green

16	3,6,17	<p>Develop interface protocols and processes with each HSCP service</p> <p>Criminal Justice;</p> <ul style="list-style-type: none"> • DTTO standard operating procedure completed. • Structured deferred sentencing pathway • Team leaders interface meeting commence • Progression towards staff interface meetings <p>Health and Community Care;</p> <ul style="list-style-type: none"> • Service manager level integration • Progression of team leader interface <p>Community Mental Health Team</p> <ul style="list-style-type: none"> • Integrated team lead meetings • Joint caseload review • Sharing of duty team lead and huddle information <p>Homelessness</p> <ul style="list-style-type: none"> • Joint caseload reviews • Joint team leads meeting 	SM-A&H SM from each service	Care & treatment sub group	November 2019 Meeting reconvened 24/2/21	COMPLETE
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17	20,21,22,23,24	<p>Develop a staffing framework for the integrated service which includes clear roles and remits for both NHS and social care staff and ensure all are appropriately trained and supported to deliver</p> <ul style="list-style-type: none"> • Consulted with Chief Social Work Officer regarding social care governance and structure • Social Worker team lead - appointed • Consulted with professional nurse lead & practice develop nurse for support for nursing staff to identify role specific tasks • Job description updated with “occasional out of hours working” added • Mock rota sent out to staff • Four open/drop in sessions arranged for staff to speak with ops manager and service manager • Staff training records collected and sent to performance & information – new training plan to be developed • Meeting arranged with performance and information analyst to look at training needs analysis. • Training for all staff to access SWIFT is underway 	SM-A&H HR Staff reps	Workforce Group	First meeting July 2019 Reconvened 11/2/21	COMPLETE
18	8,10,16	<p>Develop a recovery strategy and implementation plan as part of the wider recovery framework across the HSCP.</p> <p>Review and continue to develop the financial framework to support the implementation of the integrated service</p>	HOS-MHAH HSCP Recovery Lead	Recovery Implementation Group	Oct 2019	Green
19			HOS-MHAH CFO SM-A&H		Ongoing	Green

Report To:	Inverclyde Health & Social Care Committee	Date:	21 October 2021
Report By:	Allen Stevenson Interim Chief Officer, Inverclyde HSCP	Report No:	SW/31/2021/SMcA
Contact Officer:	Sharon McAlees Head of Children & Criminal Justice Services	Contact No:	715282
Subject:	ACTION FOR CHILDREN INVERCLYDE WELLBEING SERVICE		

1.0 PURPOSE

- 1.1 The purpose of this report is to advise the Health and Social Care Committee on the progress of the Action for Children Inverclyde Wellbeing Service Tier 2 mental health service established and launched August 2020.

2.0 SUMMARY

- 2.1 Inverclyde HSCP and Education Services have committed to improve Children and Young Peoples Tier 2 mental health in Inverclyde based on a collaborative model. This is via Action For Children Inverclyde Wellbeing Service 5 -18 year olds. This is funded jointly through Scottish Government Programme for Change monies awarded 2019-2023 for access to counselling services through schools and supplementary funding from the Inverclyde IJB.

3.0 RECOMMENDATIONS

- 3.1 That the Health and Social Care Committee note the content of this report and the Inverclyde Wellbeing Service progression to year two of service

Allen Stevenson
Interim Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 Service Delivery

The main elements to the service are the one-to-one counselling service, and programme based group work, both of which were discussed and co-ordinated with schools to support pupils to access services, in response to the Covid-19 pandemic.

4.2 One to One Counselling

Work to promote the service as a school-aged Children & Young People's service, and not purely schools based involved meeting with a range of teams and networks of services across Inverclyde, which continues, to promote the services as widely as possible, encourage self-referrals, and make sure information on the service and how to access support is as widely disseminated as possible.

Initially, a combination of online meetings, and where possible and safe to do so, in-person meetings took place, to raise the profile of the service across Inverclyde. Meetings with teams included:

- Initial online launch of the service to partners in August 2020
- GP forum
- CAMHS
- Social Work
- School Nursing Team
- Mind Mosaic
- Barnardos
- Community Learning and Development
- Parent Council Representatives
- Regular scheduled attendance at Addition Support Needs leaders WebEx meetings

A dedicated local website:- <https://services.actionforchildren.org.uk/inverclyde-children-and-young-peoples-wellbeing-service/> was developed and launched, in addition social media was used to promote and encourage self-referrals from Children & Young People as well as from parents and/or carers who wished to access the service or further available resources on supporting emotional health and wellbeing.

Over 20 contacts have been made through the website leading to a number of self-referrals from senior phase students and parents.

All parents and senior phase students also received a newsletter by email containing information on the counselling service, how to access support in a bid to encourage self-referrals. Greater access to schools for informal drop in information sessions when relaxing of Covid safety guidance applies will allow the team to continue to raise awareness also raising the profile of the service to Children & Young People, increasing the potential for self-referrals.

4.3 Counselling Delivery

Initial referrals for counselling were received from schools in October 2020 with the delivery of sessions commencing on the return to school after the October school holidays.

The service model is of 8 counselling sessions.

Review sessions within the counselling team is through line management supervision, person centered clinical supervision, discussion taking place within the staff team, and as appropriate, with school leads, local authority staff, where decisions are made to extend sessions are made on an individual basis with input from stakeholders, based on an assessment of the needs of the Children & Young People.

To date:

- **172 referrals have been received for counselling.**
- **95 Children & Young People offered access to counselling support.**
- **77 remain on the waiting list**
- **43 currently engaging,**
- **27 completing agreed sessions,**
- **7 disengaged from support,**
- **7 accessing other supports (CAMHS, Mind Mosaic, Private Counselling, LIAM),**
- **<5 no further support required on assessment (support from project staff provided),**
- **<5 moved local authority,**
- **<5 out with Local Authority post code,**
- **8 referrers contacted to follow up with Children & Young People referred/tbc.**

During the lockdown period from January 2021, Counsellors moved to a combination of telephone support, walk and talk sessions, and accessing schools hubs to continue to offer support to Children & Young People engaging with the service during this period. Return of face-to-face support as soon as pupils returned to school and access was available to both schools and Children & Young People.

Circa 780 counselling sessions were offered calculated on the staged starts of staff throughout the development of the service from September to December start dates, and restrictions in permitted contacts with Children & Young People per day.

Figure 1 below indicates the age ranges of those Children & Young People offered support.

Fig. 1

Stage specific data	11	P2-P5
Number of children in P6	12	
Number of children in P7	14	
Number of children in S1	5	
Number of children in S2	11	
Number of children in S3	16	
Number of children in S4	13	
Number of children in S5	6	
Number of children in S6	7	

Figure 2 indicates the number of Children & Young People male, female or non-binary.

Fig 2.

Number of female pupils accessing provision	46
Number of male pupils accessing provision	48
Number of young people identifying as non-binary	1

Figure 3 indicates the referral source

Fig 3.

Referrals In	
Numbers of referrals from	
Self-referral	5
School Staff	83

Social Services	1
GP	1
School Nurse	1
Health Professional	3 CAMHS 1 Disability Nurse Specialist
Other	

Figure 4 indicates the issues reported by referral information.

Fig. 4

Mental Health and Wellbeing issues reported by children and young people			
Exam Stress	1	Self-Harm	4
Trauma	1	Depression	0
Bereavement	1	Anxiety	37
Gender Identity	0	Emotional/Behavioural Difficulties	49
Substance Use	0	Body Image	0
Other:	Please add rows if required	Low Mood	2

4.4 Group Work Program

Delivery of Bouncing Back began in Inverclyde Academy, Notre Dame and Lomond View Academy and was delivered to all S3 students before the end the term at Christmas.

225 students took part in Inverclyde Academy & Notre Dame prior to Christmas 2020.
400 students took part in St Columba's High School, Clydeview Academy, St Stephen's High School and Port Glasgow High School, St Columbas Kilmacolm and Cedars between April and June 2021.

Delivery of Bouncing Back also took place in all primary schools in the final term to all P7 classes. The focus for P7 was the transition to S1, which had again been affected by the pandemic in a reduction to the usual transition which primary pupils receive when moving to secondary school.

In total 102 sessions were delivered to: -

940 pupils

68 sessions were delivered to students in secondary school classes in 8 secondary school, including Cedars and St Columba's Kilmacolm (34 classes received both sessions)

34 sessions were delivered to all primary schools P7 classes.

As part of the Inverclyde Academy's Wellbeing Programme to welcome back BGE pupils, sessions were delivered to 230 pupils across S1 to S3, on the return to school in March.

Individual pupil support drop in sessions for Children & Young People arranged with project staff were also delivered in Inverclyde Academy and Notre Dame, to 20 students, in March.

Clydeview Academy, to 6 students, May – June
St Columbas Gourrock, to 6 students, May – June

Project staff also delivered Mental Health and Wellbeing input for staff via Zoom, in October,

as a pilot programme, with a view to offer further sessions to staff teams when conditions allowed in person contact to resume.

Project staff and counsellors have continued to offer support to Children & Young People who are engaging during the school summer holidays, with counsellors accessing school buildings to see Children & Young People, and project staff attending school hubs, affordable childcare groups, CLD activities and summer based activities to both network with staff and CYP, raising the profile of mental health and wellbeing and engaging with more Children & Young People in an informal setting to lay the groundwork for working across schools on the return after the summer holidays.

4.5 Single Point of Access – Centralised Referral System

From the outset of the project, discussions around establishing a Single Point of Access steering group took place, with the aim of involving the relevant services, led by HSCP senior management and including input from Educational Psychology, School Nurse team, Barnardos, CAMHS and Social Work in a group where referrals could be taken with relevant data sharing protocols in place, to discuss and determine the correct route and service which should be offered and available to any Children & Young People's referrals brought by group members to discuss. This group meets regularly, and continues to develop the model.

4.6 Key Performance Indicators

Example Key Performance Indicators	Example Year 1 Targets:	Year 1 Outcomes:
Reach KPIs: <ul style="list-style-type: none"> ▪ Number of appointments ▪ Number of group work sessions ▪ Number of 1:1 sessions ▪ Number of preventative sessions 	<ul style="list-style-type: none"> ▪ 1,415 pupils directly supported in Year 1 i.e.: ▪ 560 primary pupils - <i>Friends Resilience</i> groups ▪ 480 secondary pupils - <i>Blues Programme</i> groups ▪ 375 pupils - targeted 1:1 support/counselling ▪ Additional 400 pupils monthly - school drop ins 	<ul style="list-style-type: none"> ▪ 1890 directly supported i.e.: ▪ 940 Primary pupils accessing groups– Bouncing Back ▪ 855 Secondary pupils accessing groups – Bouncing Back ▪ 95 offered 1:1 support/counselling ▪ 34 - school drop ins
Outcome KPIs: <ul style="list-style-type: none"> ▪ Improved CYP wellbeing, mental health and resilience ▪ Reduced Tier 3/CAMHS referrals 	<ul style="list-style-type: none"> ▪ 75% of pupils improving against selected <i>SHANARRI Wellbeing Outcomes</i> ▪ % of pupils addressing their needs without the requirement for specialist services (<i>to be agreed</i>) 	<ul style="list-style-type: none"> ▪ 89% of CYP completing agreed counselling sessions reported improved outcomes using a Young persons Clinical outcome e.g. Young Persons CORE
Quality KPIs: <ul style="list-style-type: none"> ▪ Accessible service/the right help at the right time ▪ Structured support and goal-setting ▪ Providing relationship-based interventions ▪ Informing CYP/families 	<ul style="list-style-type: none"> ▪ 75% of pupils providing positive feedback on their experience of the service - including: <ul style="list-style-type: none"> ○ Service accessibility ○ Relationship-based support ○ Quality of interventions 	<ul style="list-style-type: none"> ▪ 86% of P7 pupils gave a 4 or 5 star rating for Bouncing Back sessions, from a scale of 1 to 5 ▪ 83 % of secondary pupils (S3) gave a 4 or 5 star rating for Bouncing Back sessions, from a scale of 1 to 5

of available support		
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4.7 Next Steps – Year 2

Further relaxation of guidance around Covid safety measures within schools and establishments on the return in August 2021 will provide the service with increased opportunity to reach more Children & Young People, and begin to co-ordinate and deliver more targeted interventions i.e. The Blues Programme and increasing the number of Children & Young People who can access counselling.

School drop-in sessions, workshops, for staff and parents, will be revisited and discussed with schools to best meet their individual needs, when the opportunity to hold in person group work sessions returns. We continue to remain open to using online tools to allow wider access to Children & Young People, parents and staff, while looking forward to making further positive impact on emotional health and wellbeing, and building on the positive relationships established with schools, partners and Children & Young People in our first year.

Establishing a new emotional health and wellbeing service in the midst of a global pandemic has been a challenge, but the relationships built in the first year are an indication of the willingness of schools and partner agencies to create a positive culture going forward, where as a service we feel able to contribute and develop to become a core aspect of support to Children & Young People across Inverclyde.

We look forward to increasing our reach and engaging with more Children & Young People in year 2.

5.0 PROPOSALS

5.1 N/A

6.0 IMPLICATIONS

Finance

6.1 Financial Implications:

In year 1 the funding allocated was £290,972, with a spend of £216,026 projected to the end of August 2021. A projected underspend of £79,011 has been returned in March 2021, with the actual figure now projecting at £74,946 due to costs accrued between March and August 21. The variance in the projected underspend submitted as of March 21 to the actual underspend figure in August 21 will be included in the monthly bill for September 21.

The commissioners are considering the use of the returned underspend, with discussion around its potential to expand the counselling capacity available within the project by further recruitment of counsellors an option.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
N/A			£20,000		

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A					

Legal

6.2 N/A

Human Resources

6.3 N/A

Equalities

6.4 Equalities

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

	YES
✓	NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required

(b) Fairer Scotland Duty

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

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

	YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
✓	NO

(c) Data Protection

Has a Data Protection Impact Assessment been carried out?

	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.
✓	NO

Repopulation

6.5 N/A

7.0 CONSULTATIONS

7.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 N/A

Report to: Inverclyde Health & Social Care Committee **Date:** 21 October 2021

Report By: Allen Stevenson
Interim Corporate Director (Chief Officer)
Inverclyde Health and Social Care Partnership **Report No:** SW/32/2021/AB

Contact Officer: Alan Best
Head of Health and Community Care
Inverclyde Health and Social Care Partnership (HSCP) **Contact No:** 01475 715212

Subject: CHIEF OFFICER'S REPORT

1.0 PURPOSE

- 1.1 The purpose of this report is to update the Health and Social Care Committee on service developments which are not subject to the Health & Social Care agenda of 21 October 2021 but will be future papers on the Health & Social Care agenda.

2.0 SUMMARY

- 2.1 The report details updates on work underway across the Health and Social Care Partnership in relation to:
- Dementia Care Co-ordination Program Update
 - District Nursing Workforce
 - Learning Disability Resource Hub Development
 - Unscheduled Care Commissioning Plan Update
 - Covid & Seasonal Vaccination Update

3.0 RECOMMENDATIONS

- 3.1 The Health and Social Care Committee is asked to note the HSCP service updates and that future papers will be brought to the Committee as substantive agenda items.

Allen Stevenson
Interim Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 There are a number of issues or business items that the Committee will want to be aware of and updated on. Committee members can request more detailed reports are developed in relation to any of the topics covered.

5.0 BUSINESS ITEMS

5.1 Dementia Care Co-ordination

As part of Scotland's third National dementia strategy, Inverclyde HSCP was selected as the Dementia Care Co-ordination Programme implementation site. The Programme is supporting improvements and redesign of community based services to improve care co-ordination for people living with dementia from diagnosis to end of life.

Priority areas for improvement include care co-ordination for people newly diagnosed with dementia, ensuring a responsive and sustainable Post Diagnostic Support Service; care co-ordination for people living with moderate dementia. This will be aligned to the 8 Pillars Model of Community Support and 12 Critical Success Factors for effective care co-ordination, and care co-ordination for people living with advanced dementia at a palliative and/or end of life.

In addition, the following actions will be implemented:

- Creating a sustainable approach to dementia workforce development
- Clarification of roles and responsibilities and service pathways
- Development and testing of a self-management leaflet and app
- Local implementation of the Dementia and Housing Framework
- Enhancement of the Allied Health Professional contribution to an integrated and co-ordinated approach
- Improvement in the completion and consistency of Anticipatory Care Planning for individuals with dementia and
- Re-establishment of Dementia Friendly and Enabled community work.

5.2 District Nursing Workforce

Development is ongoing in relation to the Scottish Government investment to District Nursing aligned to Health and Social Care Workforce Plan recommendations published in December 2019.

Future reports will provide an overview of the outline plan across NHS Greater Glasgow and Clyde (GGC), including planning intentions for Inverclyde HSCP.

In late 2020, the Scottish Government wrote to Boards with regard to the allocation of funding for November 2020 - April 2021, and recurring funding until 2024/25. The Board allocation across NHS GG&C is £10,081,786 equating to 47.8 skill mixed posts, Inverclyde's allocation is £705,470 equating to 4.5 skill mixed posts realised at end point 2024/25.

A future paper will be presented to the Committee as this investment in the District Nursing workforce develops.

5.3 Learning Disability Resource Hub

The Programme Board for the Development of New Learning Disability Hub continues to meet where programme timeline, risk register and budget managed by Property Services are reviewed.

The project Design Team continue to develop the design proposals with supplementary site surveys currently being progressed to provide more detail on the shallow rock substrate across the site to inform the design for drainage. As part of the preparation of the Architectural Stage 2 report, an energy model of the proposed building has been developed including a design based on current building standards and options for consideration (subject to funding / budget constraints) that align with the impending zero carbon building standards. Formal cost planning and estimates will be prepared at the relevant Architectural stages to address a comparison of the available budget against the developing design. Consultation with service users, families, carers and learning disability staff continues supported by the HSCP Hub development team and Advisory Group.

The programme for the project estimates completion by the end of 2023 with projected construction commencement subject to the continued progression of the design stages and formal tender process.

5.4 Unscheduled Care Commissioning Plan update

Previously the Committee received a report on the Board-wide draft Unscheduled Care Plan, which was subsequently agreed by the other five HSCPs in GG&C. Since then unscheduled care services have changed in response to the Coronavirus pandemic, including a national redesign of urgent care.

A programme of engagement has also taken place, and further work undertaken on the financial and performance frameworks to support delivery of the strategy.

This report presents the updated unscheduled care programme in the form of the draft Design and Delivery Plan for the period 2021/22 to 2023/24. Similar reports are being considered by the other five HSCPs in GG&C and the Health Board.

The refreshed Board-wide unscheduled care improvement Programme will include ;

- A financial framework specifically highlighting that the funding shortfall identified will require to be addressed to support full implementation of phase 1;
- The performance management arrangements to report on and monitor progress towards delivery of the Plan, including the KPIs and projections for emergency admissions for 2022/23.
- the governance arrangements outlined to ensure appropriate oversight of delivery
- the ongoing engagement work with clinicians, staff and key stakeholders;
- Update on the delivery of the programme towards the end of 2021/22, including the financial framework.
- The Plan will be reported to all six IJBs and the Health Board Finance, Audit and Performance Committee during the next meeting cycle.

5.5 Covid and seasonal flu vaccination

As of 3rd October 93% of over 16s had received their first vaccination and 86% had received their second compared to 91.4% and 85% respectively for Scotland as a whole. For 16 and 17 year olds 74.2% had received a first vaccination and 8.9% a second compared to 71.9% and 10.8% for Scotland. Vaccinations for 12-15 year olds are now available via appointment with 16.1% having received a first dose compared to 20.4% for Scotland. These will continue to be available via the local vaccination centres.

Covid 3rd dose booster and seasonal flu vaccination are also now available via the local vaccination centres. The HSCP commenced delivery of these within adult and older people care homes for both staff and residents and these will be completed by 8th October. Vaccinations for housebound residents have also commenced with an expectation that all flu vaccinations will be completed early in December. Covid booster will continue after this time due to the 6 month timing between 2nd & 3rd doses.

6.0 IMPLICATIONS

FINANCE

6.1 Financial Implications:

One off Costs

It is proposed that the development be funded by Prudential Borrowing. A £360,000 allowance was factored into the December, 2019 Financial Strategy.

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

6.2 N/A

HUMAN RESOURCES

6.3 There are no human resources issues within this report.

EQUALITIES

6.4 There are no equality issues within this report.

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

	YES (see attached appendix)
√	NO – An Equality Impact Assessment will be undertaken with service users, carers and other stakeholders as full details of the future redesign emerges.

(b) Fairer Scotland Duty

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

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

	YES – A written statement showing how this report’s recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
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x	NO
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(c) Data Protection

Has a Data Protection Impact Assessment been carried out?

	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.
x	NO

7.0 CONSULTATION

7.1 None

8.0 LIST OF BACKGROUND PAPERS

8.1 None.



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-refreshing this plan is to ensure that the programme remains relevant and tackles the challenges that face us now.

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

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

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

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

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

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

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

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1. PURPOSE

1.1 The purpose of this 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%.

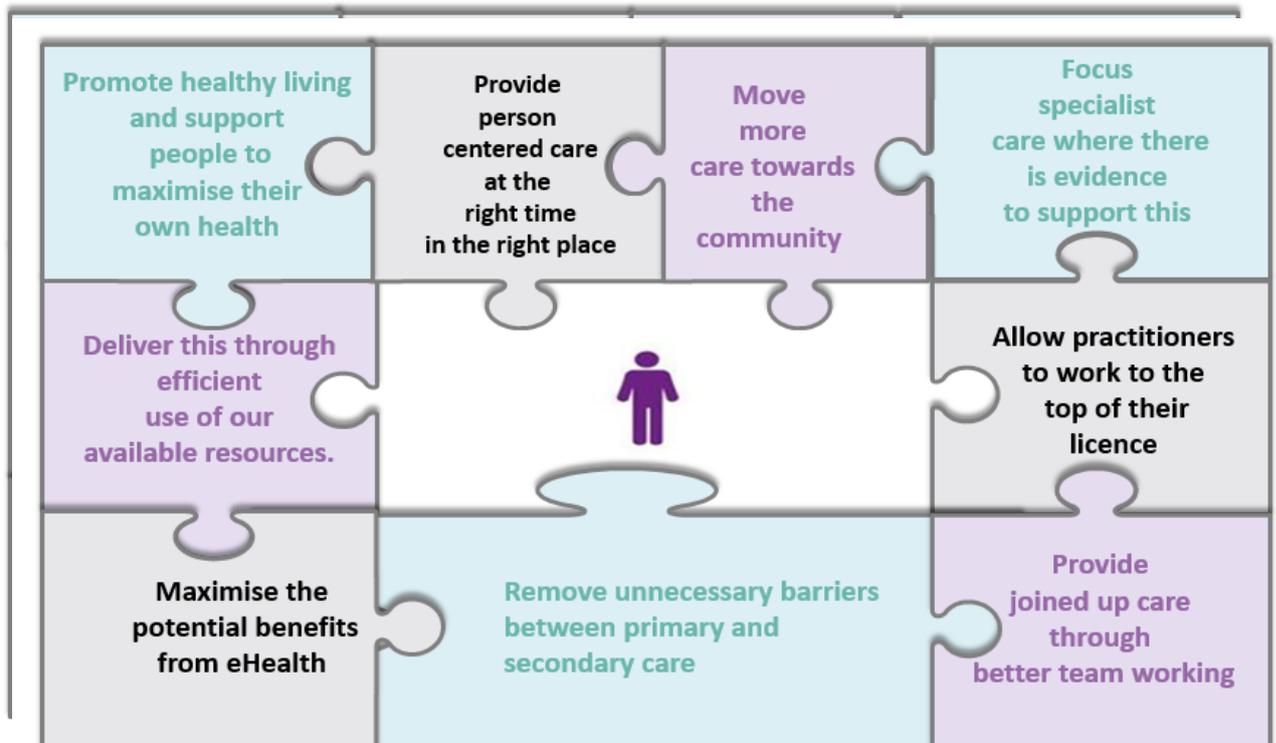
2.3 The COVID-19 pandemic has brought a series of new challenges, some of which will be explored further in this plan. And because of this it is difficult to make activity and performance comparisons with previous years. At the time of writing NHSGGC was at Level 2 escalation for performance in recognition 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.

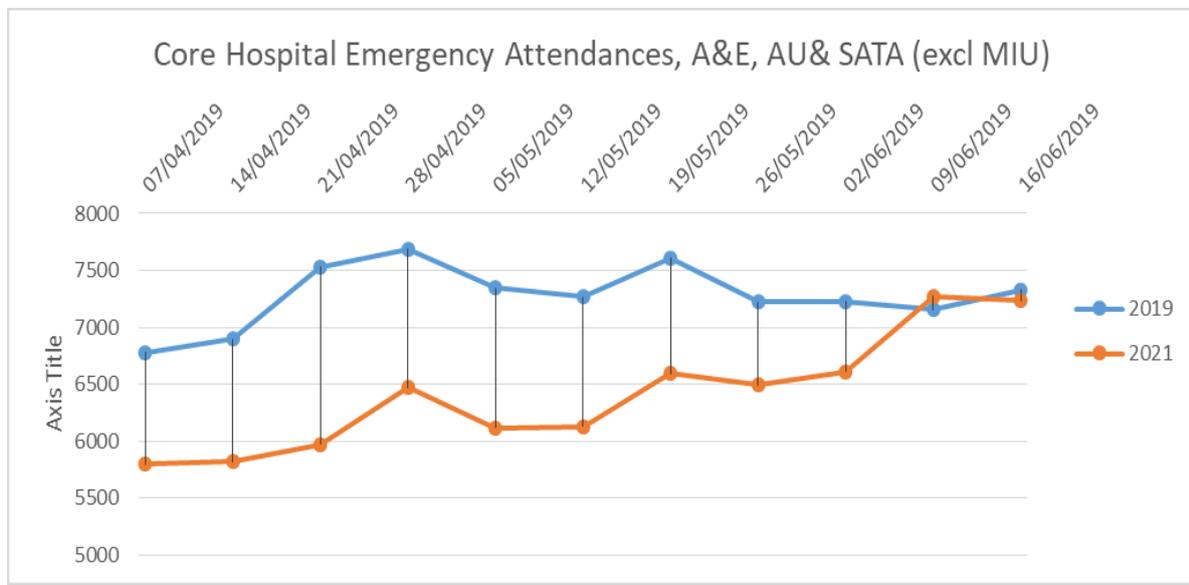
4.4 The demand profile for unscheduled care has however changed over recent months, and the Board is now experiencing a step change in demand in line with the success of the vaccination programme and easing of restrictions. At the time

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 Emergence Attendances Chart



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

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

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

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

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

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

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

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

5 DESIGN AND DELIVERY PLAN

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

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

Phase 1 – 2020/21

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

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

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

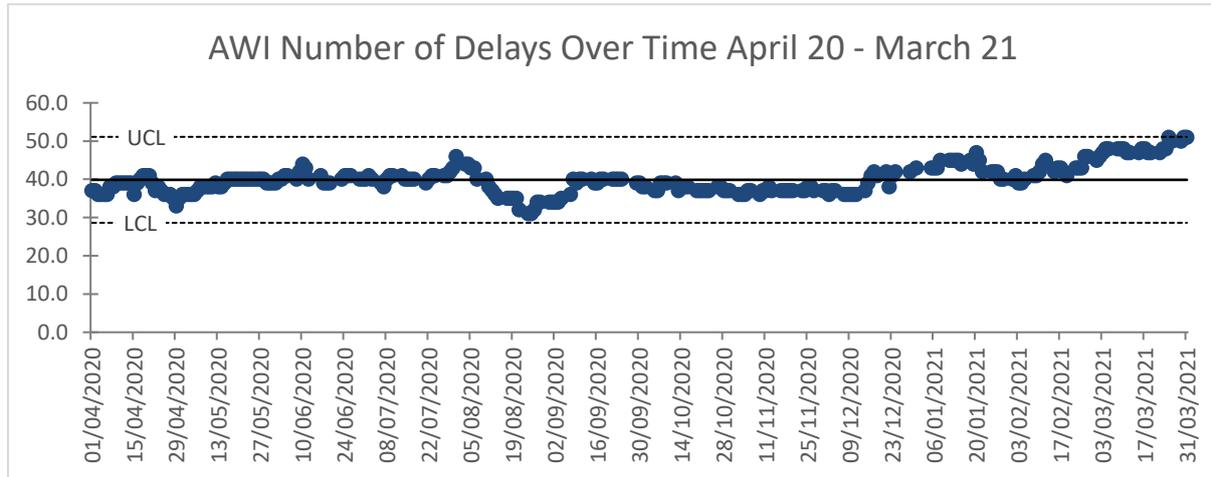
- 5.5 In the first six months of operation the FNC has completed virtual consultations for 7,000 patients with 32% of those being seen, treated and discharged without the need for further assessment.
- 5.6 **Signposting and Redirection Policy** - our signposting and redirection policy for Emergency Departments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

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

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

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

Figure 3 – AWI delays 2020/21 Glasgow City HSCP



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

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

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

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

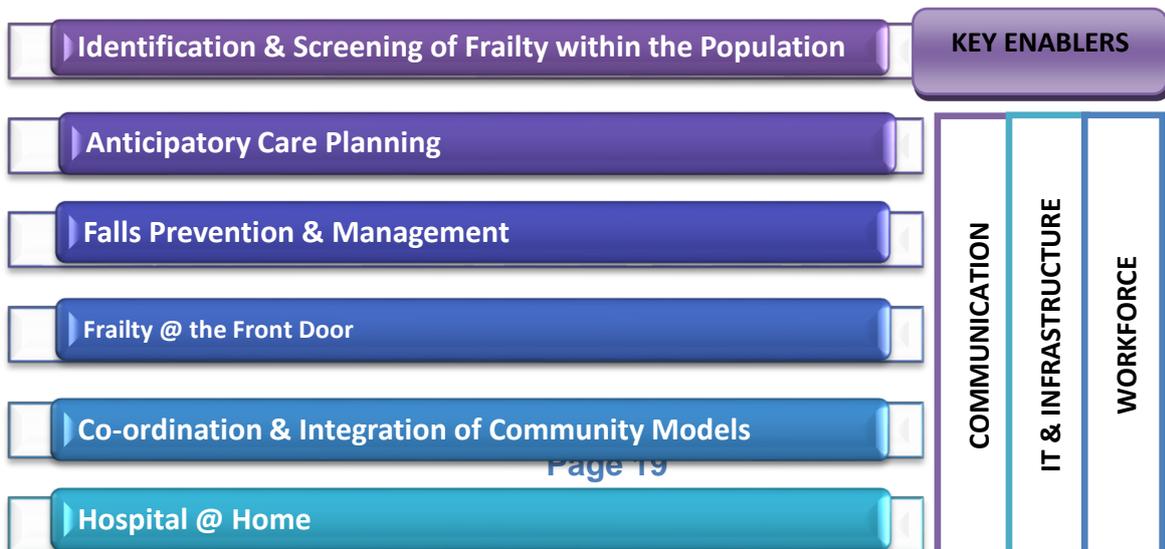
Patient Flow & Flow Navigation Centre Processes	Optimising Discharge and Reducing Delays	Prof to Prof	MSK	Falls & Frailty
<ul style="list-style-type: none"> • ED Processes • 4 hour standard • Demand Prediction & Capacity Mgmt • FNC Process Optimisation (workflow) 	<ul style="list-style-type: none"> • ‘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 • <i>Hospital at Home - Glasgow City Test of Change</i>

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.

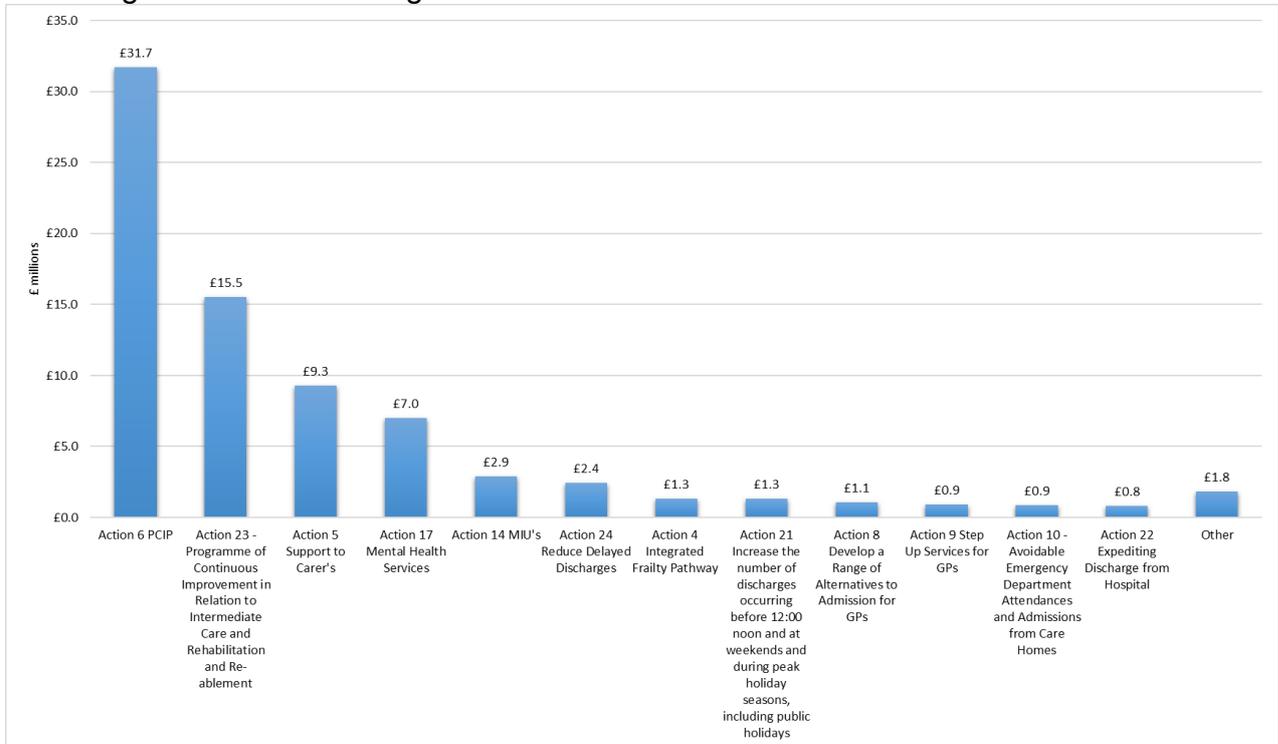
6.7 A key take away message from the engagement with GPs was that the unscheduled care programme needed to specifically recognise and include the contribution of PCIP to this agenda. The PCIP and unscheduled care programme direction of travel are closely aligned and are essentially about patients being 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 NHSGGC with many moving parts estimating and forecasting the impact of specific interventions is never an exact science. As we have seen in 2020 there are many factors that can influence the impact of any given intervention – many of which are not in our direct control e.g. changes in the economy. Forecasting or estimating the potential impact of such a wide ranging programme as described in this plan on Scotland’s largest health

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

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

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

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

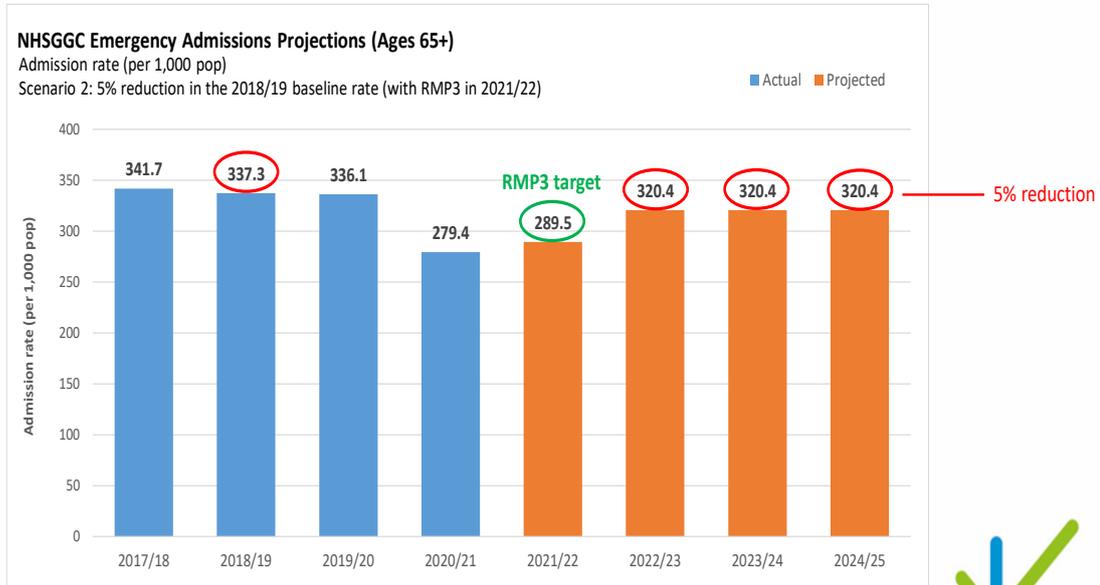
- a do nothing scenario with no implementation of the programme showing the impact demographic changes might have on current rates;
- a partial implementation of the programme taking into account that significant parts of the programme are funded non-recurrently; and,
- full implementation showing what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

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

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

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:

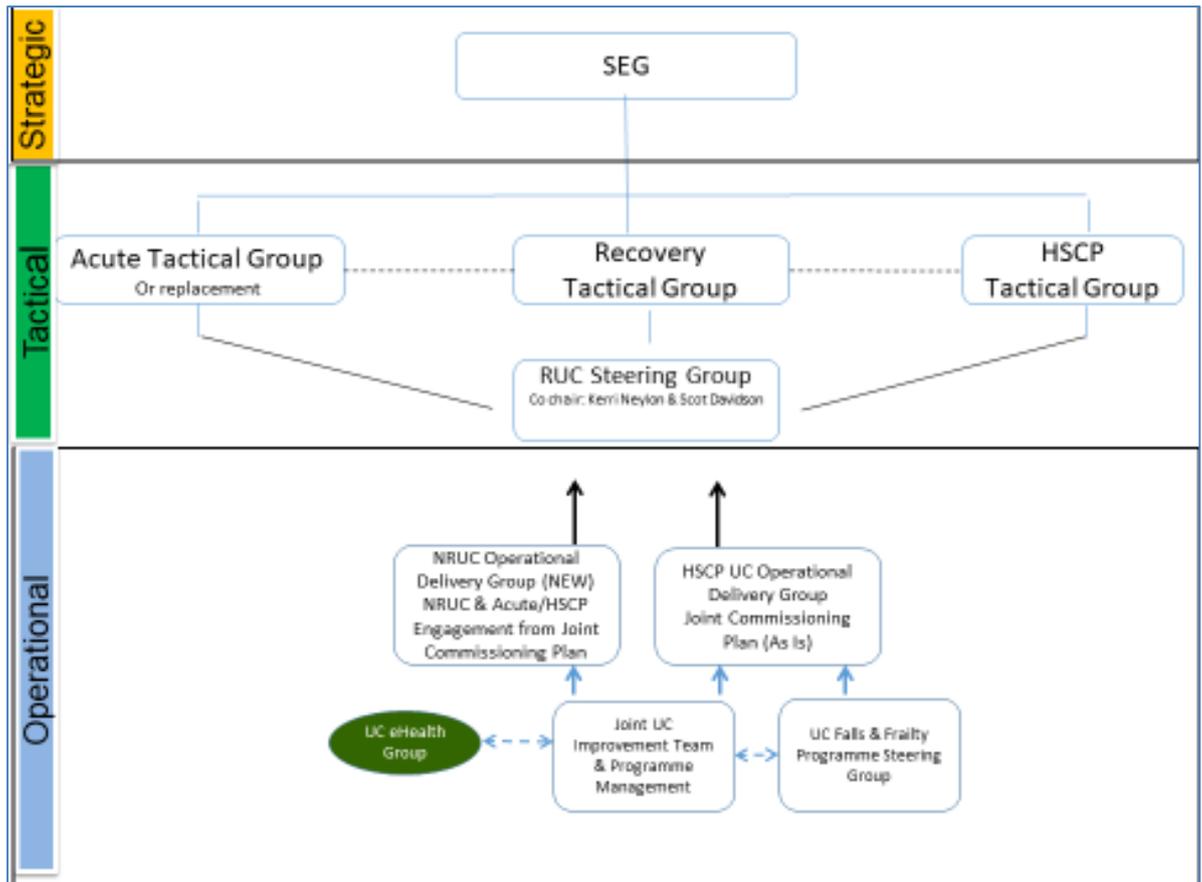
- facilitate strategic direction and operational leadership of UC;
- provide accountability for developing strategy and design via the Steering Group;
- demonstrate responsibility for implementation via Delivery Groups;
- embed the Programme Management approach to provide assurance that the programme 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.



NHS GREATER GLASGOW & CLYDE

**UNSCHEDULED CARE
JOINT COMMISSIONING PLAN**

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

ANNEXES

August 2021

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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 NMSGC 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-19 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-19 and non COVID-19 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.

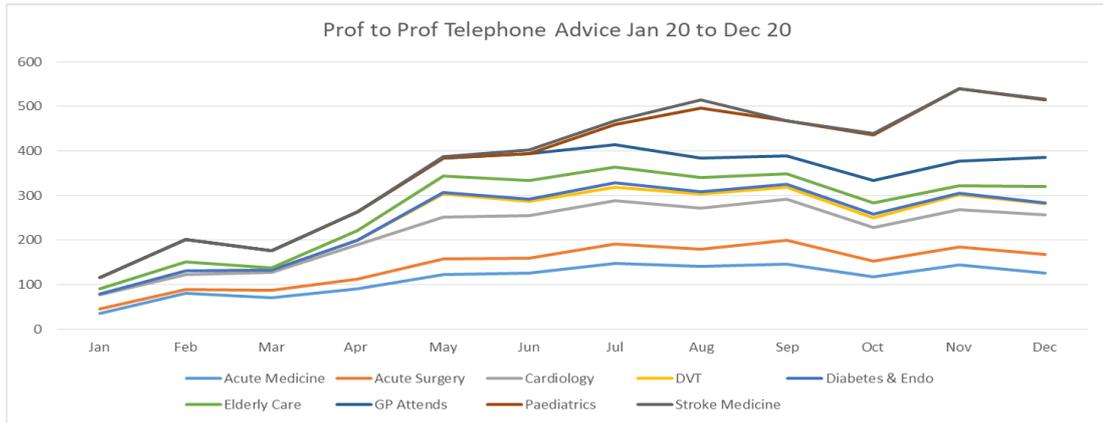
Key to successful implementation is Person Centred Care and Multi-Disciplinary Team working. The aim of all members of the MDT should be to commence planning for discharge as early as possible within the patient journey. Individual's, their family/carers will be central to decision making and engaged 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

Call to Gastroenterologist avoids admission

Dr Ali has used Phone Advice & Guidance on multiple occasions which has resulted in "possible acute admissions [being] averted". In one instance, a patient presented "with obvious inflammatory bowel disease". It was not clear what the best course of action was, and Dr Ali was unsure whether to start the patient on steroids.

How Phone A&G helped:

Dr Ali was able to use immediate Phone Advice & Guidance (via Consultant Connect) to speak to a gastroenterologist from his local hospital. The gastroenterologist provided advice and recommended commencing the patient on steroids in addition to an urgent outpatient clinic referral. This avoided an acute admission – a much better result for the patient. Both the patient and Dr Ali were satisfied by the use of Phone Advice & Guidance.



It has also had positive results for his patients. Many of them have been able to:

“ Stay at home or [have been] seen in a clinic soon after. ”

When asked what advice he would give to other GPs who are unsure about using the service, Dr Ali said:

“ Definitely use it. We need to embrace technology! ”

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

GP gets advice for elderly patient with complicated condition

An 88-year-old patient was "found to be profoundly hyponatraemic (causing bradycardia and dizziness)." He had "recently undergone tests to investigate retinal artery occlusion." Urea and Electrolyte results came back late from the lab. Using Consultant Connect's Phone Advice & Guidance service, Dr Mullin was able to immediately contact a consultant at Queen Elizabeth University Hospital to discuss the follow up options.

How Phone Advice & Guidance helped:

The patient was "seen at the Department for Medicine for the Elderly the following day where appropriate investigations were performed, and his medication was reviewed." Dr Mullin says that "this avoided a late evening admission as [she] could discuss the patient's current functional status with the consultant planning the follow up (which was very prompt)." As a result of using Phone Advice & Guidance, an "unnecessary admission" was avoided.



“ The service is an excellent resource for complex patients with concerning symptoms or findings that do not merit a same day admission but should prompt urgent specialist review during daytime/office hours. ”

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 carers 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.

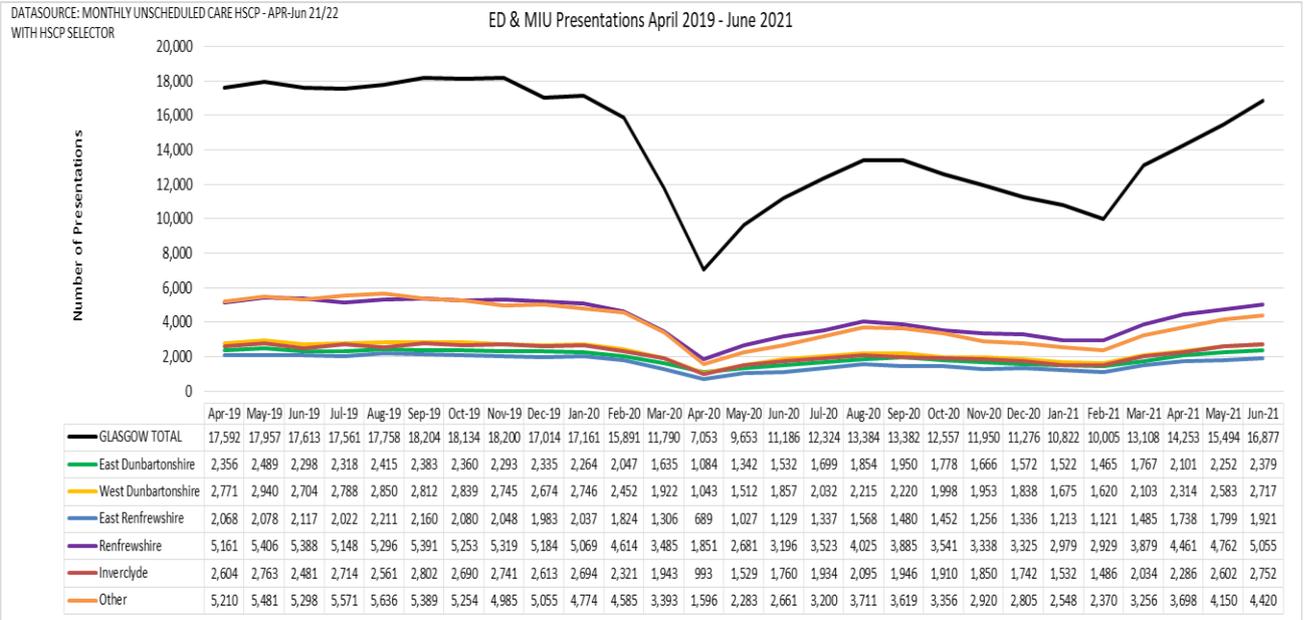
Other professional groups to be considered in a future phase (timescales to be determined) includes SAS, Police Scotland, Third and Voluntary Sectors.

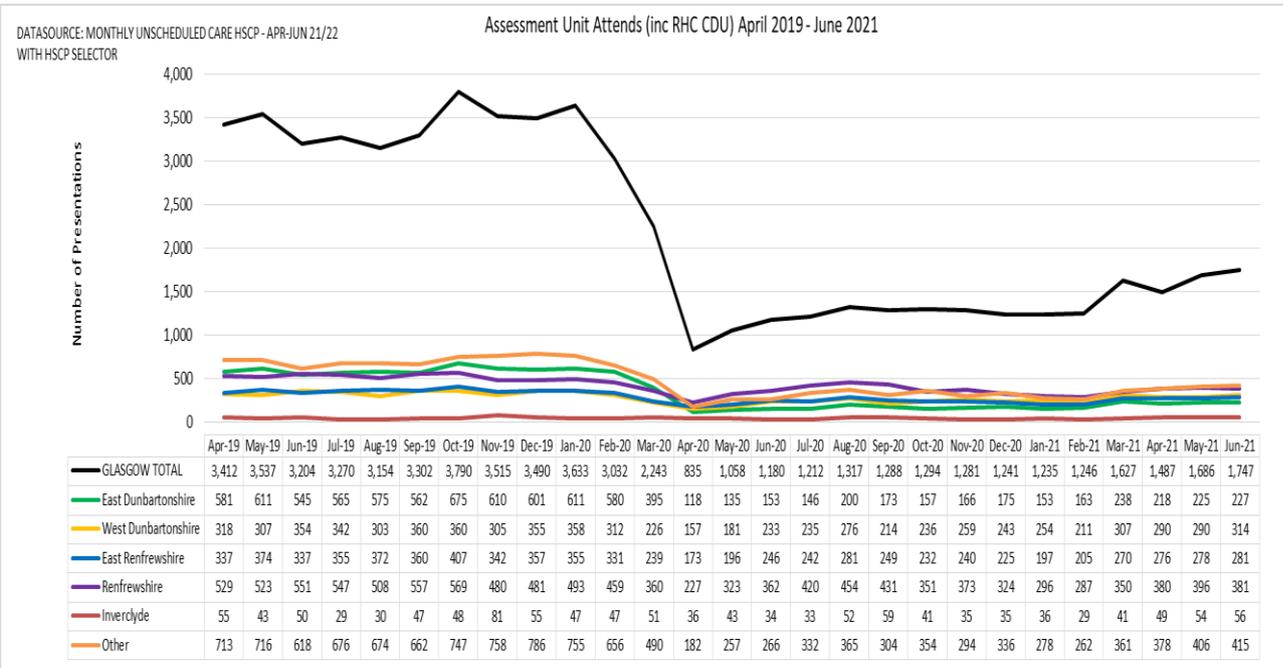
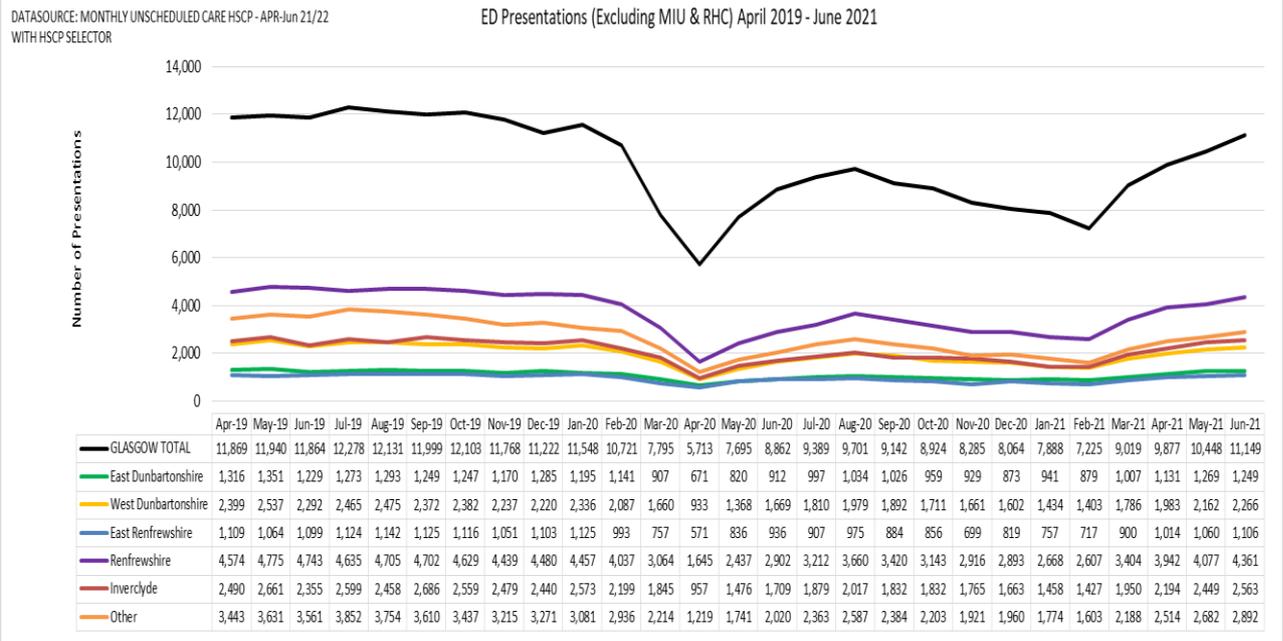
ANNEX B

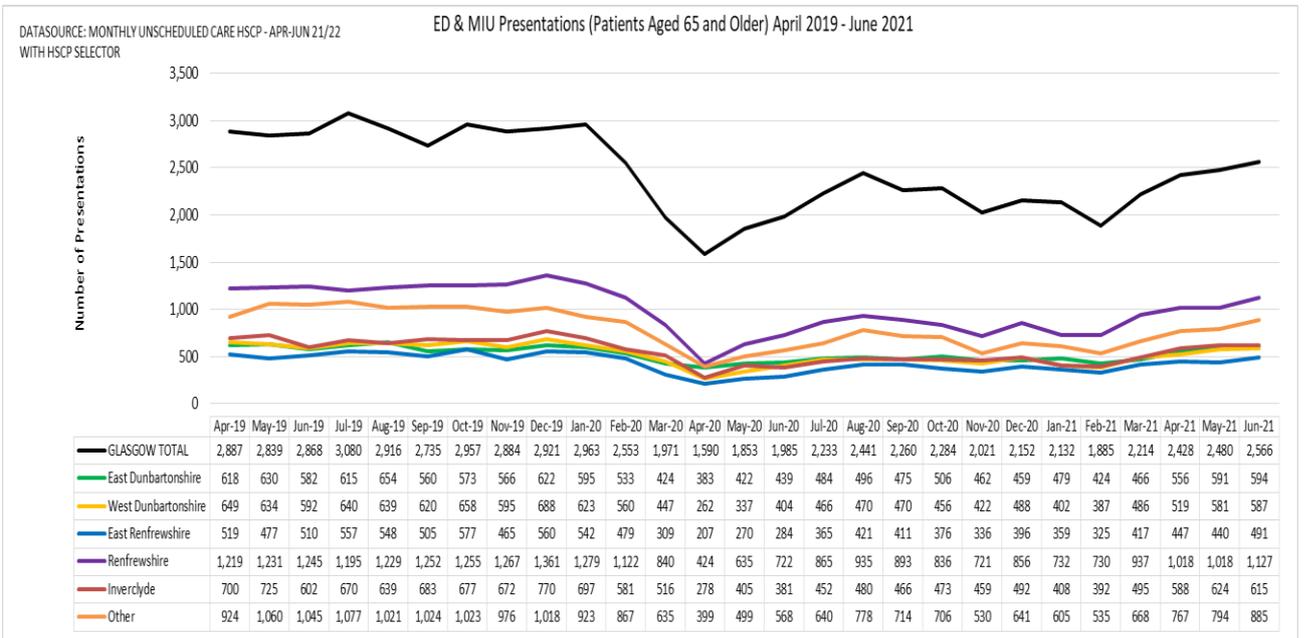
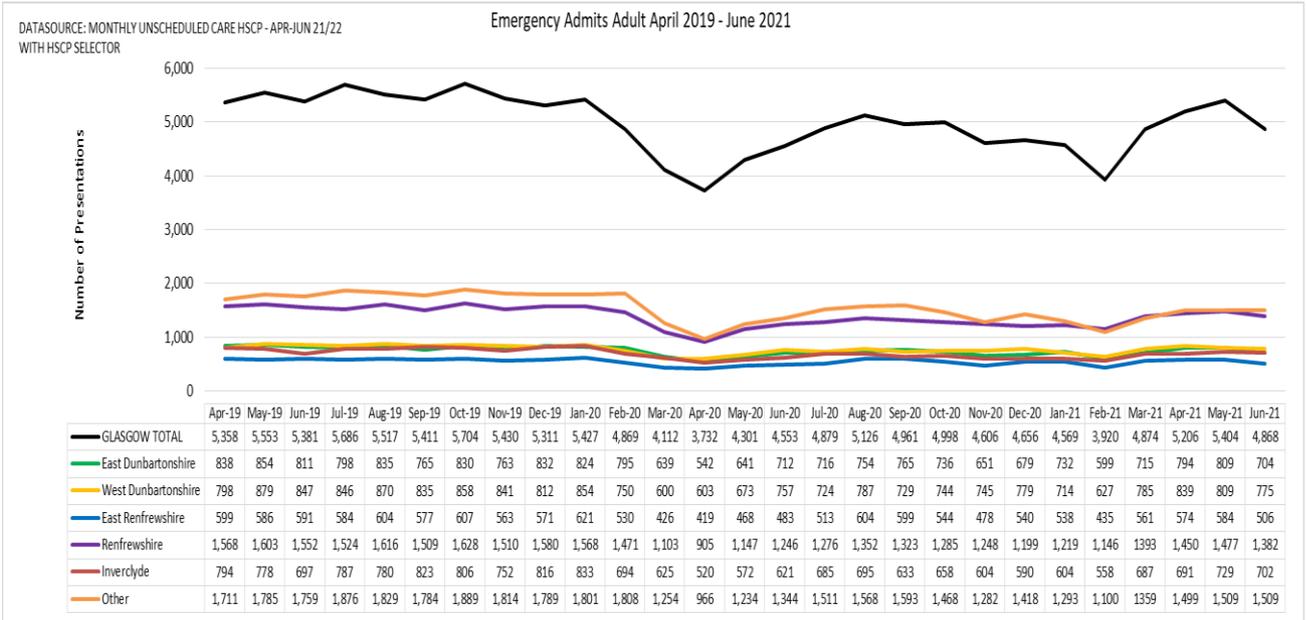
Rear View Mirror Slides

Unscheduled Care activity

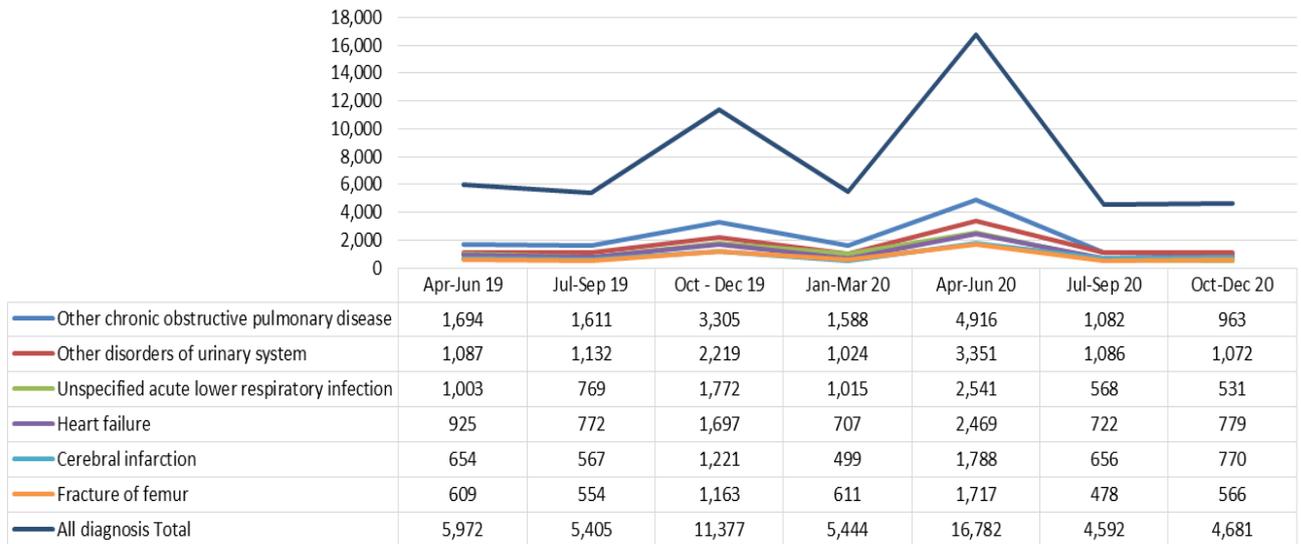
2019-2021
by HSCP and GG&C



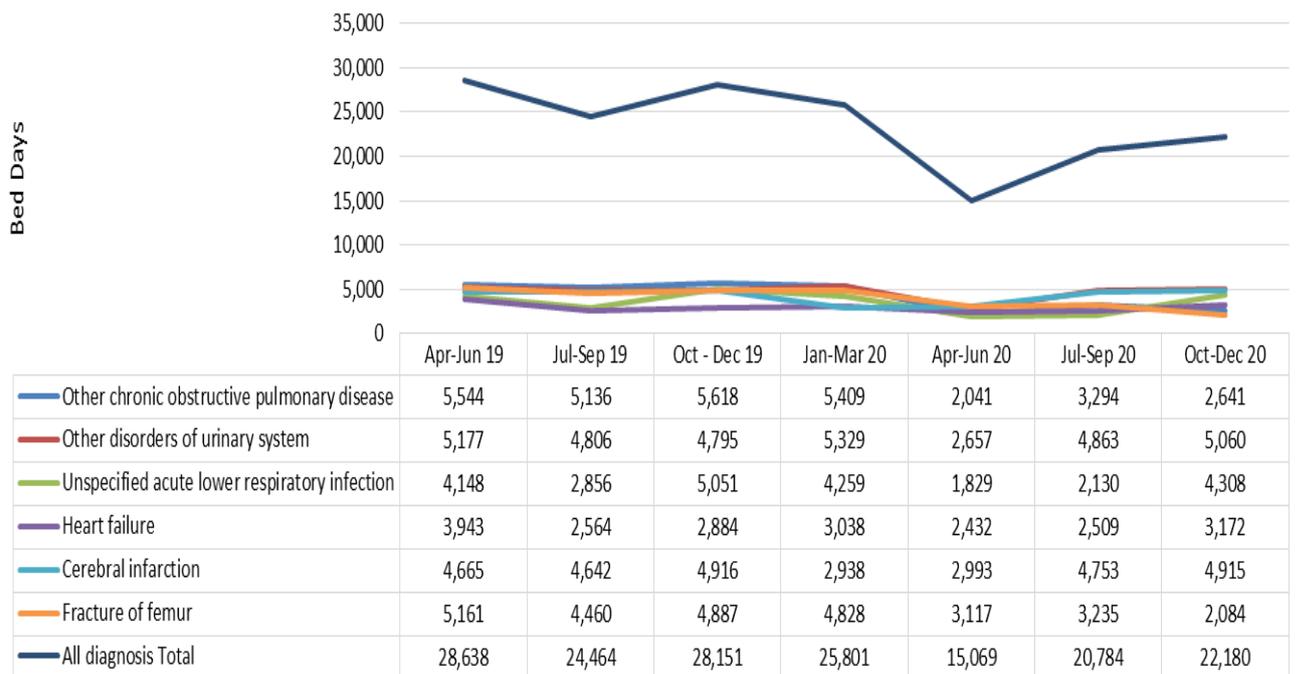




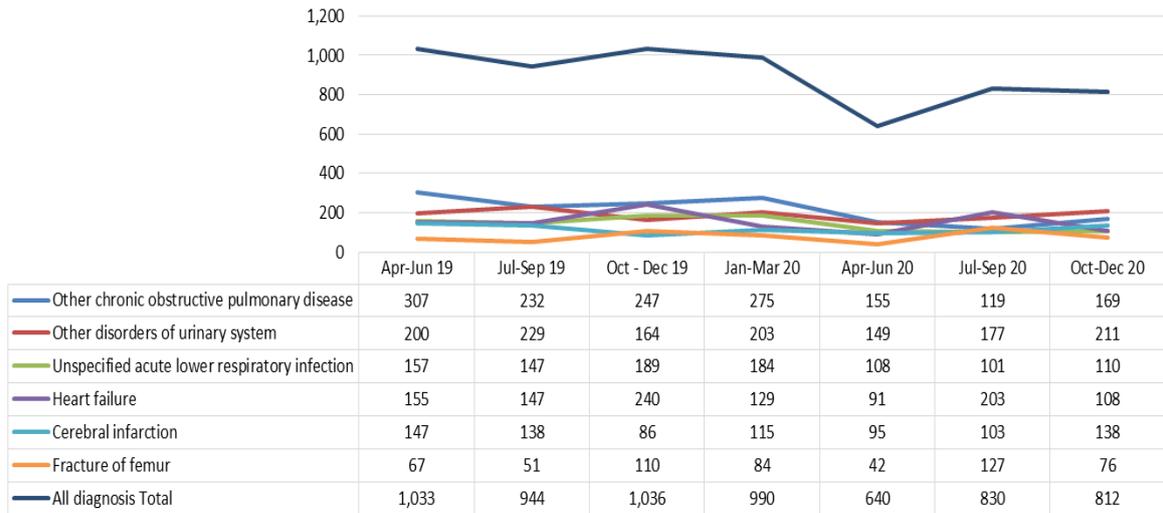
Glasgow City top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



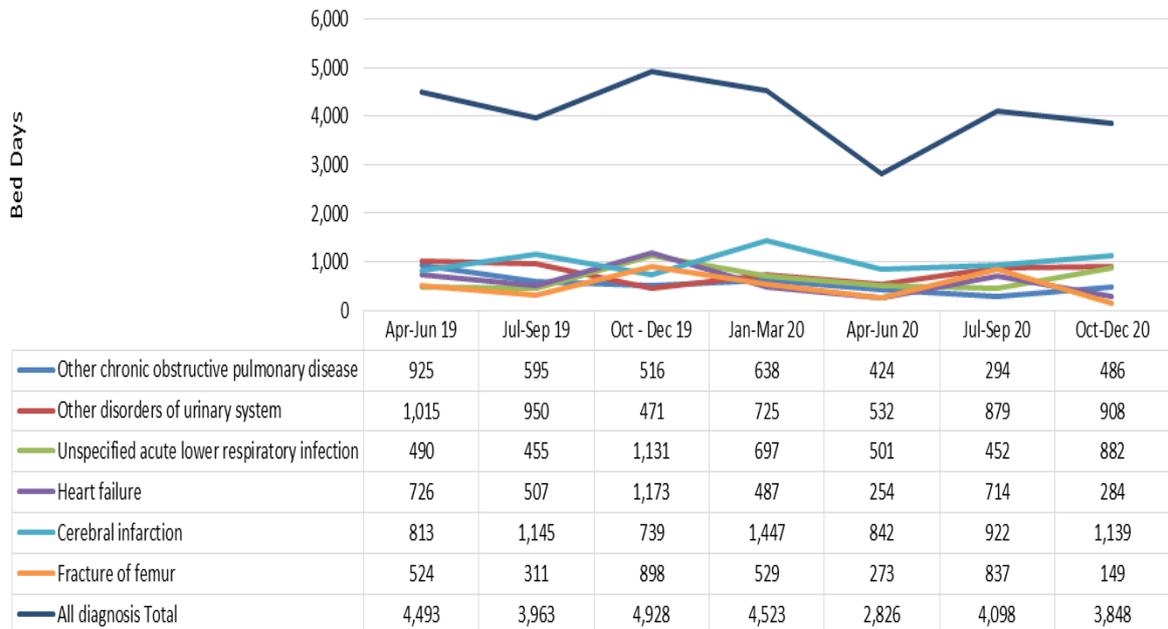
Glasgow City top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



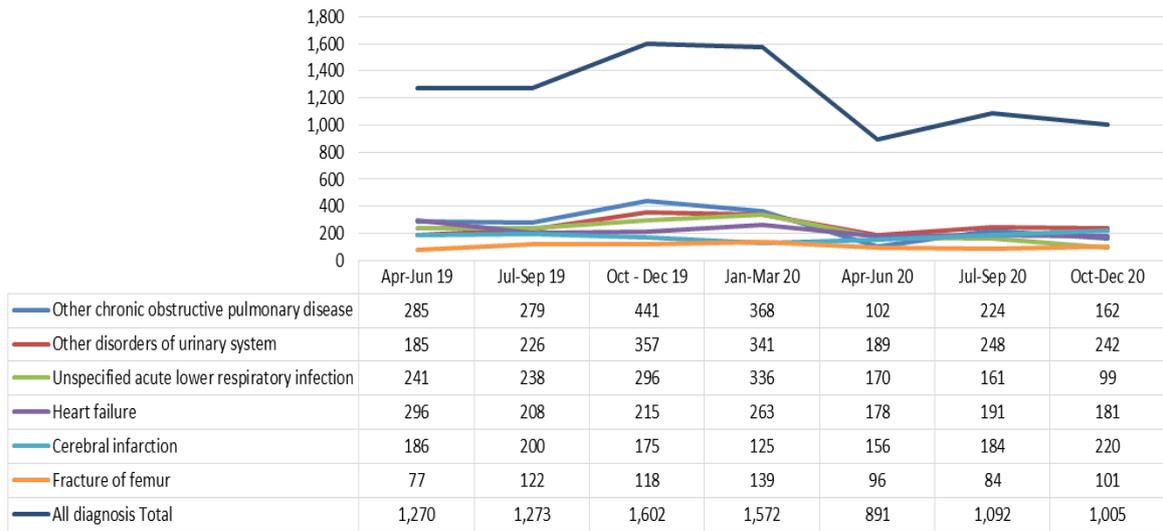
West Dunbartonshire top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



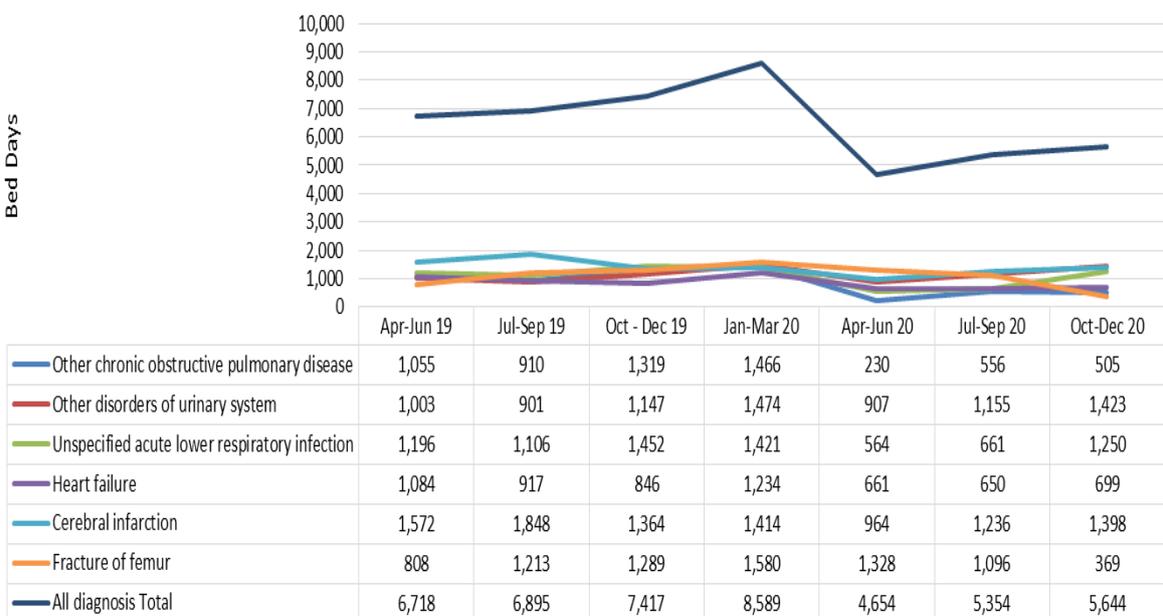
West Dunbartonshire top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



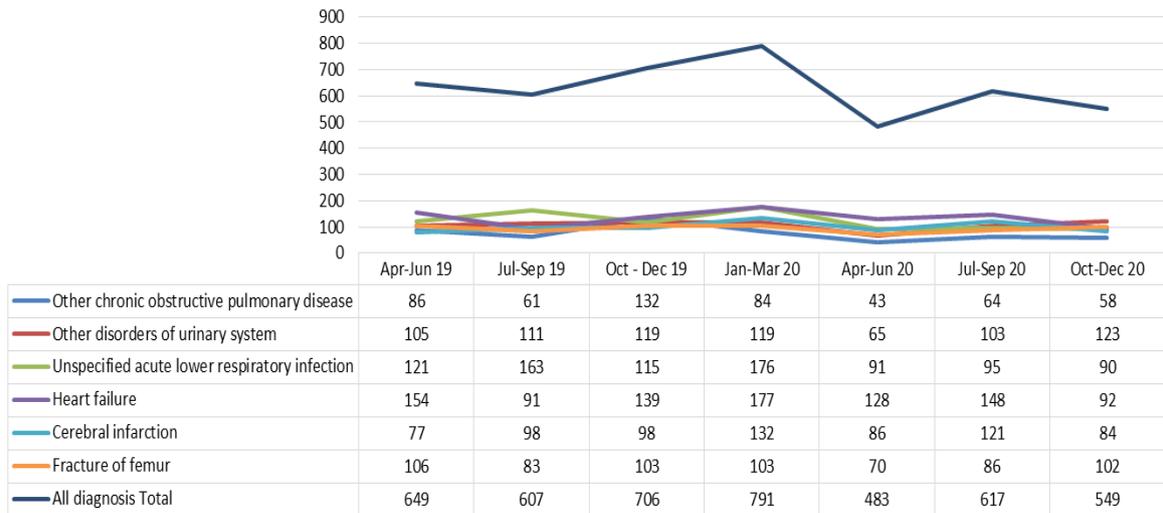
Renfrewshire top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



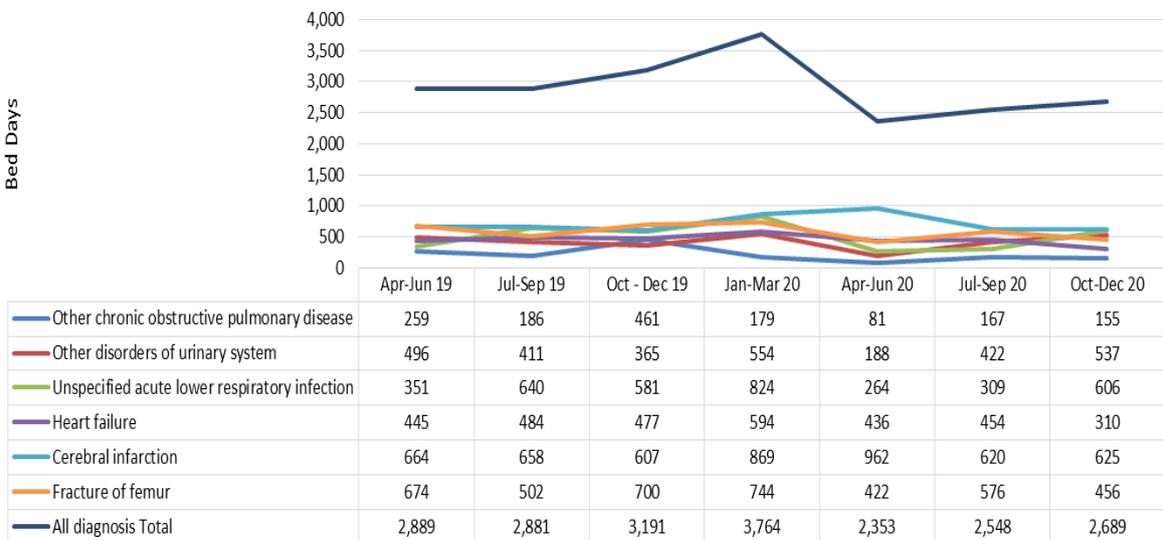
Renfrewshire top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20



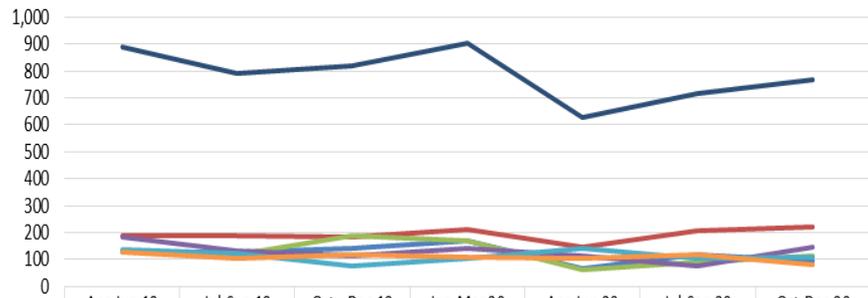
East Renfrewshire top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



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

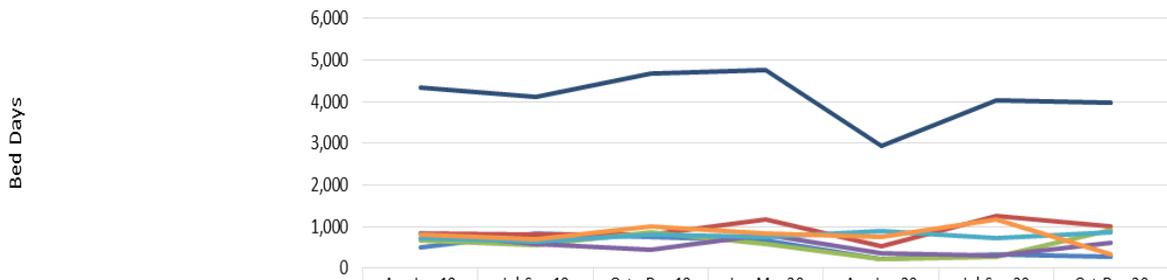


East Dunbartonshire top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



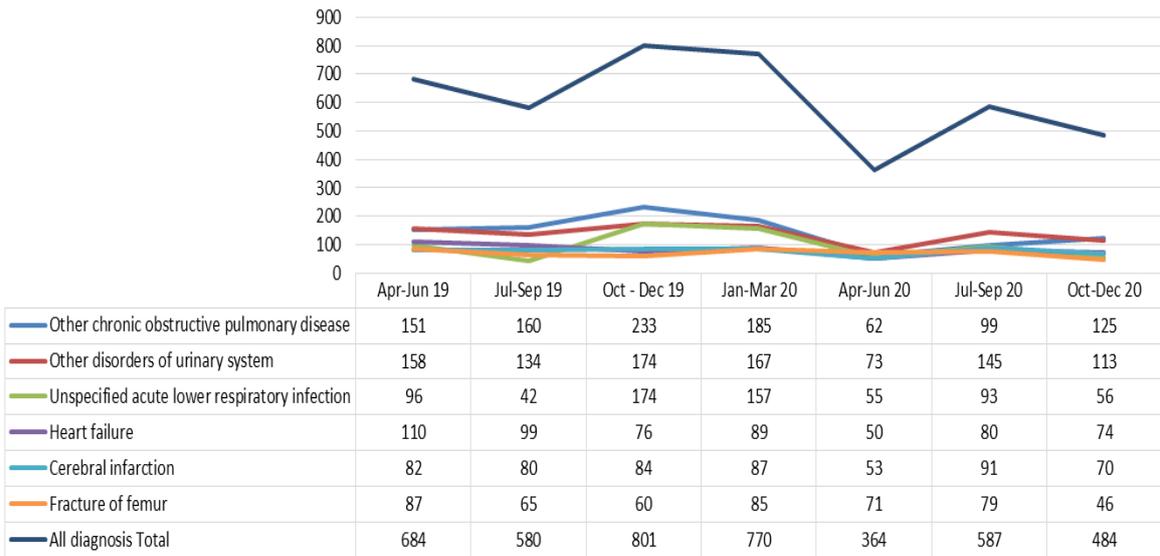
	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	129	127	143	170	68	120	96
Other disorders of urinary system	187	186	181	210	147	205	220
Unspecified acute lower respiratory infection	130	118	186	169	60	88	114
Heart failure	182	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

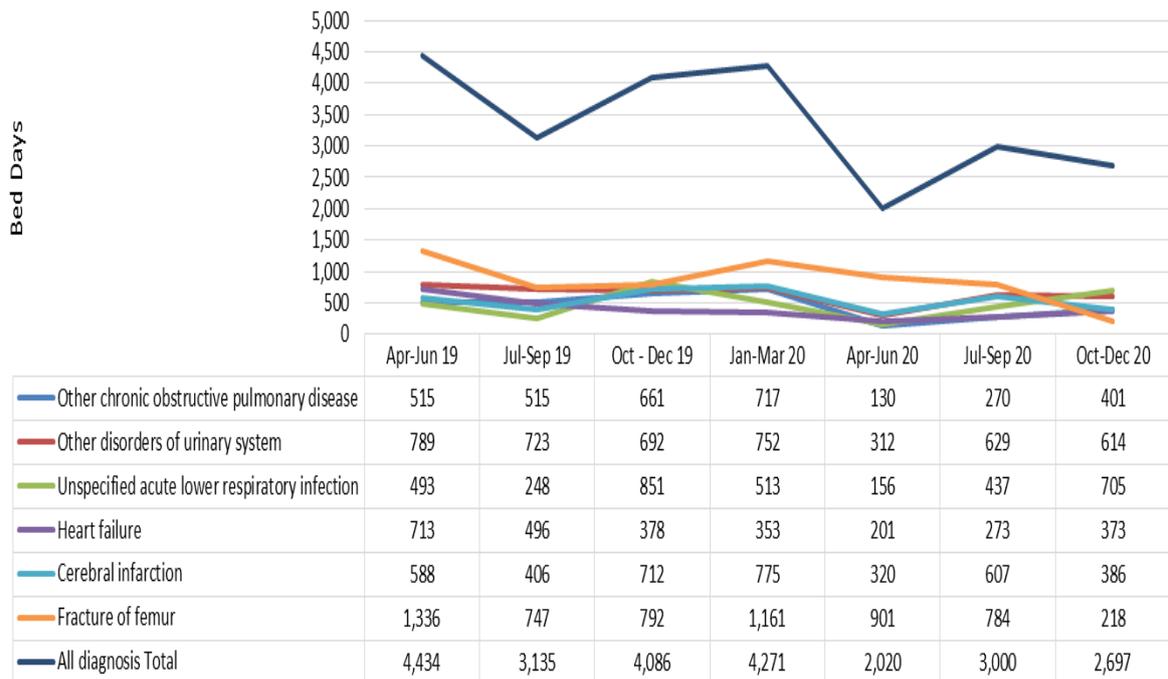


	Apr-Jun 19	Jul-Sep 19	Oct - Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20
Other chronic obstructive pulmonary disease	494	842	752	661	205	338	273
Other disorders of urinary system	843	806	797	1,170	514	1,242	1,008
Unspecified acute lower respiratory infection	655	564	855	571	206	283	910
Heart failure	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

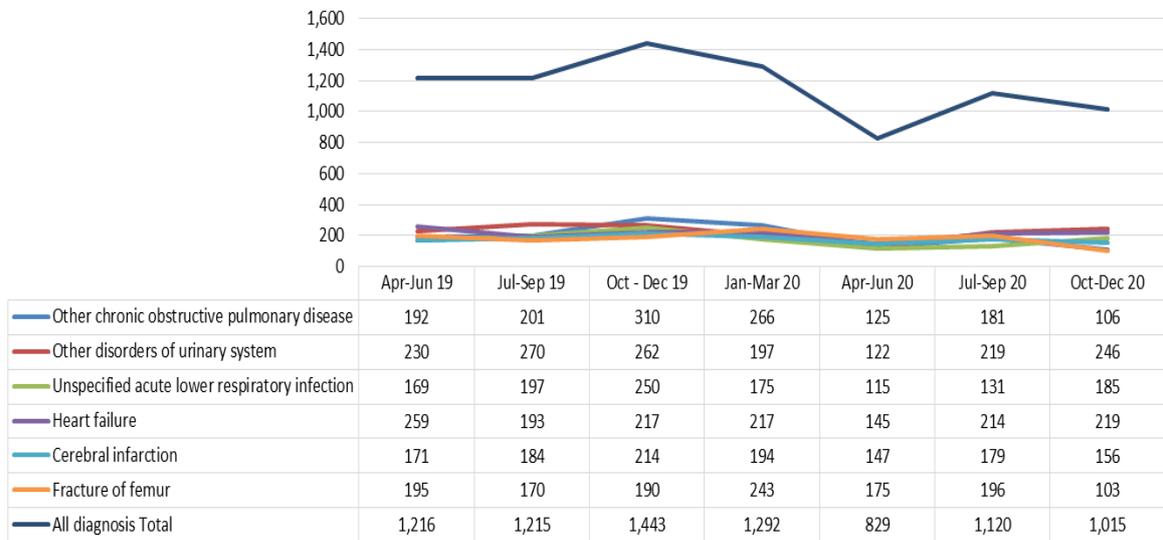
Inverclyde top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



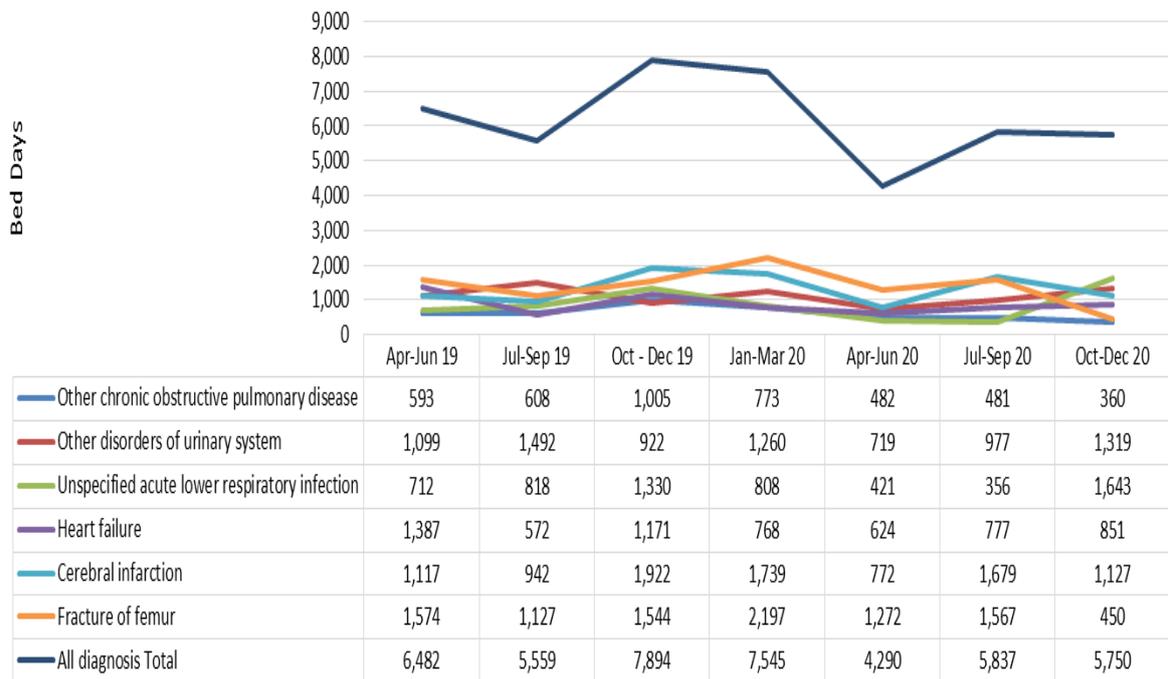
Inverclyde top 6 Presenting Conditions (Bed Days) By Quarter April '19 - Dec '20

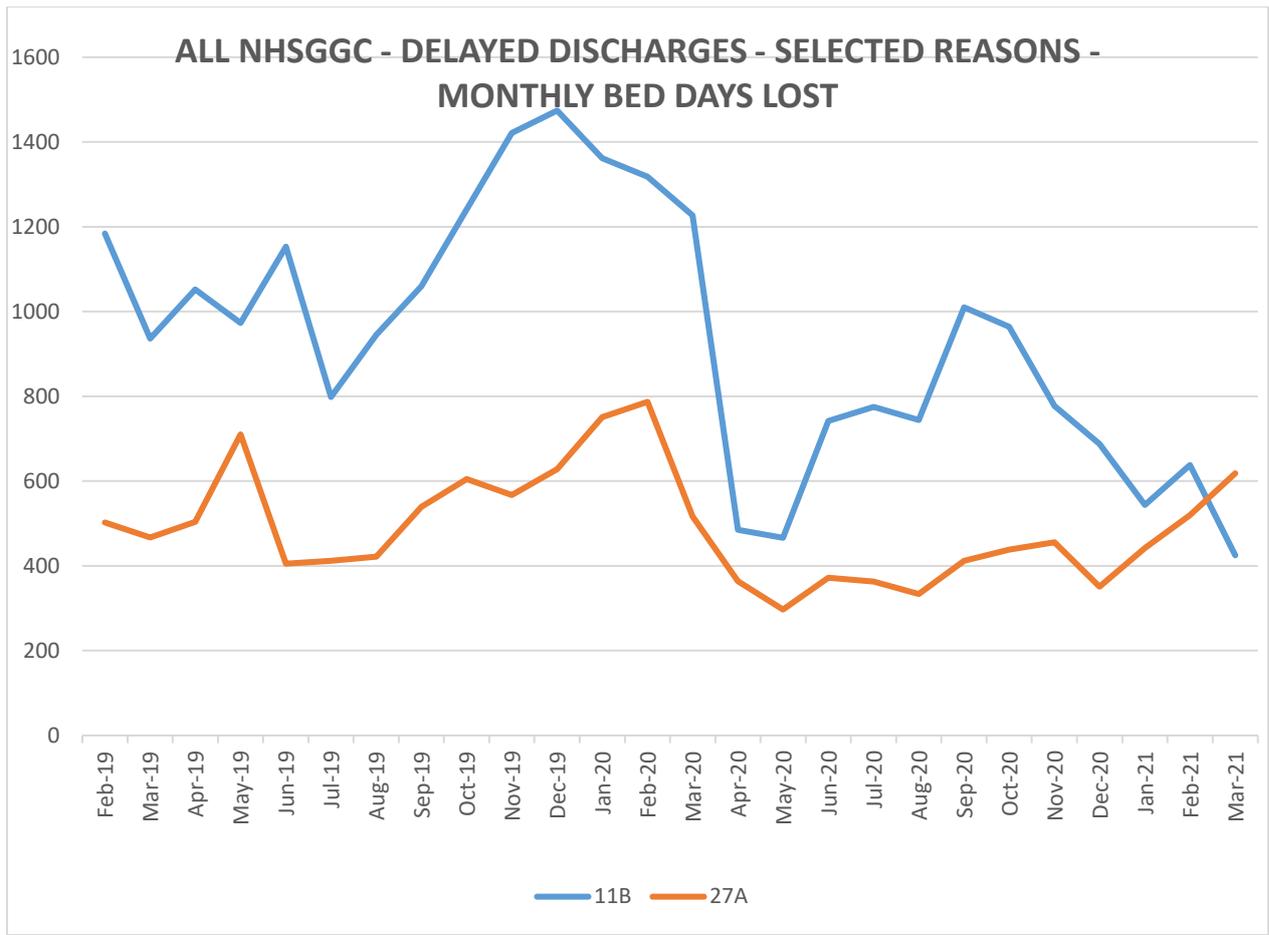


Other top 6 Presenting Conditions (Episodes) By Quarter April '19 - Dec '20



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

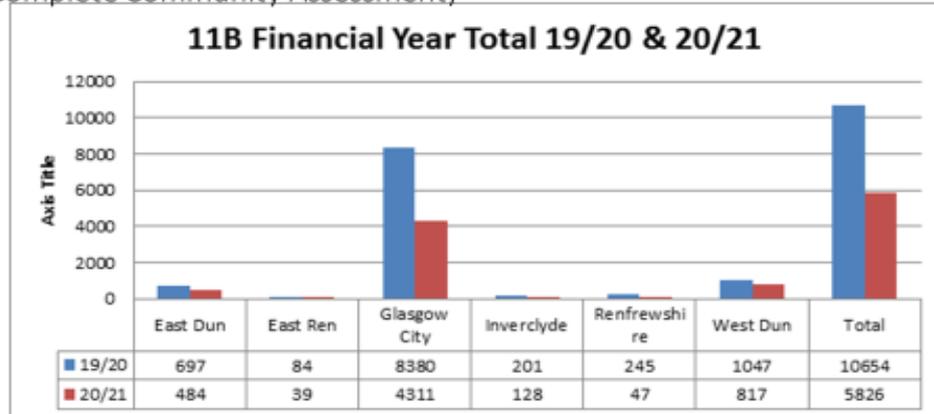




Bed Days Lost to 11B & 27A

OFFICIAL - SENSITIVE: Operational

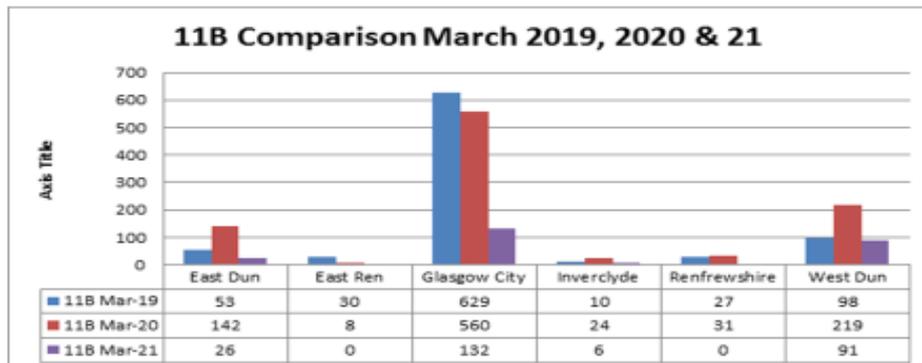
11B (Complete Community Assessment)



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

OFFICIAL - SENSITIVE: Operational

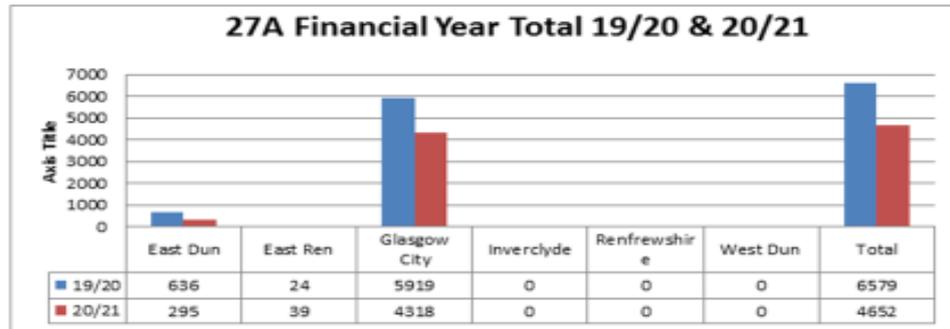
11B Comparison March 2019/20 & 21



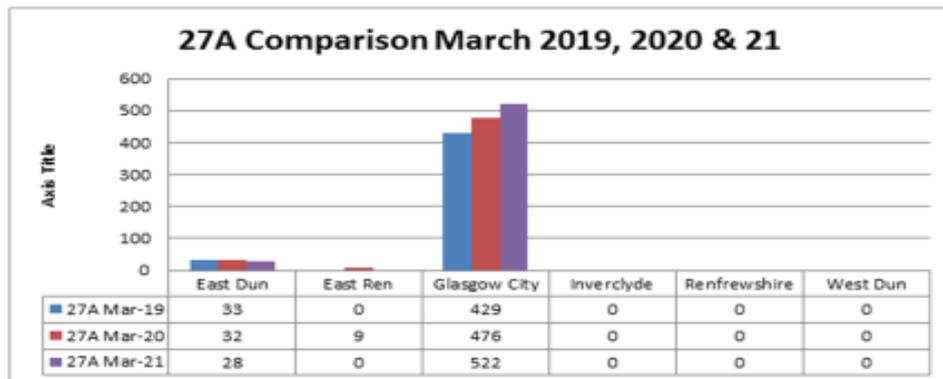
In March 2020 4/6 HSCPs evidenced an increase in bed days lost to 11B. In March 2021 there is a marked reduction across all Partnerships.

OFFICIAL - SENSITIVE: Operational

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



OFFICIAL - SENSITIVE: Operational



OFFICIAL - SENSITIVE: Operational

ANNEX C

Urgent Care Service 11 Weeks Activity Review

01/04/2021 to 13/06/2021

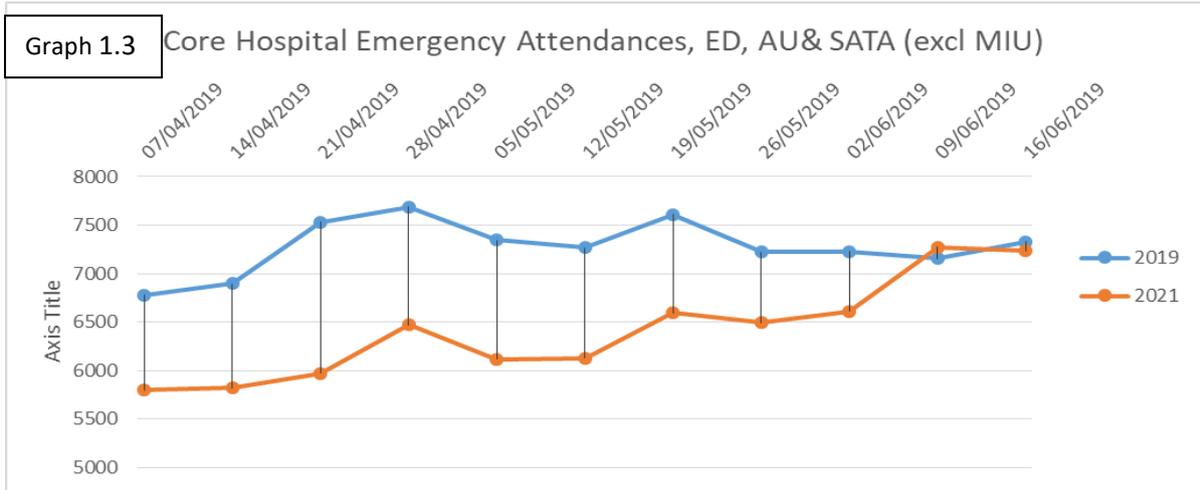
The 2020/2021 Covid19 pandemic and the impact of the public lockdown resulted in an overall reduction in emergency attendance rates across NHS GGC. This summary paper focuses on the changes in activity across a number of our urgent care activity as lockdown began to ease during March 2021.

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		

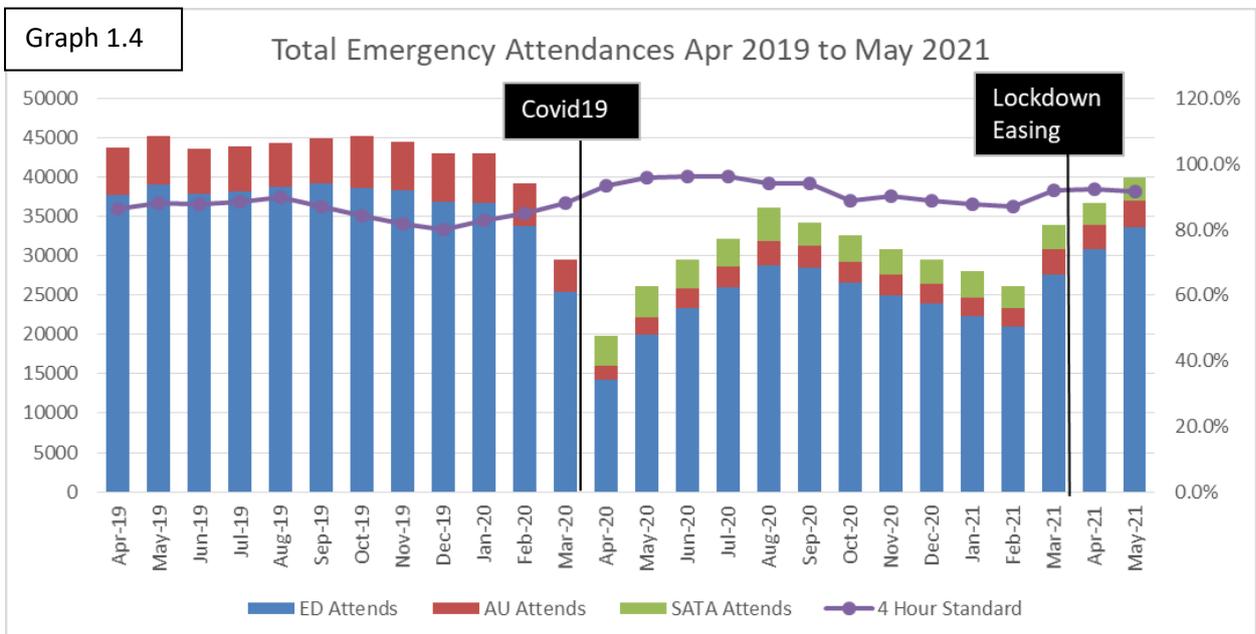
TABLE: 1.2 - April 2019 to 16th June 2019											
Week Ending - Core Sites	16/06/2019	09/06/2019	02/06/2019	26/05/2019	19/05/2019	12/05/2019	05/05/2019	28/04/2019	21/04/2019	14/04/2019	07/04/2019
Royal Alexandra Hospital	1387	1337	1386	1443	1439	1332	1305	1439	1413	1225	1309
Glasgow Royal Infirmary	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.



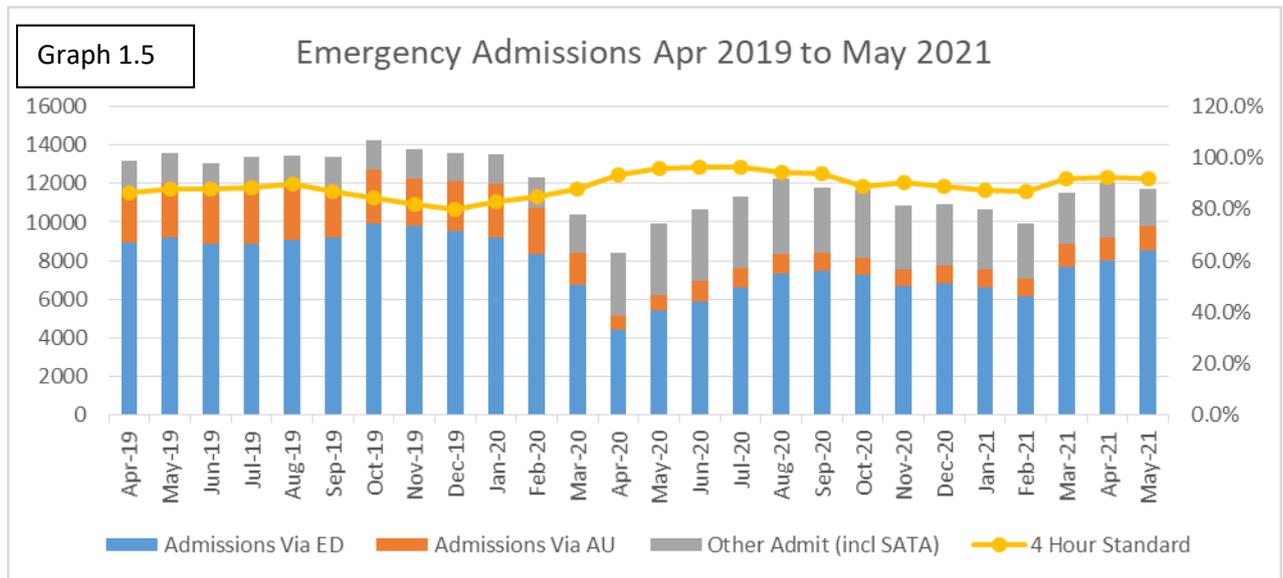
In summary UC attendances have reached pre pandemic levels whilst maintaining Covid19 pathways.

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.

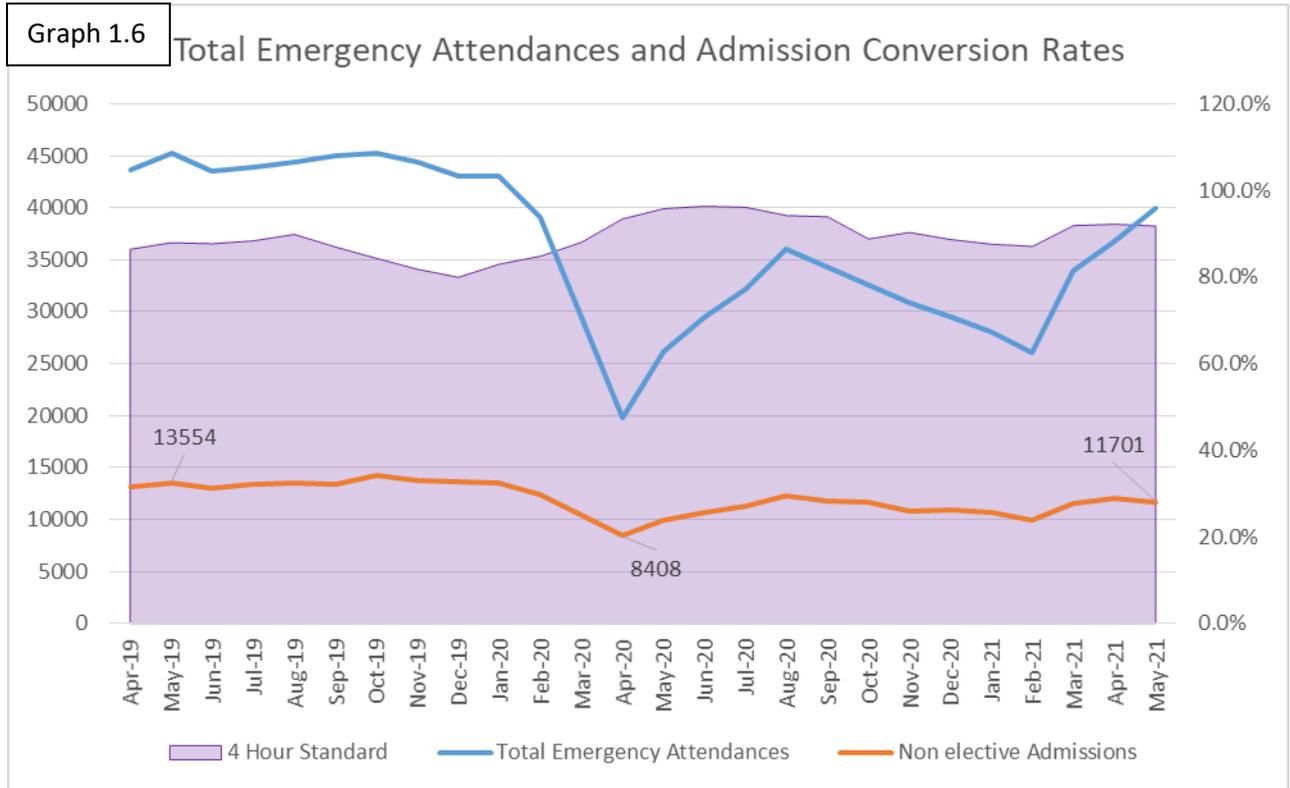


Acute Admissions: During the Covid19 pandemic the acute hospitals experienced an overall increase in the acuity of presentation with many patients requiring intensive care treatment in general new ways of working had to be quickly developed

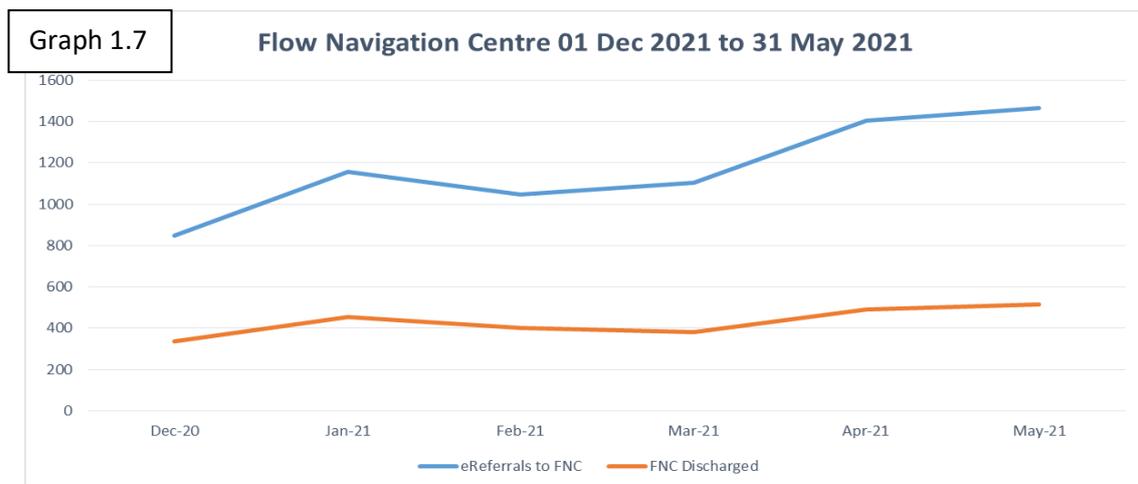
to deal with these challenges. In line with the reduced attendance profile during the pandemic the acute sites also experienced a reduction in the number of emergency admissions as the public adopted stay at home restrictions. Graph 1.5 below shows the total Emergency admissions and illustrates the correlation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

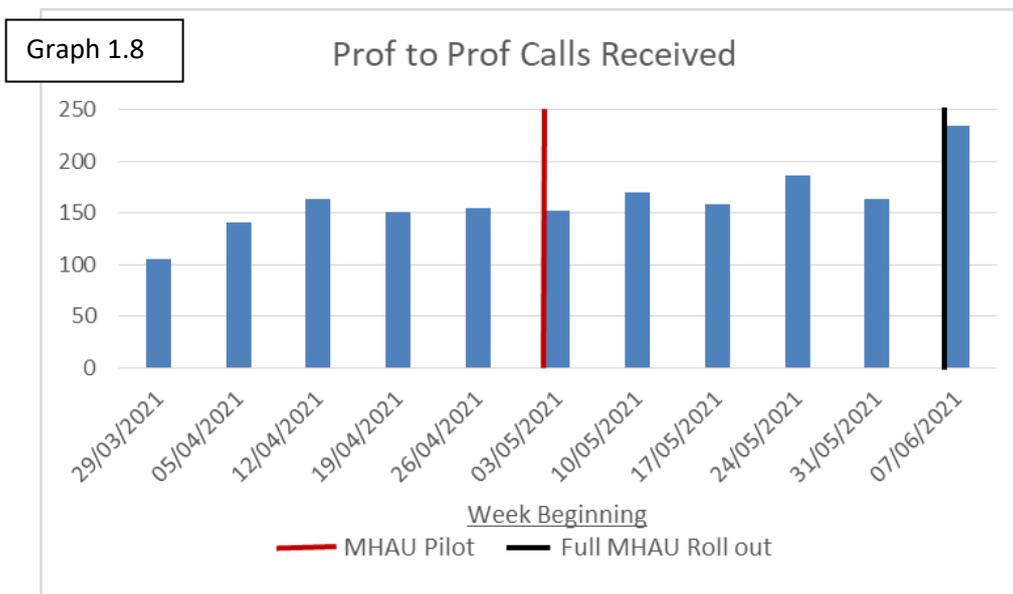


Flow Navigation Centre (FNC): The NHS111 service was launched on 1st December 2021 with eReferrals sent to the FNC for Near Me and telephone consultations. Graph 1.7 below shows the increasing number of referrals from NHS24 and a slower growth rate in the number of direct discharges from FNC. This is 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.

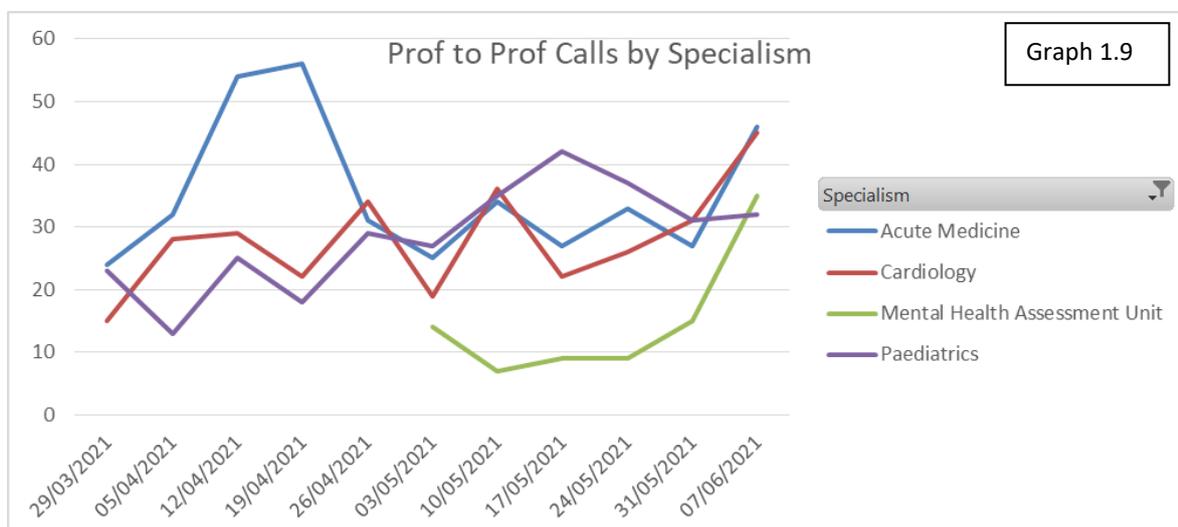


Professional to Professional Advice: The Acute hospital teams provide prof to prof specialty advice through a designated telephone system and a mobile device App. In March 20 the Mental Health Assessment Unit (MHAU) piloted a new prof to prof advice service for GP practices. This initially was for South 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.

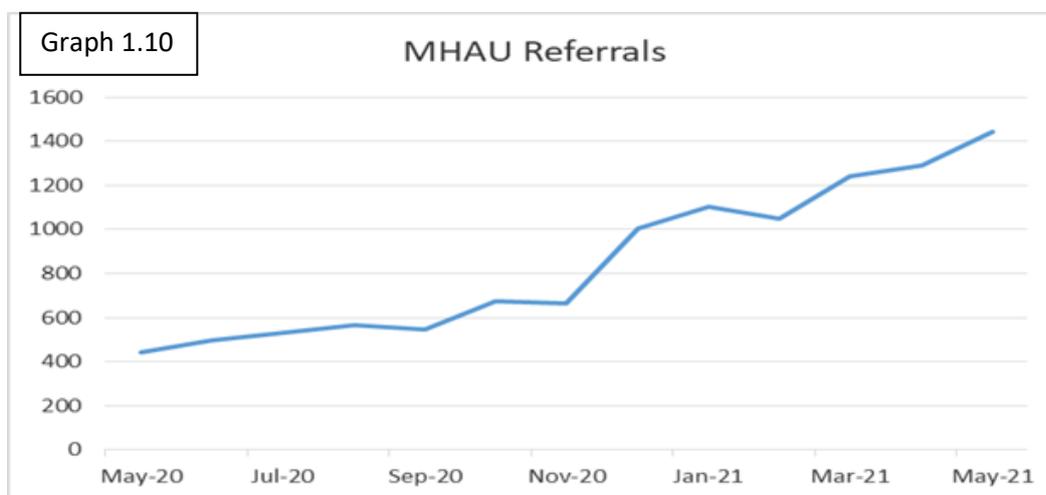


Table 1.8: MHAU Source of referral with a marked increase in referrals from NHS24.

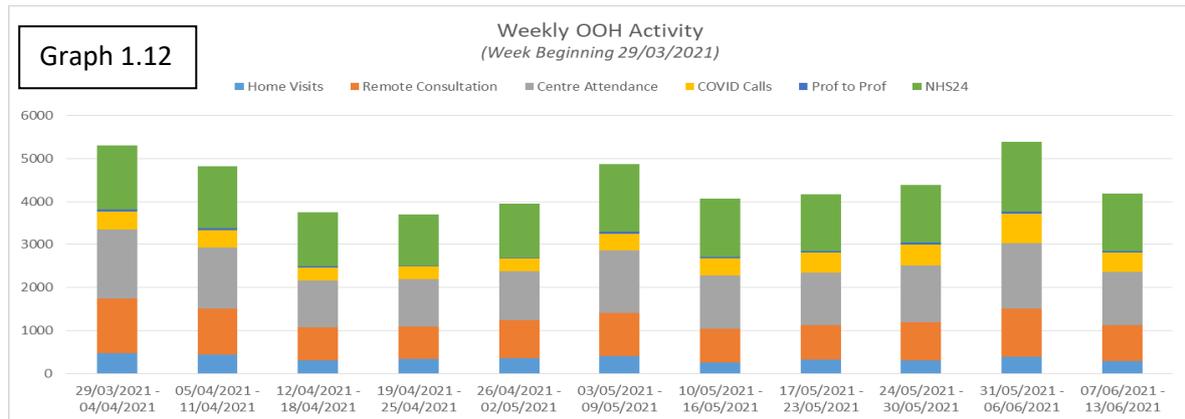
As detailed in the table referrals to the MHAU are reporting month on month increases and the service has clearly evidenced the value delivered through this route by providing direct access to the speciality.

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

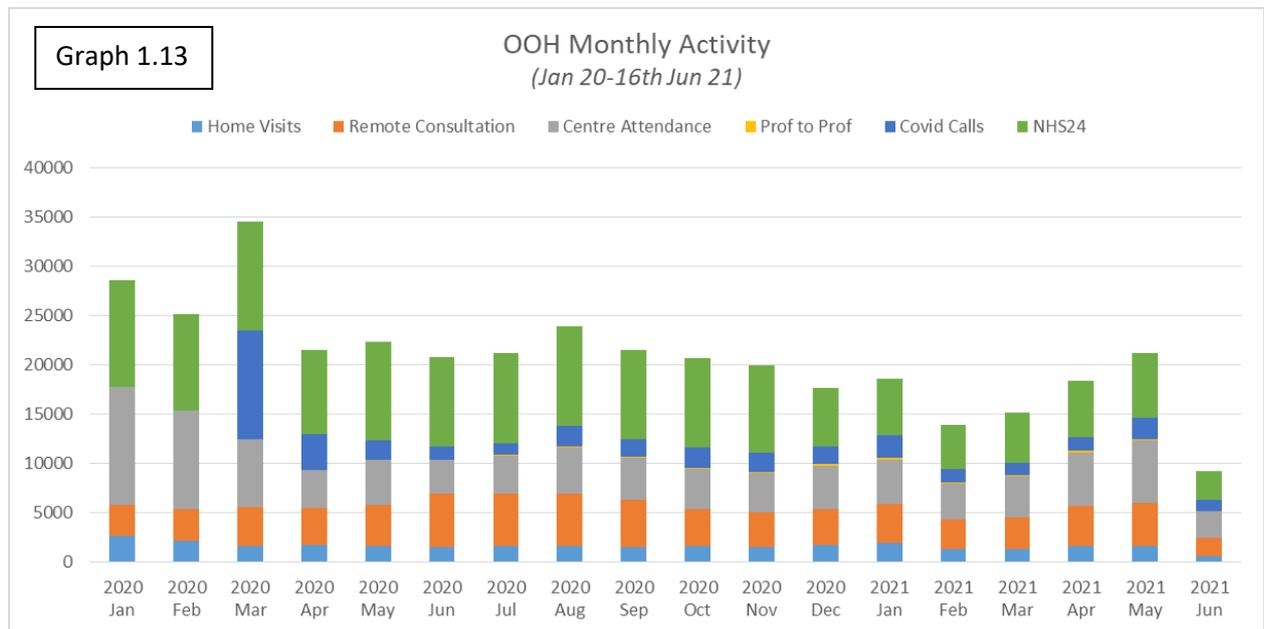
Table 1.11
As a new service established during Covid19 this represents a cumulative increased in overall urgent care demand

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

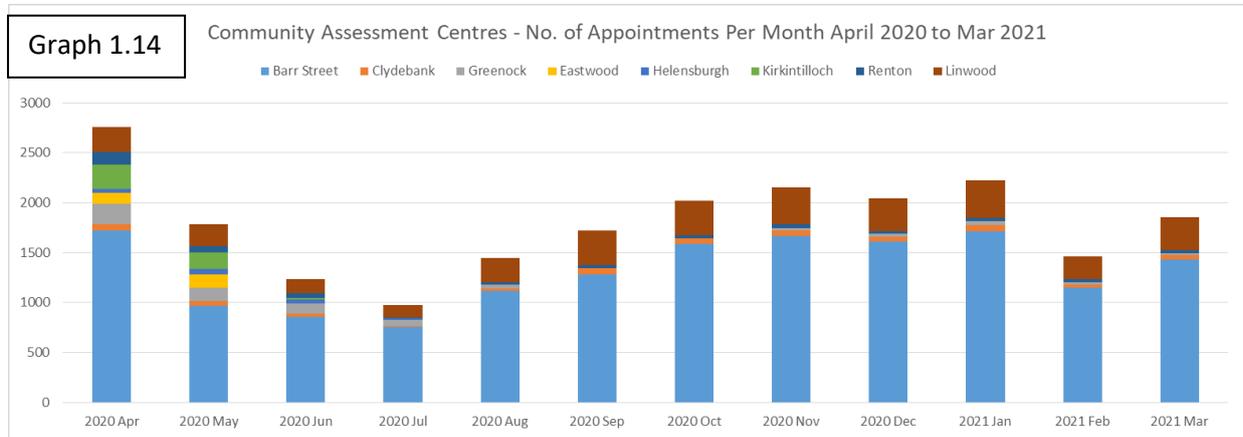


The annual picture for GPOOH’s from March 2020 to date is provided below in Graph 1.13 and illustrates the change in service provision to incorporate the delivery of remote consultations. The GPOOH’s data cannot be considered independently of the Community Assessment Centres (CAC’s) as the cumulative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

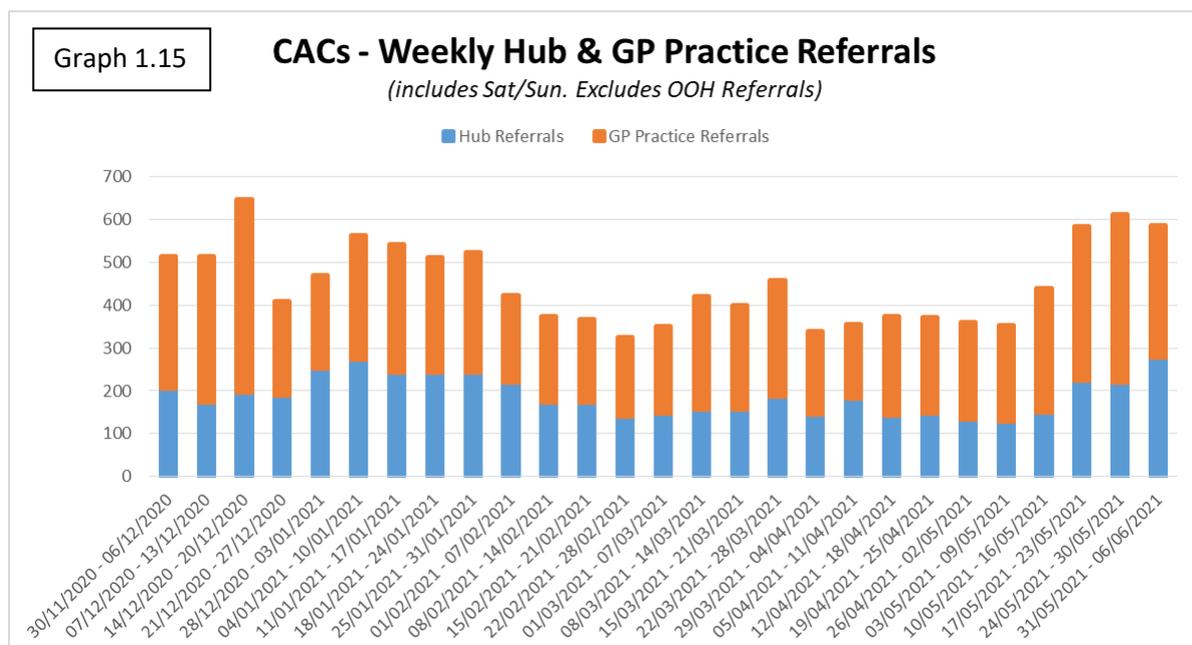


Community Assessment Centres: The CAC’s were established in April to provide an alternative pathway for GP’s both in and OOH’s to provide assessment and treatment of patients with Covid19 symptoms.

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.

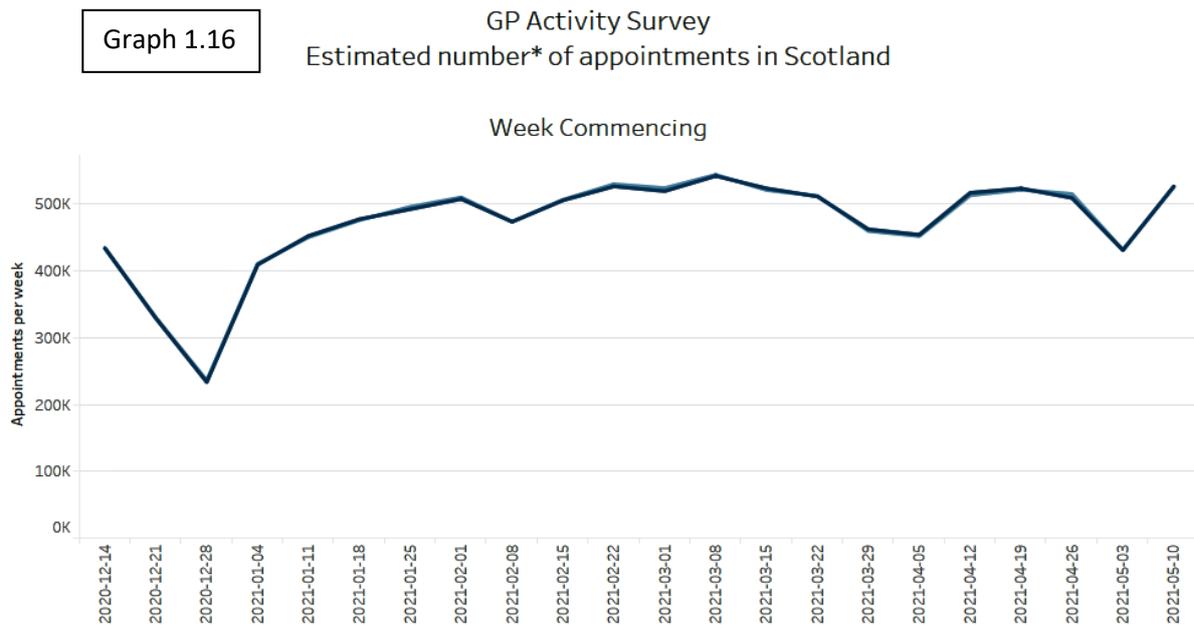


The weekly demand illustrated in Graph 1.15 below however reflects another step change in attendances in particular during May and June and this has been largely associated with the Delta variant and spread amongst younger age groups as lockdown eases. The position in the most recent three weeks reports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



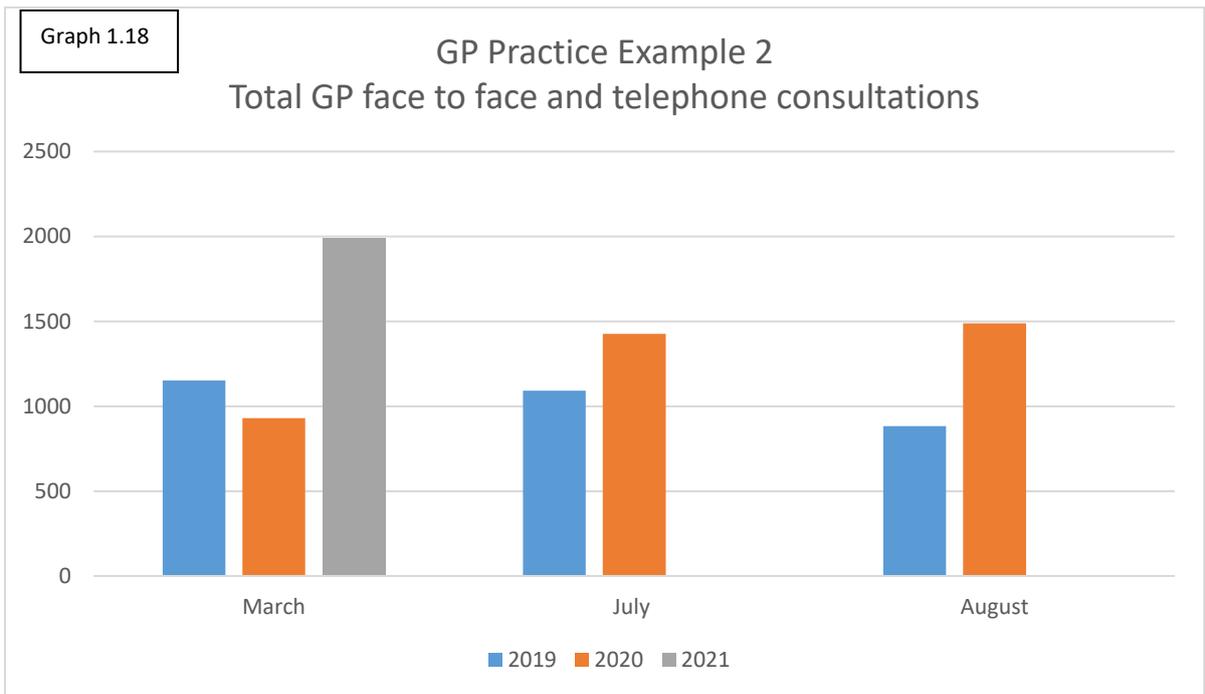
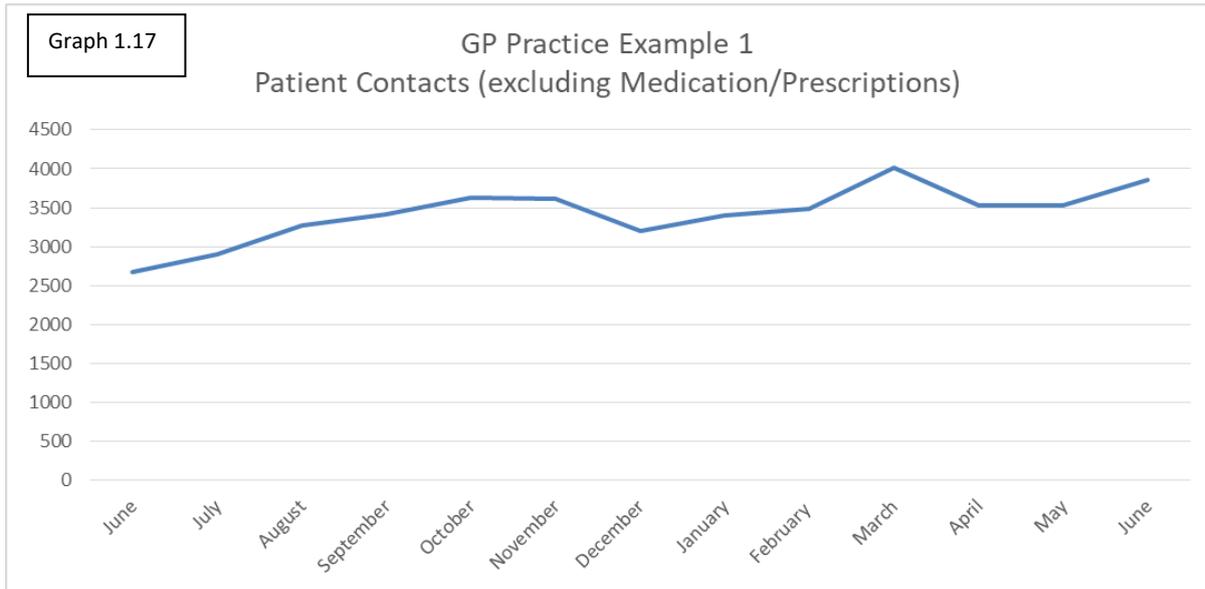
Primary Care: In the absence of available NHSGGC data we have used a combination of both the nationally published GP demand profile and an extract from two practices within NHSGGC who have shared their local data with us to support the analysis.

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.



*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.



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 presentations or replacements for what may have been previous emergency demand.

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

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	<input type="checkbox"/>	Communication & Engagement	<input type="checkbox"/>	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	<input type="checkbox"/>	Anticipatory Care Planning Work Stream	<input type="checkbox"/>	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	<input type="checkbox"/>	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	<input type="checkbox"/>	Progressed via: National Redesign Of Urgent Care Programme and GGC Falls & Frailty Programme	<input type="checkbox"/>	5.7
5	We will increase support to carers as part of implementation of the Carer's Act	<input type="checkbox"/>	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	<input type="checkbox"/>	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	<input type="checkbox"/>	
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	<input type="checkbox"/>	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	<input type="checkbox"/>	Co-ordination & Integration of Community Models	<input type="checkbox"/>	
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	<input type="checkbox"/>	Co-ordination & Integration of Community Models Falls Prevention & Management	<input type="checkbox"/>	
11	We will explore extending the care home local enhanced service to provide more GP support to care homes		Led by Primary Care	<input type="checkbox"/>	
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	<input type="checkbox"/>	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	<input type="checkbox"/>	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	<input type="checkbox"/>	Redesign of Urgent Care		
15	We will incentivise patients to attend MIUs rather than A&E with non-		Redesign of Urgent Care	<input type="checkbox"/>	

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	<input type="checkbox"/>	
17	We will improve urgent access to mental health services	Redesign of Urgent Care	<input type="checkbox"/>	
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	<input type="checkbox"/>	
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	<input type="checkbox"/>	
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	<input type="checkbox"/>	

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 is 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 reablement 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			

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

Draft Design & Delivery Plan – annexes 24.08.21

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 is 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

	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Funding : Recurring Expenditure					
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
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	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Funding : Non Recurring Expenditure					
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
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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

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)



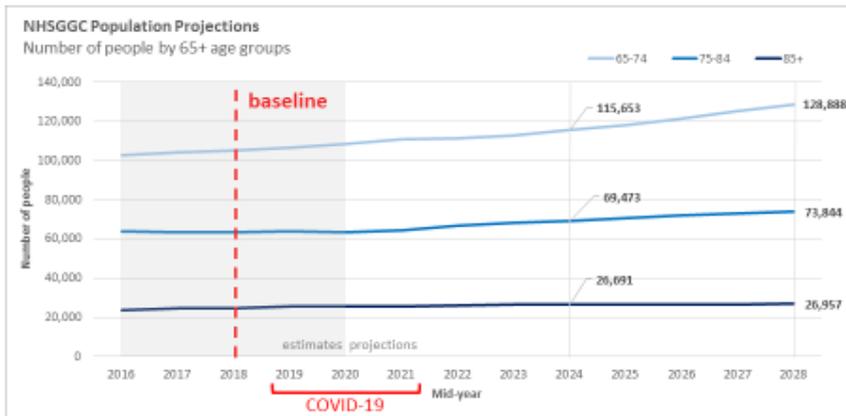
Summary

- 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



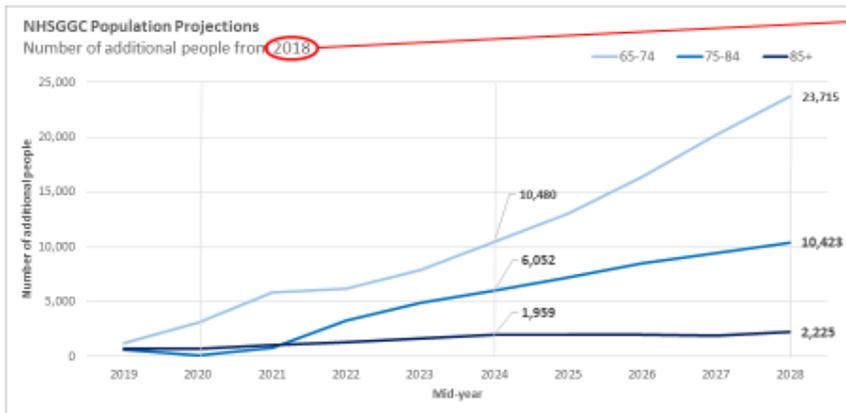
Population Projections

Number of people (aged 65+ groups)



Population Projections

Number of additional people (aged 65+ groups)

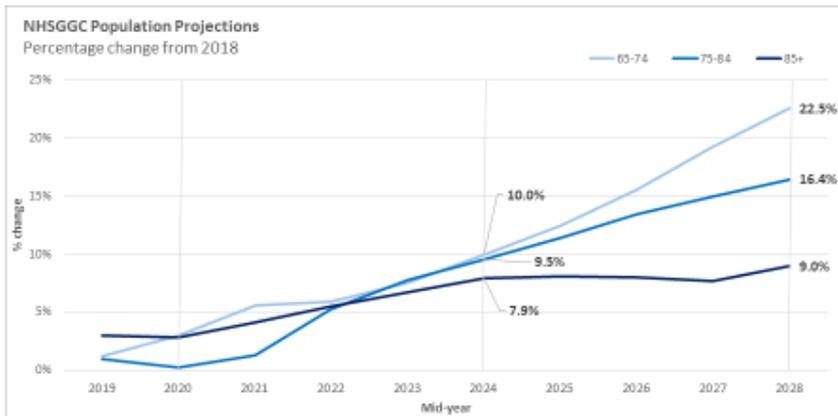


baseline year 2018/19



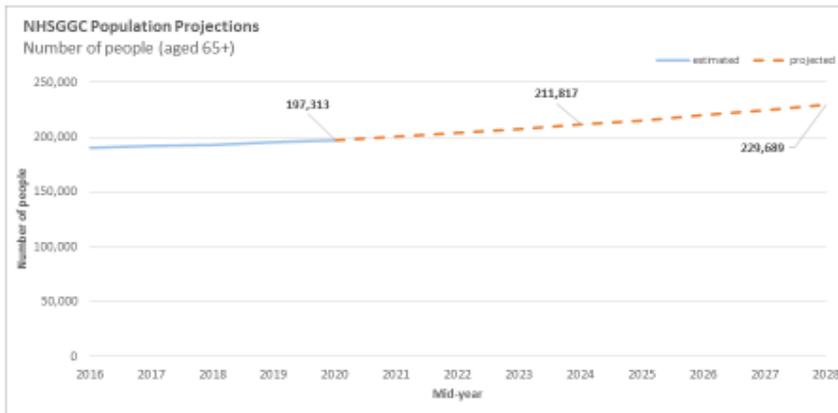
Population Projections

Percentage change from 2018 (aged 65+ groups)



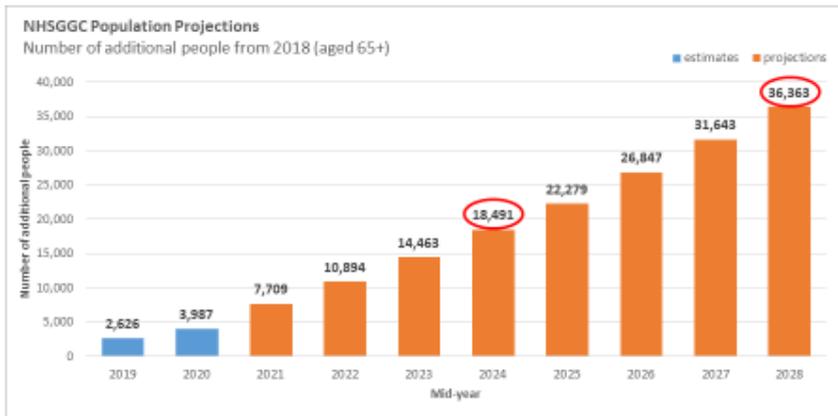
Population Projections

Number of people (aged 65+)



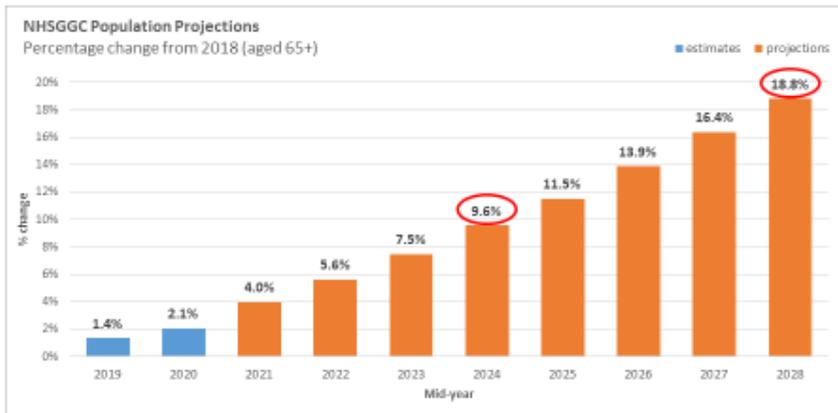
Population Projections

Additional people from 2018 (aged 65+)



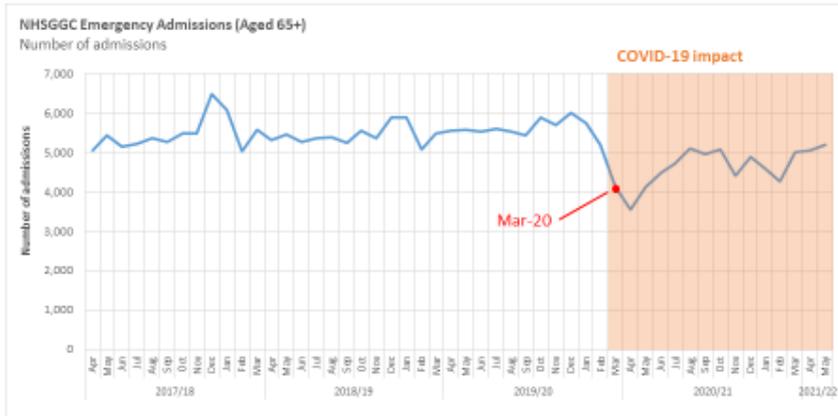
Population Projections

Change from 2018 (aged 65+)



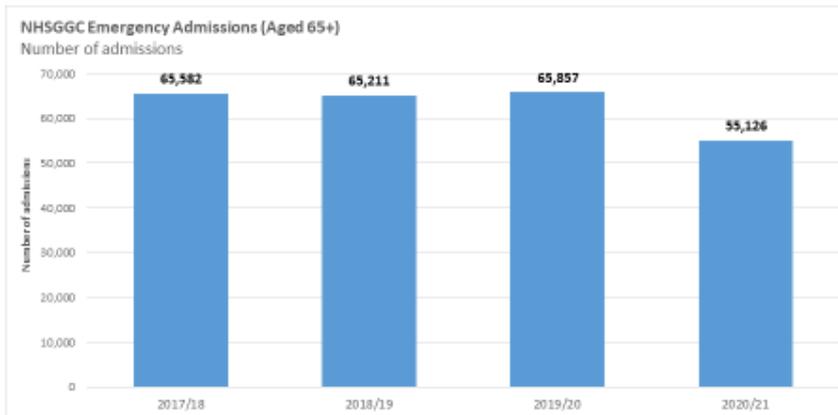
Emergency Admissions (Ages 65+)

Number of admissions

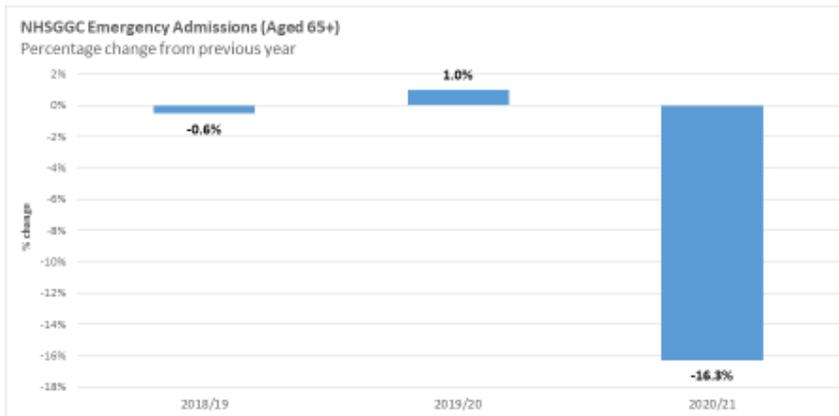


Emergency Admissions Ages 65+

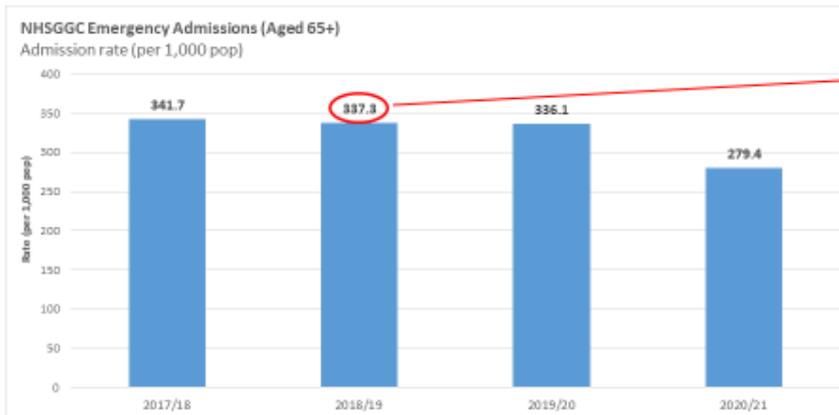
Number of admissions



Emergency Admissions Ages 65+ % change from previous year



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



baseline year



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

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

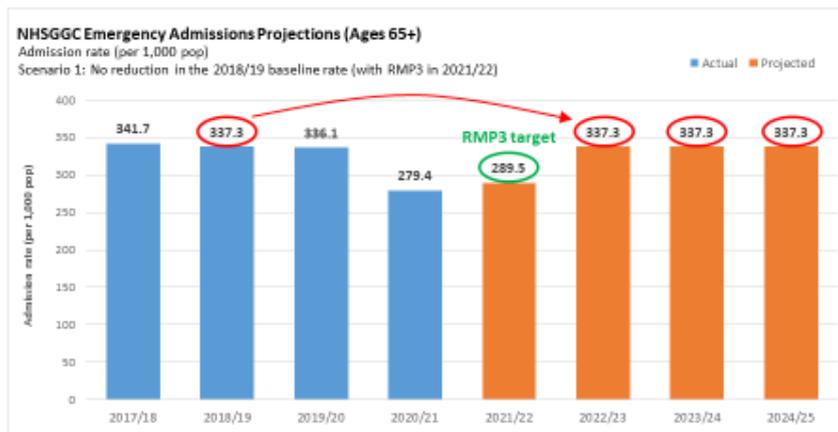
Estimate for ages 65+:
 $138,594 \times 42\%$
 $= 58,209$

Ratio of EAs:
Age 65+
All ages

⇨ While factoring in RMP3 targets for 2021/22

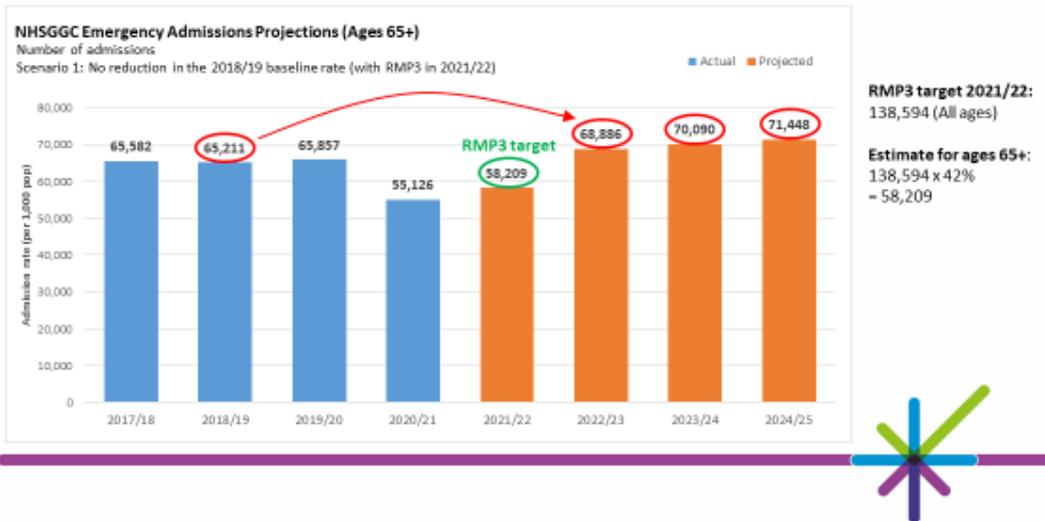
Scenario 1: No reduction in 2018/19 baseline (no implementation)

Admission rates (per 1,000 population)



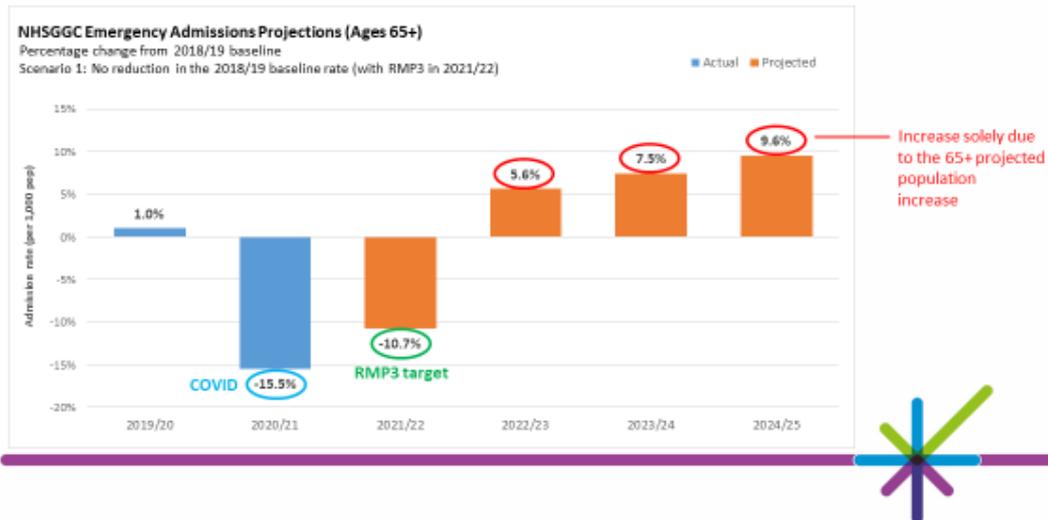
Scenario 1 No reduction in 2018/19 baseline (no implementation)

Number of Admissions



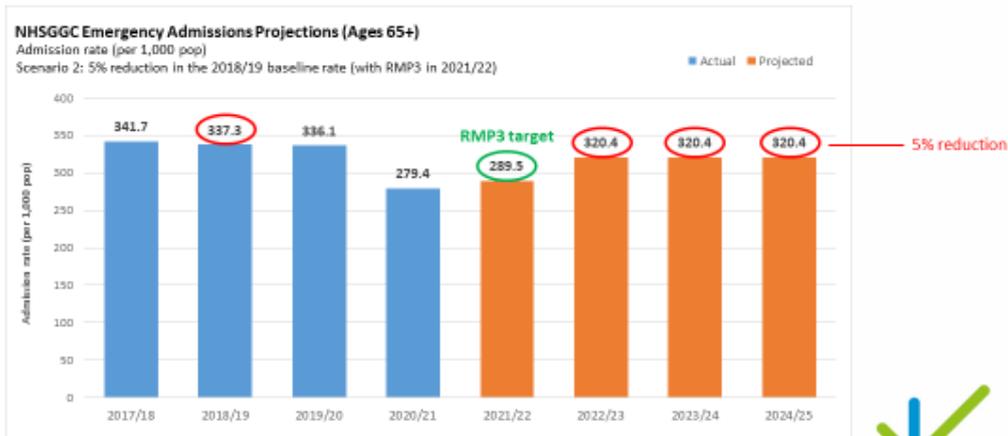
Scenario 1: No reduction in 2018/19 baseline (no implementation)

Percentage change from 2018/19 baseline



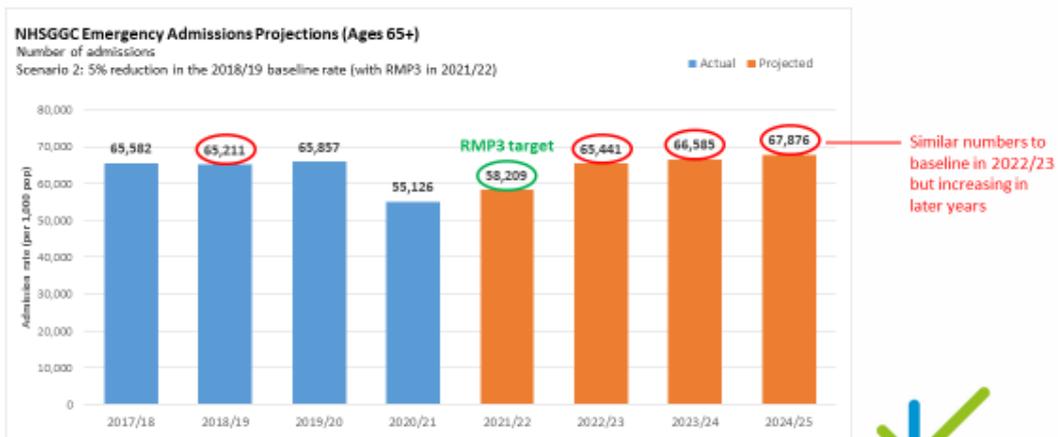
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Admission rates (per 1,000 population)



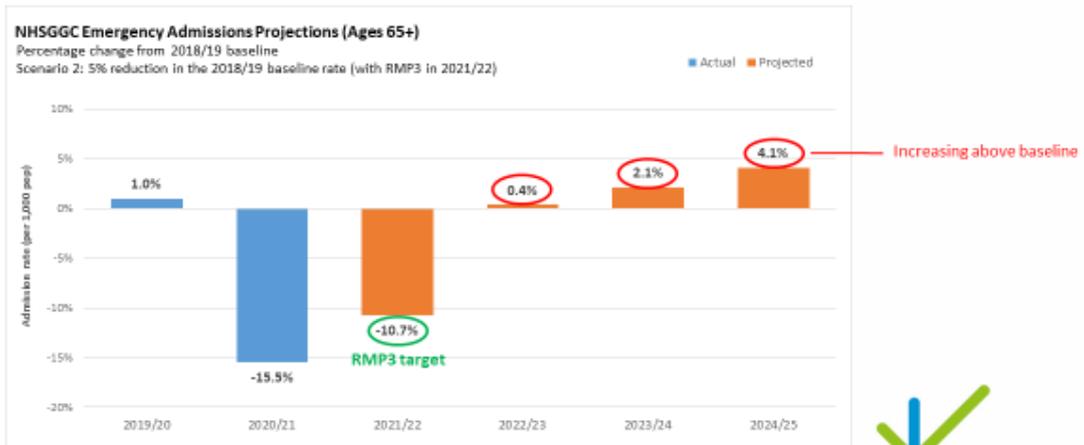
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Number of Admissions



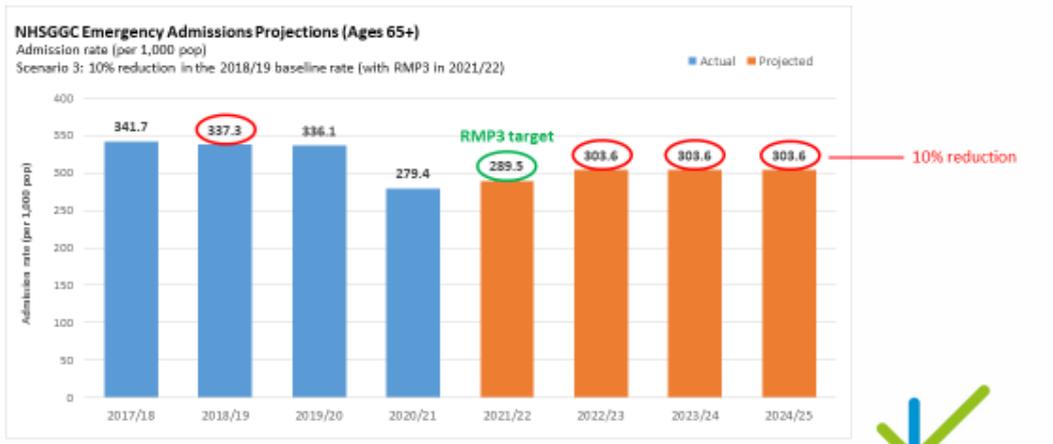
Scenario 2: 5% reduction in 2018/19 baseline (partial impl.)

Percentage change from 2018/19 baseline



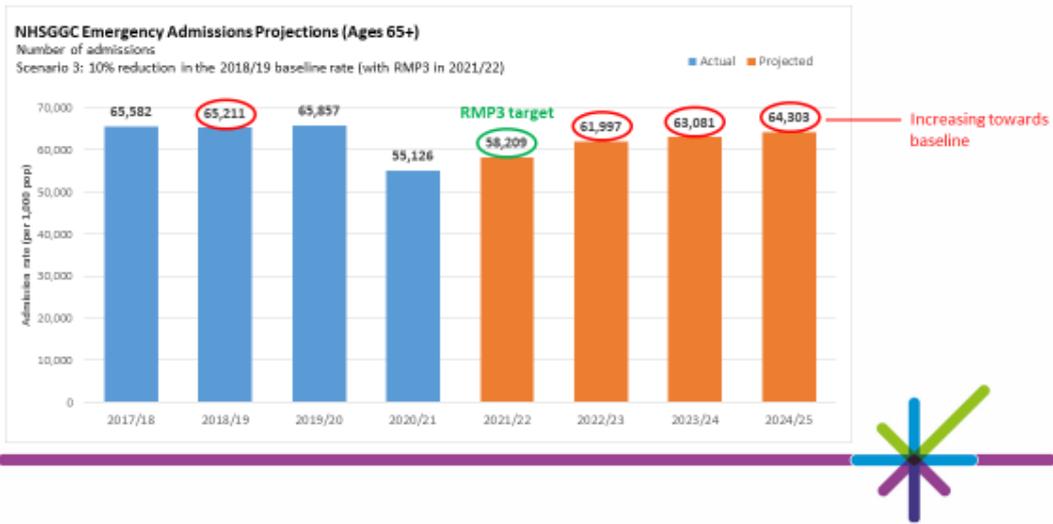
Scenario 3: 10% reduction in 2018/19 baseline (full impl.)

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

