Item No: 8

Meeting Date: **Wednesday 28th August 2024**

Glasgow City Integration Joint Board

Report By: **Stephen Fitzpatrick, Assistant Chief Officer, Older People**

Contact: **Stephen Fitzpatrick**

Phone: **0141 287 0499**

Hospital at Home Model

Purpose of Report:	This paper proposes a revision to the existing Hospital at Home (H@H) service in Glasgow City and includes the delivery of Glasgow City Call Before You Convey (CBYC), given the alignment of purpose around admission avoidance and synergies in respect of professional and clinical skill sets.

Background/Engagement:	The proposals contained within this report have been discussed with relevant Health Board and staff side colleagues.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☒ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☐ Not Applicable ☐

Recommendations:	The Integration Joint Board is asked to: a) Approve the discontinuation of the existing hospital at home model from 8th November 2024; b) Approve the transition to the successor hospital at home service from 8th November 2024; and

	c) Note the associated saving of £1.78 million attached to this transition.

Relevance to Integration Joint Board Strategic Plan:

The proposals in this report align clearly with the Strategic Plan's commitment to support people at the right time and in the right place.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome(s):	The proposals in this report principally relate to national outcomes 2,3 4 and 7.
Personnel:	Section 13 of the report details the proposed new staffing model for hospital at home. A formal HR process will be undertaken to support staff in the current hospital at home service to transition to the new service or to seek new opportunities elsewhere. The transfer of District Nursing budgets described at 12.3 confirms the associated deletion of vacancies on the staffing establishment.
Carers:	There is no expected change to the role of carers as an outcome from these proposals.
Provider Organisations:	No expected implications for provider organisations.
Equalities:	The equality considerations of the proposals within this report can be accessed on our website. https://glasgowcity.hscp.scot/equalities-impact-assessments
Fairer Scotland Compliance:	No issues.
Financial:	A saving of £1.78 million is associated with this report's recommendations and is delivered through the discontinuation of the current hospital at home model. Full details of the financial framework are outlined at section 12.
Legal:	No issues.
Economic Impact:	No issues.
Sustainability:	No issues.
Sustainable Procurement and Article 19:	No issues.

Risk Implications:	There is a risk that redirecting district nursing budget and associated vacancies will reduce the capacity of that service. There is a continuing risk to the financial sustainability of the new model based on elements of non-recurring and potentially non-recurring funding; and, given the potential impact of any national regrading of grade 5 district nursing staff.

Implications for Glasgow City Council:	None.

Implications for NHS Greater Glasgow & Clyde:	If approved these proposals would confirm the retention of a hospital at home service within the wider Board area.

Direction Required to Council, Health Board or Both	
Direction to:	
1. No Direction Required	☐
2. Glasgow City Council	☐
3. NHS Greater Glasgow & Clyde	☒
4. Glasgow City Council and NHS Greater Glasgow & Clyde	☐

1. Purpose

1.1 This paper proposes a revision to the existing Hospital at Home (H@H) service in Glasgow City and includes the delivery of Glasgow City Call Before You Convey (CBYC), given the alignment of purpose around admission avoidance and synergies in respect of professional and clinical skill sets.

1.2 It places an emphasis on cost effectiveness, sustainability, scalability and mainstreaming as part of the wider spectrum of community health care and resources.

1.3 This paper provides detailed proposals in relation to staffing, finance and professional governance.

1.4 It proposes an entirely community-based model with no acute Consultant input.

1.5 The proposal is intended to progress a number of key strategic priorities simultaneously, including H@H, CBYC and Transforming (Nursing) Roles. Frailty is likely to be a component of assessment of each patient and the paper details agreed referral processes.

1.6 The initial proposed capacity of the H@H model is 11 virtual beds that can support up to 1,000 patients per annum; and c2,600 care home residents per annum via CBYC.

2. Scope

2.1 The proposed service comprises two key elements:

- Hospital at Home – phased growth from current South and partial North-West Localities to a city-wide service
- Call Before You Convey – phased implementation providing support over time to all 61 Glasgow City Care Homes

2.2 The proposed model would deliver:

- CBYC Referrals – weekends and public holidays from 8am to 6pm
- Referrals from GPs, Scottish Ambulance Service (SAS) and Acute (Emergency Department (ED), Acute Assessment Units (AAU) and wards).

3. Criteria

3.1 Hospital at Home – in line with the existing model this service will exclude any patients who present with an urgent condition that would be expected to be managed in an acute setting (including chest pain, abdominal pain, stroke, DVT).

3.2 The level of interventions and the higher-level clinical skills will support patients aged 65 and over who present with an acute functional decline, frailty, delirium, dehydration, infection, exacerbation of a known condition such as Chronic Obstructive Pulmonary Disease (COPD) or an acute presentation of suspected advanced malignancy.

3.3 The Multi – Disciplinary Team (MDT) approach enables the service to intensively review and amend treatment plans on a daily basis. Where this level of intensive support is no longer required the patient is discharged.

3.4 Users of this service will be individuals who cannot be managed within existing mainstream community services due to the intensity of support they require as well as the requirement for hospital level diagnostics and rapid turnaround of blood results to support clinical decision making.

3.5 For the duration of their care, patients will be admitted to the Hospital at Home service and upon discharge, the GP will be informed via an Immediate Discharge letter of the outcomes of their care. There are circumstances in the current service where elements of shared care are delivered. Specialist wound care may, for example, be continued by a District Nurse whilst the acute care episode is managed by the Hospital at Home Team. The agreement would be that only the Hospital at Home Team would amend prescribing and teams would liaise around care.

3.6 Call Before You Convey – has been identified as an important element of the Health Board's unscheduled care planning and within that, winter planning for 2024/25.

3.7 Each HSCP has been developing its own local model of CBYC in accordance with local circumstances and resources.

3.8 The aim of the model is to prevent care home residents at risk of conveyance to the hospital front door being conveyed. This being achieved via preventative assessment by an appropriately qualified clinician such as an Advanced Nurse Practitioner.

3.9 Glasgow City's initial development of CBYC was very much an interim model/test of change, having been developed at very short notice in advance of winter 2023/24 and reliant on overtime and agency funded nurses as well as some GP sessions. Its coverage was partial, covering only a fifth of the city's care homes, all of which were in North-East Locality.

3.10 This was never intended to be the sustainable long-term CBYC model for the city. The proposal in this paper is that in the future the CBYC function is resourced from within H@H staffing. This will place the model on a sustainable footing and enable expansion of CBYC to all 61 of the city's care homes.

3.11 Based on the evaluation of the past winter's CBYC model, this expansion can be expected to further reduce the number of the city's care home residents being conveyed to hospital.

3.12 Under the proposal the H@H team will provide telephone advice and reassurance as well as the opportunity to visit and review the resident, prescribe, or escalate to admission to either the H@H team or into an acute setting.

3.13 The residents in-scope for this service will predominantly be aged 65 or over, but under 65 presentation is also a possibility.

3.14 Whilst with the Call before You Convey service the resident will remain under the responsibility of their registered GP and any interventions, prescribing or record of care will be shared with the care home, the GP, and any Care Home Liaison staff of ANP's linked to the care home.

3.15 Residents' profiles may include those at risk of deterioration of a known condition where a short term input may be required to stabilise them, where they have developed an infection that may be helped by an early prescribing input, or where the resident has a condition or circumstances where the care home does not have the knowledge or skills to manage a device that is causing immediate distress to a resident – such as a catheter or stoma.

3.16 An essential component of this process is the feedback to the care home clinical lead/ANP and GP to identify opportunities for learning, training, and avoiding similar issues in future.

3.17 Whilst there is a risk of creating care home dependency on this service, the aim is to work collaboratively to improve knowledge and skills and confidence within

the care home and to manage expectations and identify opportunities for improvement and early intervention in the future.

4. Referral Process

4.1 This will continue to use existing tested processes with calls received by a coordinator who will confirm that the patient meets the criteria and that there is capacity to take the patient. This will then trigger an assessment process, typically undertaken on the same day and the development of an agreed treatment plan for the duration of the care to be given.

4.2 The patient will be discussed at the next multi-disciplinary team (MDT) meeting, but meantime senior clinical decision making will be picked up immediately by Advanced Nurse Practitioners (ANP's) with support from the lead ANP and GP With Special Interest (GPwSI).

4.3 A QR code system is in place for GPs to access information on bed availability and the criteria and scope of the service.

4.4 A comprehensive communications and information plan will be developed to maximise activity and use of available capacity.

4.5 There is currently an SAS pathway in place for the South locality only, which would expand over time to be city wide.

4.6 The existing Home First Response pathway will be further developed geographically as the service grows and also to maximise this as a route for referrals to prevent admission. There are also opportunities to develop enhanced links to the Flow Navigation Centre routes for potential referrals.

4.7 Frailty is likely to be a component of assessment of each patient and as such there are agreed referral processes for patients identified as frail. These include:

- South care home patients presenting at ED via the Advanced Frailty Practitioners
- Immediate Assessment Unit (IAU) via Medicine for the Elderly Acute (DME) medical staff.
- Acute Receiving Units (ARUs) 1-5 via DME medical staff.
- Wards 2a and the 50s in the Langlands unit at QEUH via DME medical staff.

4.8 Call Before You Convey - Some residents may be flagged by ANPs or Care Home Liaison Nurses (CHLNs) who will note any concerns or risks of deterioration ahead of the weekend or public holiday period. Enhanced staffing for the Call Before You Convey element provides capacity to respond to this. This will then be communicated by a telephone call to the home or as a planned visit by the team.

4.9 A second more reactive route will enable care homes to call the team to request advice or support and a decision will be made on whether telephone support is sufficient, or an in-person visit is required.

4.10 There may be further opportunities to develop links with the Acute Flow Navigation Centre (FNC) in the event of care home calls that may be diverted to the service.

5. Interventions

5.1 Hospital at Home – on assessment a range of diagnostic options are available to the team including:

- ECG
- Bladder scan
- Hospital level imaging (CT / X-ray / Ultrasound)
- Rapid turnaround blood testing to support decision-making
- iSTAT blood gas analyser

There are a range of provisions available that include:

- Intravenous antibiotics and other medication such as Furosemide
- Prescribing
- Intravenous fluids and sub-cutaneous fluids
- Provision of oxygen via Oxygen Concentrator
- Home care support – commence or increase existing packages of care
- Medication management – reviews and medicines reconciliation
- Access to carer support services

5.2 The team is staffed to provide intensive assessment and treatment with an average of 8 visits over an average 4-day length of stay with the team. Some patients may initially require multiple visits per day whilst others may require fewer.

5.3 Call Before You Convey – involves assessment and review of clinical need with the aim of supporting the care home to prevent the admission of the resident where possible and provide interventions such as support around catheter care, prescribing (oral antibiotics, analgesia) and escalation to Hospital at Home or to an acute care setting.

5.4 There is capacity for visits to the care home to provide support and review of residents. Where demand exceeds capacity, referrals will be prioritised.

6. Governance

6.1 Hospital at Home -This is a multi-disciplinary team with a GP with Special Interest (GPwSI) and lead ANP acting as senior clinical decision makers across the Monday to Friday period. The GPwSI will fulfil the requirement of Responsible Medical Officer when the patient is admitted to the service. A multi-disciplinary meeting is held on weekdays to review patients and support the plan of care (including any diagnostic requirements, prescribing or discharge planning).

6.2 Advanced Nurse Practitioners and Advanced Practitioners deliver higher level interventions using agreed Standard Operating Procedures that meet policy and governance standards for NHSGG&C.

6.3 They are managed on a day-to-day basis by the service management team and have supervision from a Lead ANP or their respective professional lead.

6.4 As senior decision-maker, GPwSI supervision will be provided by the HSCP's Clinical Director for Older People and South Locality.

6.5 The remainder of the team consists of nurses, health care support workers, pharmacist/ pharmacy tech and administrative staff. Additional support is proposed for access to Occupational Therapy or Physiotherapy through existing enhanced community services such as Community Rehabilitation.

6.6 Case reviews, reviews of incidents and clinical reviews will be lead through the service management team with input from the GPwSI and lead ANP.

6.7 Call Before You Convey – Nurses will deliver the agreed level of interventions using approved Standard Operating Procedures and interventions within their scope of practice such as prescribing or clinical interventions.

6.8 The service will be managed by the service management team with clinical supervision provided through the ANP/ AP structure. There will be opportunity to review cases through the wider MDT.

6.9 There will be a focus on learning and improvement to identify opportunities where the need for input could have been prevented, where intervention could have occurred at an earlier stage and any learning opportunities to feed back to the clinical lead for the care home and the ANP/ CHLN or GP associated with the care home.

7. Escalation

7.1 Hospital at Home - During the hours of operation there will be senior clinical decision-making support from the GPwSI or lead ANP (9am-5pm Monday to Friday excluding public holidays). Out with these hours additional support is available from ANP staff within the service.

7.2 The current service has the option to contact the Department of Medicine for the Elderly (DME) on-call consultant up to 8pm. With the new service there would be a requirement to renegotiate the relationship with the DME on a city-wide basis.

7.3 From 8pm to 8am there is an agreed process of escalation with the GP Out of Hours Service. Evidence over two years of the existing H@H service indicates very little escalation during the out of hours period.

7.4 Attendance at hospital can be arranged immediately where the patient deteriorates beyond the limits of the service.

7.5 Call Before You Convey – If the interventions or level of support required are beyond the remit of the service the resident could be referred to the Hospital at Home service or may need to be conveyed to hospital. ANP advice and support will be available to support decision-making. Based on experience to date hospital conveyance rates are anticipated to be no more than 3-4% of all CBYC referrals.

8. Digital Opportunities

8.1 For each element of the service there are opportunities to explore the use of remote devices to support the diagnostic/ assessment element of care and to identify where efficiencies can be made or to enable the availability of information to support clinical decision making. This includes the use of equipment to support point of care testing in order to get immediate information to support care.

8.2 The Near Me call system is available for practitioners to link to other senior clinical decision makers where there is the requirement to escalate or seek additional advice. This is already in use within the Hospital at Home service.

8.3 Digital opportunities for point of care testing, or to reduce the need for staff travel/ visits where not necessary, will aim to maximise the available capacity and to target resources on a prioritised basis.

9. Patient Information System

9.1 TRAK Care will continue to be used by the Hospital at Home service to enable diagnostic and laboratory ordering as well as supporting day-to-day record keeping, provision of discharge information, updated information for Out of Hours services or escalation where required.

9.2 A similar provision is in development for the Call Before You Convey service to enable record keeping and communication of information to all stakeholders, especially the patient's GP.

10. Activity

10.1 Hospital at Home -Based on an average length of stay of 4 days and a provision of 11 virtual beds it is anticipated that the service could see up to 1,000 patients per year.

10.2 There is a recognition that the average length of stay for an Acute geriatric assessment bed is 11 days and that Hospital at Home is a much shorter stay as the person remains in their own home, so the assessment and discharge process is accelerated.

10.3 The potential bed day savings based on a conservative estimate of acute length of stay could be between 8,000-12,000 bed days per year.

10.4 There is a working assumption that a small percentage of Call Before You Convey calls will result in admission to the Hospital at Home service.

10.5 As at present, capacity in respect of available beds, patient acuity and available staffing will be reviewed daily.

10.6 Throughput will continue to be managed via senior clinical decision makers, daily MDTs focused on discharge and the use of criteria-based discharge to prevent delays in moving patients on.

10.7 The service has thus far maintained criteria whereby the patient remains with the team only when necessary and is discharged to or remains with appropriate community services when they do not require the higher-level input.

10.8 The mainstreaming of H@H within the broader spectrum of community services is intended to improve seamless transition between community resources.

10.9 Call Before You Convey - The cumulative staffing presented in the 11-bed capacity model also aims to provide the resource required to meet the anticipated weekend and public holiday demand from Glasgow's 61 care homes. The actual demand (numbers and nature) is likely to develop over time and this will be part of the ongoing evaluation of the model.

10.10 This will enable a handover toward the end of the week from ANPs and CHLNs in respect of vulnerable care home residents who may be the subject of a call, or alternatively could benefit from a planned review and possible visit.

10.11 In addition, it provides a focused resource to receive and support any unplanned direct calls from care homes.

10.12 The assumptions are based on the initial test of change for Call Before You Convey with a potential for around 30 calls per day at weekends and public holidays. This is an estimate based upon extrapolation of activity during the pilot to the 61 care homes across Glasgow City.

10.13 A significant proportion of calls are likely to be managed by telephone advice, including follow up review by telephone, although a small number may require a visit which is captured in the available resource.

11. Benefits

11.1 There is emerging evidence of the economic benefits of Hospital at Home as well as recognition of the wider community and system benefits.

11.2 For Acute Services a potential 8,000 to 12,000 bed day saving would equate to between 22 to 32 acute beds per year.

11.3 Based on the past winter's test of change the expanded city-wide Call Before You Convey service could potentially prevent around 2,600 hospital attendances per annum.

11.4 Published evidence notes significant risks to older people associated with (avoidable) attendance or admission to hospital. This includes deconditioning

not directly associated with the presenting medical condition that triggered admission, reduced mobility, muscle wastage, higher risk of falls, confusion due to changes in environment, demotivation, increased risk of incontinence, higher risk of exposure to hospital acquired infection and an increased risk of transfer to a higher level of care placement upon discharge.

11.5 Deconditioning drives increased higher levels of post-discharge care and support from social care, primary care and community services. There are broader system-wide benefits from supporting the person in their own home or care setting.

11.6 Prevention of attendance and admission reduces the risk of delayed discharge; H@H patients typically access fewer diagnostic tests than acute patients; significantly reduced conveyances reduce pressure on SAS resources; care home staff are less likely to spend extended periods supporting residents at A&E.

12. Financial Framework

12.1 In its budget report of 20th March 2024 Glasgow City HSCP identified current H@H expenditure of £1.78M per annum as a saving from the discontinuation of the existing model, of which £1.035M will be delivered in 2024/25.

12.2 This paper proposes a recurring reinvestment of £1.121M to fund the revised H@H and CBYC combined service. The table below summarises how this will be funded.

	£ millions
Removal of District Nursing Vacant Posts	0.764
Care Home Collaborative Funding	0.257
Primary Care Funding	0.100
	1.121

12.3 Recurring funding of £0.764M has been identified from the Glasgow City HSCP District Nursing (DN) budget. This reflects current vacancies which will be redirected to support delivery of the H@H model described in this paper.

12.4 Work is being progressed to plan for the impact on reduced DN funding and to identify options for the DN workforce to effectively utilise the skills and training that they have undergone.

12.5 This work will involve a review of the specification of the service, caseloads, and skill mix. Work will be progressed to support staff who have undertaken or are progressing formal training to support them to enable theory to be put into practice, establish competence, and build confidence.

12.6 A further £0.257M will come from Glasgow City's NRAC (National Resource Allocation Formula) share of the Care Home Collaborative (CHC) funding from the Health Board to support delivery of CBYC.

12.7 This funding has not yet been confirmed as recurring although the Scottish Government has given some indication the CHC funding will continue from 2025/26. A distinct piece of work will be progressed to maximise the synergy between the two elements of service provision and to implement at pace.

12.8 Therefore, there is some financial risk attached to this element of the financial framework.

12.9 In addition, £0.100M of recurring primary care funding has been earmarked whilst the HSCP was recently awarded £0.164M for 2024/25 by Health Improvement Scotland (HIS) on a non-recurring basis to support development of the new approach.

12.10 The total recurring H@H budget will be £1.121M with an additional non-recurring £0.164M in the current financial year.

13. Staffing

13.1 H@H staff will comprise senior clinical decision makers and skilled staff who are able to deliver higher level interventions than currently exists within community; and a multi-disciplinary team who can support patients in their own home or care setting.

13.2 The team will operate within a robust governance structure, working to clear clinical pathways and operating to agreed standard operating procedures.

13.3 The table below highlights the grade and band mix of staff required to deliver the overall service. Any existing H@H staff displaced under this revised model will be subject to redeployment in accordance with NHSGG&C's HR policies.

Band	**Medic**	**7**	**5**	**4**	**5**	**8a**	**3**	**7**	**8B**	**6**	**8A**	**8A**
Staff	GPwSI	AP	Staff Nurse	HCSW	Pharm Tech	Lead ANP	Admin	Team Lead	CSM	NP	Lead Nurse	Lead Pharm
WTE	1.43	4.2	2.6	3	1	0.4	0.8	1	0.5	2	1.0	0.8

- AP – Advanced Practitioner
- HCSW – Health Care Support Worker
- Pharm Tech – Pharmacy Technician
- Lead ANP – Lead Advanced Nurse Practitioner
- CSM – Service Manager (half time with this service and half time with HFRS)
- NP – Nurse Practitioner
- Lead Pharm – Lead Pharmacist /AP
- The recurring cost of these posts is £1.017m and will be met from within the recurring budget of £1.121m (unless, where funding may be a shared resource and funded from another HSCP source/ joint funded)

14. Evaluation/ Review & Monitoring

14.1 There is an established evaluation framework for Hospital at Home looking at how both qualitative and quantitative information is used to maximise use of capacity, develop efficiencies, and deliver higher quality care to patients.

14.2 For both services the ongoing review will include measures around demand, activity, capacity, and queue. In addition, there will be measures around declined activity, throughput, incidents, interventions, visits, diagnostics, attendance, and admission avoidance as well as a wider understanding of benefits to community services from early intervention and management of patients in their own home or care setting.

14.3 All care pathways are subject to formal review to identify opportunities for improvement and efficiencies.

15. Conclusion

15.1 This paper sets out a detailed proposal for the future evolution of the H@H service into a model that broadens the spectrum of care within community nursing. The service will be based on a 11 virtual bed capacity.

15.2 The H@H service will expand its geographical coverage from South Locality and part of North-West to take referrals from all of North-West Locality and from all of North-East Locality for the first time.

15.3 This is intended to increase the occupancy levels of the service that until now have oscillated between 50 to 70 per cent.

15.4 H@H staffing resources will also be deployed to deliver the CBYC model to all 61 care homes in the city. This represents an increase in coverage from the 20% of Glasgow homes that were supported by the service during winter 2023/24.

15.5 This proposal will cement H@H as a community health led service, mainstreamed within the broader spectrum of community health resources.

15.6 It will continue to support patients with higher acuity than are typically supported within community and in so doing will serve the aims of the Transforming (Nursing) Roles ambition to support nursing professionals to develop and use their more advanced skills, knowledge, expertise and clinical judgement.

15.7 In contrast to the existing standalone H@H service, if proven to be successful this mainstreamed approach creates the potential for the model to be scalable beyond the initial 11 virtual bed capacity. That is, there would be the potential to progressively increase the re-direction of mainstream community capacity to support patients with higher acuity.

15.8 Successful delivery of the revised H@H model would bring significant benefits to all stakeholders, especially patients and their families.

15.9 The model has the potential to deliver material economic savings, with defined benefits to GPs, care homes, broader community health services, Scottish Ambulance Service and Acute Services.

15.10 This proposal would support Glasgow City HSCP's budget sustainability by delivering the proposed £1.78M per annum saving.

15.11 If approved by the IJB at its extraordinary meeting on 28 August, this revised service model would go live on 8 November 2024.

16. Recommendations

16.1 The Integration Joint Board is asked to:

a) Approve the discontinuation of the existing hospital at home model from 8th November 2024;
b) Approve the transition to the successor hospital at home service from 8th November 2024; and
c) Note the associated saving of £1.78 million attached to this transition.

Direction from the Glasgow City Integration Joint Board

1	**Reference number**	280824-8
2	**Report Title**	Hospital at Home Model
3	**Date direction issued by Integration Joint Board**	28 August 2024
4	**Date from which direction takes effect**	28 August 2024
5	**Direction to:**	NHS Greater Glasgow and Clyde
6	**Does this direction supersede, revise or revoke a previous direction – if yes, include the reference number(s)**	No
7	**Functions covered by direction**	Budget 2024-25
8	**Full text of direction**	NHS Greater Glasgow and Clyde is directed to implement the savings of £1.178m by discontinuing the current Hospital at Home model from 8 November 2024, and implement the revised Hospital at Home and Call Before You Convey combined service as outlined in this report.
9	**Budget allocated by Integration Joint Board to carry out direction**	The budget for 2024-25 is as delegated to NHS Greater Glasgow and Clyde and Glasgow City Council in the March IJB Report. Funding for the revised Hospital at Home and Call Before You Convey combined service is detailed in para 12.2 of this report.
10	**Performance monitoring arrangements**	In line with the agreed Performance Management Framework of the Glasgow City Integration Joint Board and the Glasgow City Health and Social Care Partnership.
11	**Date direction will be reviewed**	1 April 2025