NHS Greater Glasgow and Clyde

Greater Glasgow and Clyde NHS Board

Director of Planning and Policy **20 December 2016** **Paper No16/71**

Recommendation: The Board approves this paper as the basis to:-

- Radically reshape the delivery of acute services across NHS Greater Glasgow and Clyde.
- Establish the detailed programmes of clinical service planning required to deliver the transformation described;
- Establish the required implementation arrangements;
- Deliver extensive internal and external communication;

Transforming the Delivery of Acute Services

1. CONTEXT

1.1 The attached paper sets out why we need to transform the delivery of acute services in NHS Greater Glasgow and Clyde to continue to deliver the highest quality of care to patients over the short, medium and longer term.

1.2 The paper is written in the context of the National Clinical Strategy which establishes a clear direction for service change and is set out in the following sections:-

- **Purpose and context**
- **Why do services need to change**
- **Population Health**.
- **Shifting the balance of care: demand for acute care**.
- **A new system of care**.
- **Resources for acute care**.
- **Implications for Hospital Services and Sites**.
- **Public engagement**.
- **Conclusion.**

1.1 The paper is intended to deliver the following objectives:-

- Ensuring the short term service changes which the Board needs to make for 2017/18 are set in the context of clarity on the medium to long term direction.
- Enabling the early establishment of the staff engagement framework and communication which is critical to short and medium term detailed planning.
- Enabling the early establishment of the required public and patient engagement which is the precursor to due process on detailed changes.
- Enabling the development and delivery of an external communications programme.
- Ensuring our detailed service change proposals are able to be shaped by public and patient engagement.
- Moving the Board away from the recent approach where our engagement is about single service changes.
- Providing the platform to link service, financial and workforce planning.
- Establishing a position for engagement with the developing architecture of regional and national planning.

This paper is not the material which would be used for pubic and patient engagement. It provides a basis for documentation fit for that purpose to be developed, at a whole Board level and for each geographic and service area.

1.2 HSCPs are critical to the development and delivery of acute services change. This paper sets the acute service changes, for which the Board will lead planning and implementation, in the context of the radical change which is required across to transform the whole system of health and social care, for which IJBs have a critical leadership role. This covering paper highlights the need for that wider transformation to come together across the whole health and social care system.

2. IMPLEMENTATION ARRANGEMENTS.

2.1 The delivery of this programme of service transformation will need robust development and implementation arrangements to shape how we use our resources and expertise in clinical and managerial leadership, public health, intelligence, planning, financial, communication, workforce and engagement. We also need to assess the additional skills and resources which are required. Effective programme arrangements need to be established for the Board's responsibilities and with HSCPs which interdigitate with or reshape our existing management processes and governance arrangements. This rest of this section describes, at headline level, the most immediately critical areas of activity.

2.2 Staff Engagement and Communication

A critical element of the programme is a detailed and sophisticated engagement and communication programme with staff, operating at a range of different levels. The communication needs to include:

- Clear and consistent messaging which continuously relates back to Transforming Delivery of Acute services (TDAS) in communicating on short term change and financial issues.
- Targeted information for key groups including senior clinical staff; clinical advisory structures and staff partnership representatives.
- Supporting Directors with tailored communication for their areas of responsibility.

The engagement element needs to include:

- Refreshing the team briefing arrangements to make sure they enable upward feedback as well as downward messaging.
- Refreshing the FTFT programme to offer all staff clear opportunities to engage with the programme and contribute positively to shaping and delivery.
- Engaging the Acute Partnership Forum in regular briefings and in shaping service change.

The Director of Corporate Communications is planning the initial staff communication to coincide with the December Board. The programme will build on the Acute Division's Staff Engagement Framework which complements the Boards Managing Workforce Change Policy to ensure that appropriate levels of staff engagement occur at appropriate stages of the transformational programme.

2.3 Media Relations

In addition to the public and patient engagement, a critical strand of activity to go live around the Board meeting is a comprehensive plan for media engagement. The Director of Corporate Communications is leading the development of this planning.

2.4 Public and Patient Engagement

There are a number of distinct elements to the public and patient engagement process which need to be developed into a much more detailed plan, continuously updated and

reviewed. A critical first phase is the launch of TDAS in the new year, planning needs to start now for this including:

- Development of launch material for wide distribution.
- Early web based material and potential for active engagement.
- Coordination with HSCPs communication activity.
- Planning a series of engagement events across the Board area.

A second phase will be developing a sophisticated suite of material about specific clinical models and about specific sites and the related extensive engagement required.

2.5 Political Engagement: HSCPs and MSPs

We need to establish early briefing for MSPs and we should ask the HSCPs to plan similar briefing for Councillors. A major issue in relation to that communication is the extent to which the national clinical strategy becomes more prominent and how the financial challenges across public services become more apparent.

2.6 Developing Detailed Clinical Service Plans and Change Programmes

We have a number of clinical services change plans at different stages of development. A core part of this programme will be to establish a single, detailed, consistent and comprehensive clinical service plan, including plans for each of our sites. That clinical service planning will require significant clinical time and a range of support to deliver the detailed plans required. This work needs to be synchronised with HSCPs planning and we need to review our current planning arrangements with HSCPs to ensure assess their durability for this critical element of the transformation programme

2.7 Governance arrangements

It is proposed that the Board Acute Services Committee will provide oversight of the transformation programme.

2.8 Wider transformation

In addition to developing the arrangements to transform acute services the full Board needs arrangements to develop a picture of what the complete range of health and social care services and wider NHS responsibilities might look like from 2020 onwards. This vision of the future will need to pull together all the national and local plans and strategies that are being developed to support the triple aims of:-

- improving the health of the people of Scotland,
- improving the quality of healthcare, and
- achieving value and financial sustainability.

2.9 The Board needs to adopt an approach that brings together, in a coherent whole, for Board consideration, the implementation of a Public Health strategy with the transformation of acute services, the Mental Health Strategy, the Cancer Strategy, the six HSCP strategic plans, and the 23 initiatives included in the NHS Scotland Transformational Change Programme.

2.10 Alongside the development of the programme arrangements for acute services we will establish a programme approach to this wider transformation challenge with the full Board providing governance.

TRANSFORMING THE DELIVERY OF ACUTE SERVICES

2. PURPOSE AND CONTEXT

2.1 This paper sets out why we need to transform the delivery of acute services in NHS Greater Glasgow and Clyde to continue to deliver the highest quality of care to patients over the next few years.

2.2 This paper is written in the context of the National Clinical Strategy. The Strategy, published in February 2016, sets out a framework for the development of health services across Scotland for the next 10-15 years. Key points from the strategy include:-

- *Where clinically appropriate we will continue to plan and deliver services at a local level. Where there is evidence that better outcomes could only be reliably and sustainably produced by planning services on a regional or national level, we will respond to this evidence to secure the best possible outcomes.*
- *We need to increase the shift of work from acute hospitals services to primary care, and we need to ensure that we benefit from integration of health and social care, with particular emphasis on an anticipatory approach to those at risk of avoidable hospital admission, the development of flexible alternatives to hospital admission to reduce those avoidable admissions, and the prompt discharge of patients from hospital care.*
- *In primary care we need to build capacity and provide a more broadly based mix of professionals based around practices.*
- *In secondary and tertiary care the case for redesign of services is clear and compelling. Clinical teams who provide complex and high-tech services more often get better outcomes for their patients. We must review services, specialty by specialty, considering the potential for developing fewer inpatient sites that will provide more highly specialised services, linked into local hospitals which will provide a comprehensive range of outpatients, diagnostics and day case surgery. In addition, local hospitals will need to provide suitable primary emergency treatment for all conditions, with some patients referred, as now, via clinically agreed pathways, to larger centres for specialist care.*
- *These changes are complex, and require consideration of workforce resources, potential outcomes, inter-relationships between specialties, and finance. It will require careful yet thorough conversations with the public and their representatives. However, failure to change will limit the potential to build on world-class standards of care.*

2.3 Reflecting that National direction this paper also sets out how this transformation will integrate with the planning and delivery of community and primary health and social care services to change and improve the care delivered to our population.

2.4 The overriding objective which frames the delivery of services is the Board's purpose which is to:

"***Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities."***

2.5 The primary focus of this paper is the delivery of clinical services and how they can be organised to deliver the best possible outcomes for patients, but it is important to restate that the Board remains committed to improving the health of our population, by the development of actions, in concert with our partners, to address the determinants of poor health - poverty, lifestyle, educational, economic, employment, and environmental. The paper describes the important public and population health issues which are the context within which we need to transform our services.

2.6 The development of a longer term plan for acute services has a number of purposes:-

- Sets the service changes which we need to make in the short term in the context of longer term change. This is particularly important to establish engagement with patients and the public; this theme is amplified in a later section of this paper.
- Enables development of plans for each of our sites and longer term capital investment priorities.
- Enables planning with HSCPs for the changes to their primary care, community health and social care services which need to be synchronised with changing acute services.
- Ensures that we have affordable, productive and efficient acute services, and that, across the Board and IJB responsibilities, there is a financial framework which integrates with and underpins the whole system of health and social care.

2.7 The paper has the following sections:

- **Why do services need to change?**
- **Population Health.**
- **Shifting the balance of care: demand for acute care.**
- **A new system of care.**
- **Resources for acute care.**
- **Implications for Hospital Services and Sites.**
- **Public engagement.**
- **Conclusion.**

3. WHY DO SERVICES NEED TO CHANGE?

3.1 There are a number of reasons why services need to change. Through dialogue with clinical staff and patient and public engagement we have identified a series of drivers for change which underpin the rest of this paper. These reflect and amplify the direction provided by the National Clinical Strategy, they are:

- **Population health:** the health needs of our population are significant and changing. This paper describes why we cannot meet the needs of our population by continuing to deliver care in the same way.

- **Prevention and early intervention:** we know people want to stay healthy. We need to do more to prevent disease through addressing the determinants of health and supporting healthy lifestyles. We also need to better support people to manage their own health and prevent crisis. Inadequate focus on prevention and support for people at an early stage in their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages of illness. Prioritising development of resources for preventative and anticipatory care and for primary care and community services is essential to address these issues.

- **Shifting the balance of care:** we provide more acute care to people who live in Greater Glasgow and Clyde than in the rest of Scotland and comparable parts of the UK. We must redesign services to deliver more care in the communities close to people's homes. We need to do more to make sure that care is always provided in the most appropriate setting and to address the growing pressure on primary care and community services. The objective is to deliver more care at home or in a homely setting; admitting people to hospital only where there is no alternative way to deliver care and achieving the most rapid clinically appropriate discharge. The growing complexity of need, including multi morbidity and a wide range of care and support needs, mean that patients and carers can feel inadequately supported and services can feel complex and fragmented if we do not get local care and coordination right.

- **Clinical quality and service delivery:** healthcare is changing and we need to keep pace with best practice and standards. We need to provide the highest quality specialist care. This poses significant challenges to the way we deliver health services. Aiming to deliver care as locally as possible but balancing local delivery with clinical quality, productivity and efficiency.

- **Populations required for acute services:** there is increasing clinical agreement and evidence that the populations required to organise the full range of acute services will be higher than at present. This means that we need to review all of our acute services and assess how we can balance patient access and the need for larger services

- **Resources:** there are real pressures on the resources available to provide health and social care and we need to ensure that our services are organised to deliver value for money and achieve the highest level of care for our patients within the resources we have available.

- **Workforce:** workforce challenges have amplified in the last few years and we need to plan for a different workforce and less staff working in acute services with more staff in HSCP services, including specialist staff who might previously have worked in hospitals. We also need to shape and support our workforce to meet future changes.

- **Primary care:** developing the services provided by GPs will be a critical part of reshaping our system of care. The pressures on GP services have continued to increase, there is clarity that investment in and different ways of delivering those

services need to be delivered, including more integrated working between GPs and wider community teams. The Scottish Government has committed to major additional funding for the GP contract from within the current health allocation. We welcome that commitment and need to plan for the changes to acute services to release those resources.

- **Funding:** there is a substantial gap between the resource which will be available in future years and the growth in costs of NHS services across Scotland. This transformation approach and our shorter term plans, need to deliver high quality care at reduced cost. We need to express a realistic financial framework for acute services, which will be substantially less than the Board currently spends on acute care. This is the only way in which we can ensure that the increased primary and community care services can be funded within the overall resources. The risk if this is not achieved is that more and more people are treated in an unaffordable acute hospital model when their needs would be better met in their local HSCP services.

- **Capital funding:** capital funding is seriously constrained for the foreseeable future, so our planning needs to be realistic about delivering service change, at least in the medium term with limited capital investment and, in the longer term, have a tight focus on the most important clinical priorities. In recent years we have transformed both our hospital and community estate, going forward, shifting the balance of care means we need to focus investment in community facilities.

3.2 These drivers for change tell us that we need to improve outcomes by organising and delivering services differently to prevent ill health in the first place, to support patients with multiple conditions more effectively and to enable older people to live more independently.

3.3 We also need to change our hospitals to ensure that high quality care is consistently available, that there is timely access for all patients to specialist care with round the clock access to specialised emergency care. This paper sets out how services will be shaped in the medium and longer term and provides the framework for service changes which we need to make in the shorter term, between 2017 to 2019, which will enable us to make progress in this direction.

3.4 The drivers for change we have set out reflect the Government vision for healthcare in Scotland which has been restated through the National Clinical Strategy.

"Our vision is that by 2020 everyone is able to live longer healthier lives at home or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back to their home or community environment as soon as appropriate, with minimal risk of re-admission."

3.5 The National vision statement also acknowledges that:

- Health and social care services are facing a rising tide of demand driven by demographic changes, advancing medical science and new technologies, at a time of constrained resources.
- As people live longer, healthy life expectancy is not advancing at the same pace. This means that we will have more people, many of whom are older, living with multiple long-term conditions and often complex needs, more reliant on support and intervention from health and social care services.

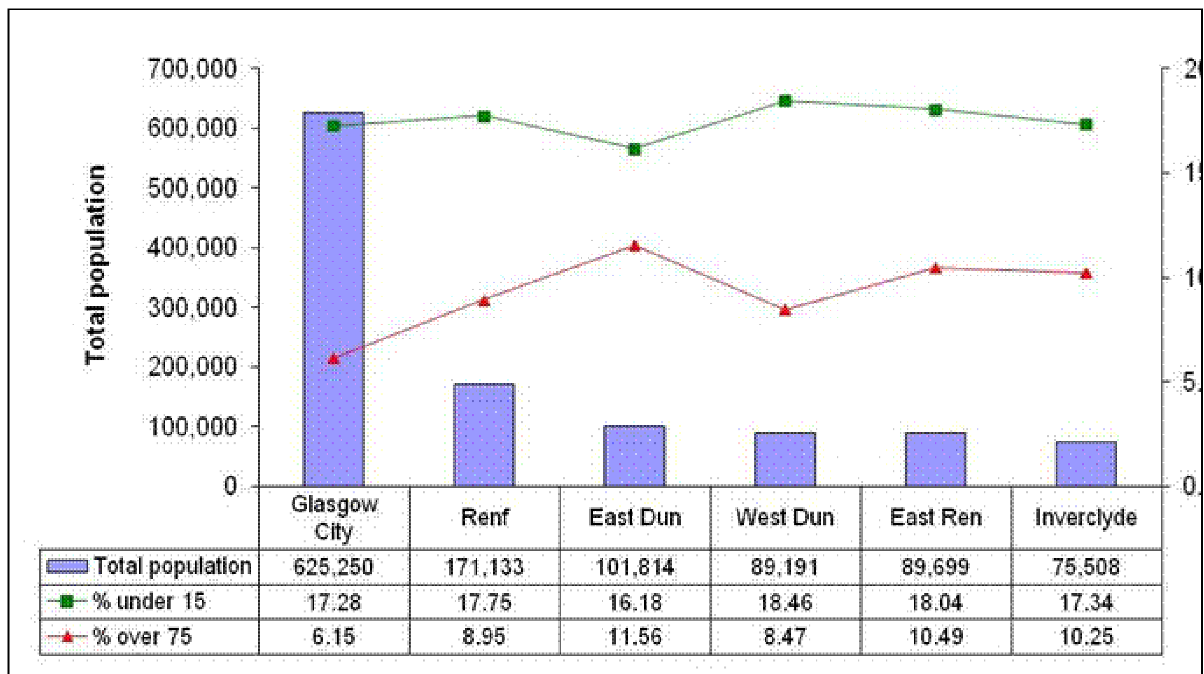
- This means we need to change our approach by shifting the balance of care away from acute hospital-focused care to one where there is a greater emphasis on prevention and community-based intervention.

4. POPULATION HEALTH:

4.1 The Population of NHSGGC: Demographics

Our population is relatively young compared to other parts of Scotland, although this varies significantly between local authority areas. Women predominate in the older age groups.

Figure 1: The Population of NHSGGC, Demographics



The population of the NHS Greater Glasgow and Clyde area in 2010 was 1,203,870. This population is expected to increase overall by 2.4% by 2020.

Table 1: Population of NHSGGC 2010-2025

Age Group	Population 2010	Population 2015	% Change by 2015	Population 2020	% Change by 2020	Population 2025	% Change by 2025
0-14	**194,562**	197,268	1.4	202,876	4.3	199.911	2.7
15-24	**166,320**	150,265	-9.7	137,743	-17.2	139,286	-16.3
25-34	**176,434**	193,672	9.8	184,614	4.6	166,623	-5.6
35-44	**167,002**	156,647	-6.2	172,422	3.2	187,458	12.2
45-54	**177,130**	177,566	0.2	159,827	-9.8	149,426	-15.6
55-64	**136,201**	147,198	8.1	164.852	21.0	165,878	21.8
65 & over	**186,221**	197,206	5.9	210,174	12.9	233,297	25.3
All Ages	**1,203,870**	**1,219,822**	**1.3**	**1,232,508**	**2.4**	**1,241,879**	**3.2**

During this time, the age profile of the population will continue to change. In common with much of Scotland, in most areas there will be a steep rise in the numbers and proportion of older people. The over 65 population will increase by 12.9% by 2020. This will impact differently across Greater Glasgow and Clyde with areas like East Dunbartonshire and East Renfrewshire already experiencing significant rises in numbers of older people, whilst

Glasgow City is projected to see a short term decline in the numbers of older people, before following the same longer term trends. A small increase in the number of children together with a larger decrease in the number of people aged 15-29 will result in an overall reduction in the 0-19 age group.

It is a population with high levels of deprivation compared to the rest of Scotland. 30.4% of people in NHS Greater Glasgow and Clyde live in the 15% most deprived data zones (Scottish Index of Multiple Deprivation). This ranges from 3.1% in East Dunbartonshire, to over 50% North and East Glasgow.

Summary of key trends:

- The **top 10 causes of death** in Scotland account for 44% of all deaths. Each of the causes of death are amenable to prevention by not smoking; being a healthy weight; being physically active; drinking within recommended levels of alcohol and maintaining a healthy diet. Tackling these issues is a major part of our public health challenge.

- **Population projections** estimate that Glasgow City is due to have a modest rise in population to 2033, whereas, all other local authorities in NHSGGC will have a decrease in population. This will be most marked in Inverclyde and East Dunbartonshire.

- **Our population is ageing**. Between 1911 and 2008 there has been an increase in the number of people aged over 65 years in Scotland of 221%. However, NHSGGC is ageing at a markedly slower rate than the rest of Scotland on account of age specific death rates.

- There are **wide variations within NHSGGC**. East Dunbartonshire experienced a 47% increase in people aged 65+ and Glasgow city a 25% decline between 1982 and 2007.
- **Forecasts predict the under 50's will shrink** from 70% in 2008 to 62% in 2033; whereas the over 50's will expand from 30% to 38%. The biggest increase is expected in the over 65's age group.

- **Dependency ratios are due to increase** to 2040 across NHSGGC. Within NHSGGC there are marked variations. Current dependency ratios vary from 44% in Glasgow City to 60% in East Renfrewshire by 2031 these are predicted to increase to 51% in Glasgow City to 91% in East Dunbartonshire and 89% in East Renfrewshire. A male born in East Glasgow can expect to live in a healthy state for 15 years less than a male born in East Dunbartonshire.

- **Older single person households are expected to increase**. It is anticipated these will account for 54% of households by 2031. We know this will be a major challenge for the delivery of health and social care services.

- Life expectancy and healthy life expectancy is lower in NHSGGC than the rest of Scotland. People living in NHSGGC can expect to have the **longest period of unhealthy life at 10.5 years.**

- Aging is associated with an **increased incidence of long term conditions** and chronic disease.

- There will be a significant growth in the **numbers of people with dementia** as the population ages. There will be an estimated 18% increase in dementia in GGC by 2020. One in three people aged over 65 will die with a form of dementia and one in four hospital inpatients will have dementia.

In recent years across NHSGGC, there have been some significant improvements in health. Overall life expectancy has risen; rates of premature mortality have fallen, with particular improvements for Coronary Heart Disease. Cancer survival has improved significantly across a range of cancers. However, there remain many significant health challenges and marked inequality across NHS Greater Glasgow and Clyde. Overall, average life expectancy in NHS Greater Glasgow and Clyde is well below the Scottish average. Again, there is considerable variation between different parts of NHS Greater Glasgow and Clyde. Table 2 sets out this information in detail.

Healthy life expectancy in NHS Greater Glasgow and Clyde is even lower compared to the Scottish average. People in NHS Greater Glasgow and Clyde live for many years in ill health, with the consequent impact on quality of life, economic and societal contribution and need for services. Over the past 10 years, the gap in healthy life expectancy between the 20% most deprived and the 20% least deprived areas has increased from 8 to 13 years.

Table 2: Life Expectancy at Birth by Gender 2007-2009
Source: NRS (formerly GRO(S))

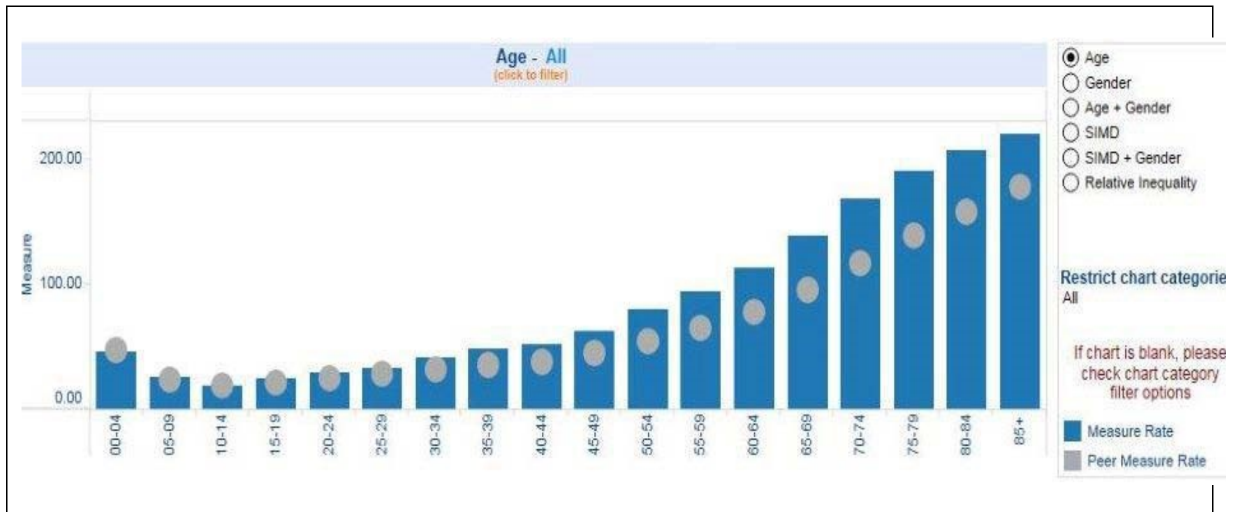
CH(C)P	Male	Female
Glasgow City	71.1	77.5
East Dunbartonshire	78.3	83.1
East Renfrewshire	77.8	82
Renfrewshire	73.7	79.2
Inverclyde	73.1	79
West Dunbartonshire	72.5	78.4
NHSGGC	**73.1**	**78.9**
Scotland	**75.4**	**80.1**

5. SHIFTING THE BALANCE OF CARE: DEMAND FOR ACUTE HEALTHCARE

5.1 A critical factor to deliver this transformation is to shift the balance of care by changing demand for acute care. The material set out in the rest of this section illustrates the extent to which our population uses more acute care than the rest of Scotland and also the extent to which our current acute services are providing care to patients who could be more appropriately receive care in other settings.

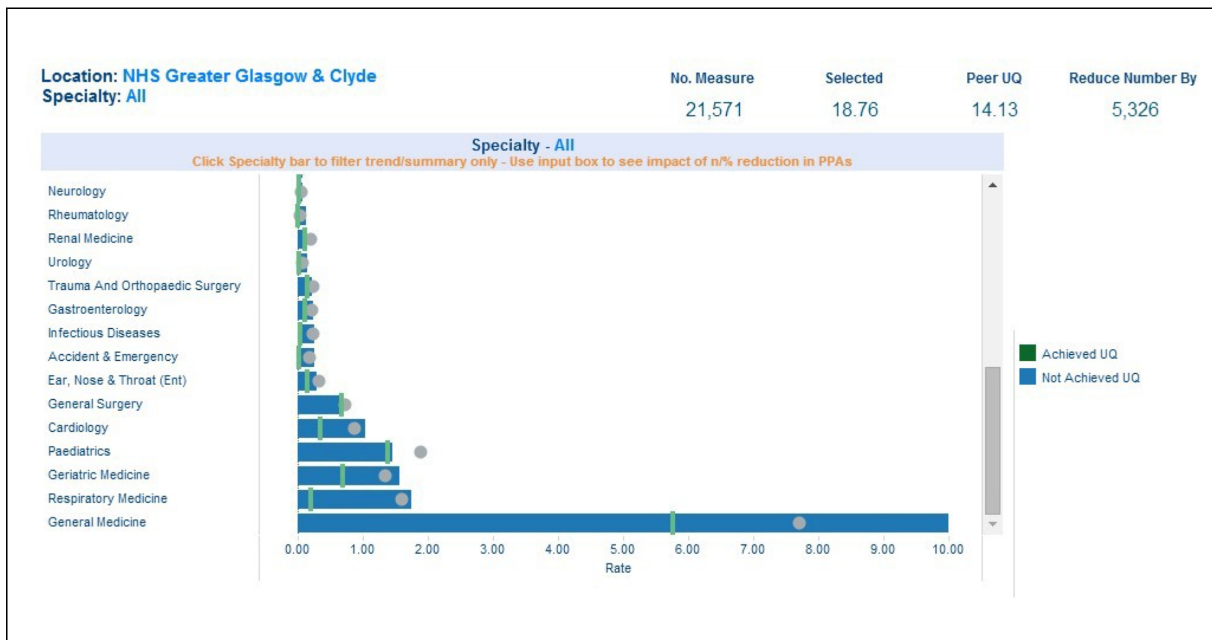
5.2 Section 5 goes on to set out how we intend to develop a different system of care so that we can reduce demand and make the required shift.

Figure 2: Admission per 1000 Population Resident from April – June 2016
NHSGGC - Admission Condition and Type – All



5.3 Figure 2 shows the admission rate per 1,000 population resident in NHS Greater Glasgow and Clyde (blue bar and line) is higher compared to the admission rate per 1,000 population among our peers (gray dot and line) for all age groups with the exception of zero to four year olds.

Figure 3: NHSGGC All Specialties

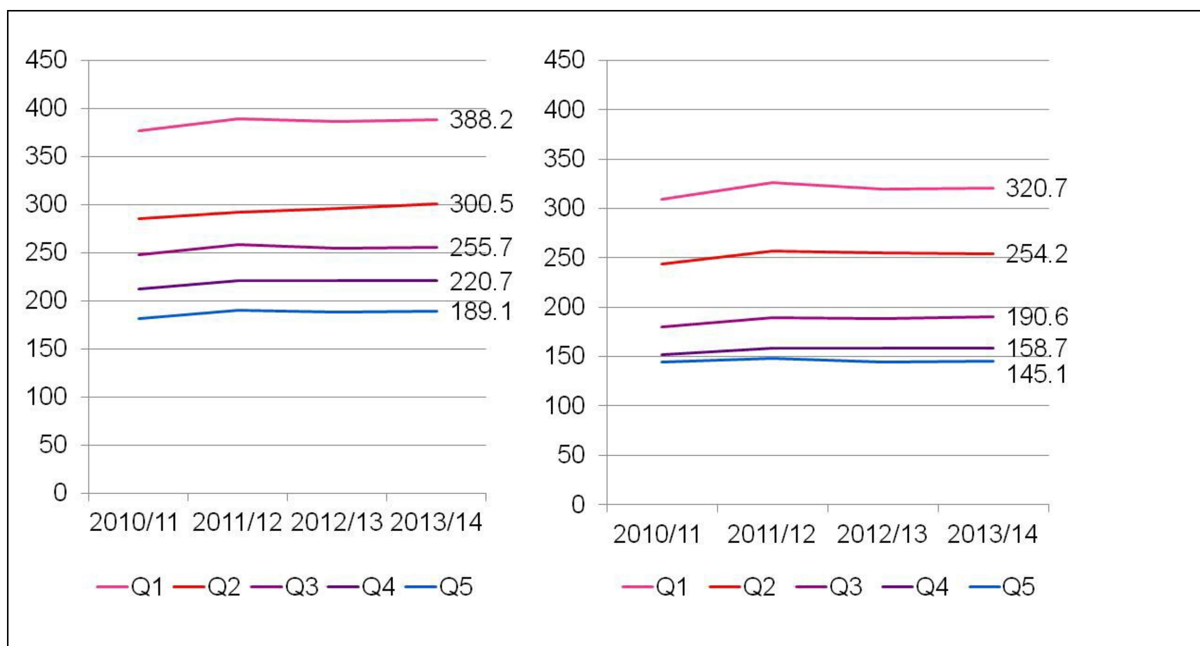


5.4 Figure 3 shows the rate of PPA (number of potentially preventable admissions per 1,000 population) by speciality and the summary for all specialities; The blue bar and line are the rate for NHSGGC; the gray dot and line are the rate for our peers (across Scotland) and the green line represents the upper quartile (UQ) of the peer's rate.

We estimate that during 2015 there were 21,581 potentially preventable admissions across all specialities, giving a rate of 18.77 per 1,000 population. Had our rate been 14.16 per 1,000 we would have had 5,297 fewer admissions.

The calculation can be done for each speciality: in general medicine we would have had 4,745 fewer admissions and in respiratory medicine we would have had 1,781 fewer admissions in 2015.

Figure 4: European Age Sex Standardised Attendance rate (per 1,000) to EDs in a patient's Health Board of Residence by SIMD and Health Board of Treatment (Financial Years 2010/11 to 2013/14)



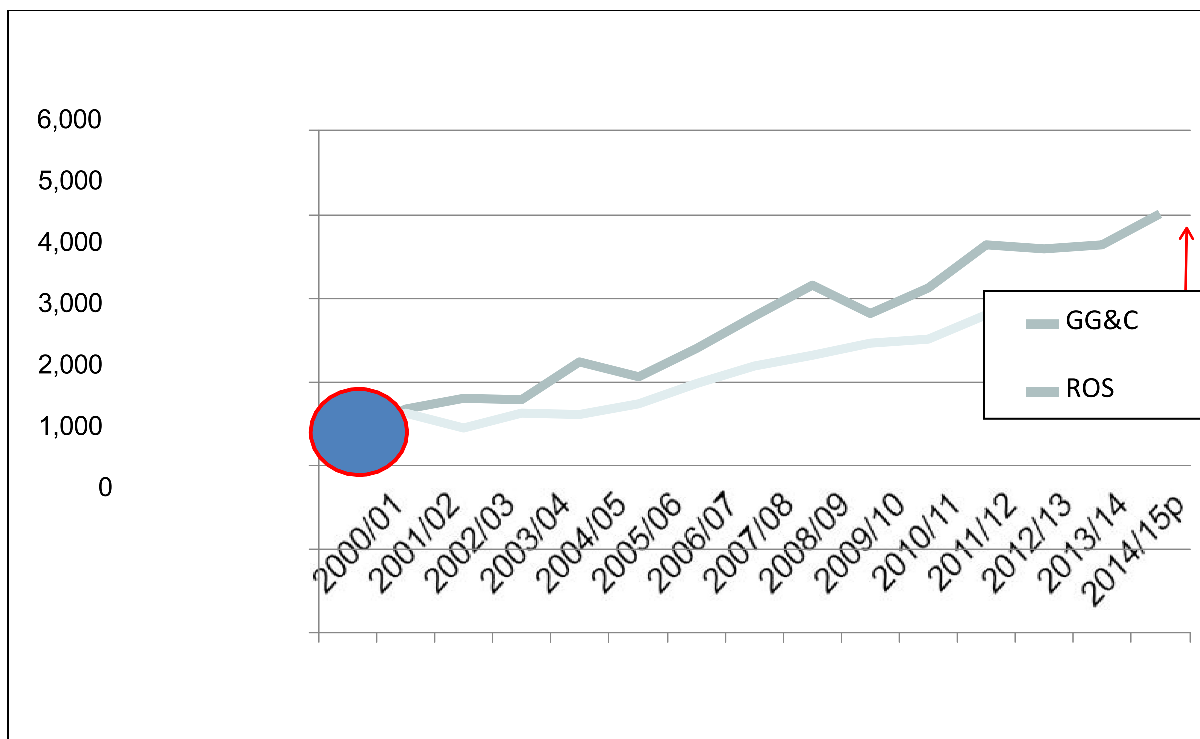
5.5 Figure 4 indicates that NHS Greater Glasgow and Clyde residents have higher attendance rates to emergency departments (left side of figure above) compared to the rest of Scotland residents (right side of figure) for all levels of social deprivation. The analysis using Europe as the standard population provides evidence that there is a strong social gradient in both NHSGGC and the rest of Scotland in attendance and that all the quintiles in NHSGGC are experiencing considerable excesses in attendance compared to the equivalent quintile in the rest of Scotland, including the most privileged, quintile 5.

5.6 For NHSGGC residents these are standardised for age, sex and deprivation, using the rest of Scotland as the standard population. This activity does not include the incoming cross boundary flow of patients (both elective and emergency. The red dashed line indicates that the contour of the line is higher for 2011/12 and 2012/13 than it appears because of the failure to record GRI AAU short stays for those two fiscal years.

Differences between NHSGGC standardised admission rates and the rest of Scotland crude rate cannot be attributed to differences with respect to age, sex or deprivation between the two populations and any excess is due to some other factor, including possibly over-provision of supply. The fact that the red line for NHSGGC is well above the blue line for the rest of Scotland confirms the excess activity in NHSGGC cannot be attributed to the basic variables for which standardisation has been carried out.

The fact that the green line for NHSGGC and the blue line for the rest of Scotland converge in recent years is encouraging and desirable; NHSGGC's activity for its residents should be similar to that of the rest of Scotland once these variables are adjusted for. The divergence seen in the red line for NHSGGC suggests that the availability of AAU beds has driven up activity to levels not experienced in the Rest of Scotland.

Figure 5: Multiple Emergency (3+) admission patients aged 85 yrs who are residents of NHSGGC vs Rest of Scotland: Crude rates per 100,000, 2000/1 to 2014/15
Source: ISD Scotland



5.7 Figure 5 illustrates that NHSGGC experienced a marked rise in crude rates of multiple emergency admission among patients aged over 85 after 2005/6, considerably more than in the Rest of Scotland despite the fact that the Rest of Scotland is demographically considerably older than NHSGGC. This suggests that a major factor in the steep rise in emergency admissions in NHSGGC was due to a steep rise in multiple emergency admissions in the very elderly. The difference suggests that the services required in the community like that of a general practitioner, a district nurse, social services for the elderly of a range of types, palliative care, respite care for their carers NHSGGC are less available.

Table 3: Activity Rates in NHSGGC and Scotland (All Specialties)

Type of Activity	Crude Rate per 10,000		Standardised Ratio (%)
	NHSGGC	Scotland	
Day-cases	1,289	941	135.5
Elective in-patient admissions	309	270	115.2
Emergency in-patient admissions	941	828	107.9
In-patient bed days	9,784	8,796	110

5.8 Table 3 shows that the standardised ratio for day-cases was 135.5%. This means that the level of day-case activity was 35% greater in the population of NHSGGC than in Scotland and that this could not be accounted for by demographic differences.

The standardised ratio for elective in-patient admissions was 115.2%. This means that the level of elective admission was about 15% greater in the population of NHSGGC than in Scotland and that this could not be accounted for by demographic differences.

The standardised ratio for emergency in-patient admissions was 107.9%. This means that the level of day-case activity was about 8% greater in the population of NHSGGC than in Scotland and that this could not be accounted for by demographic differences.

The standardised ratio for emergency in-patient admission was 110.0%. This means that the level of consumption of in-patient bed-days was about 10% greater in the population of NHSGGC than in Scotland and that this could not be accounted for by demographic differences.

The excess (or deficit) in bed-days can be expressed as a notional number of beds by assuming an occupancy rate of 85%. Overall, the excess in bed-days corresponded to an excess of about 329 in-patient beds (Table 4).

Table 4: In-patient Bed-day Rates in NHSGGC and Scotland

Type of Activity	
Actual inpatient bed-days	1,117,889
Predicted inpatient bed-days	1,015,839
Difference in inpatient bed-days	102,050
Beds	329

5.9 Figure 6 shows data from ISD Scotland on Quality Outcome Measure 10 – the percentage of the last six months of life spent at home or in a community setting by health board. This measure is used to chart progress made by boards towards implementation of the national "Living and Dying Well action plan". This particular measure was chosen as a proxy for the preferred place of death as no data are recorded for the latter. It should be noted that this is a broad measure that includes people who died from causes that may not have required palliative care services, e.g. heart attacks. However, patients who died from external causes, e.g. unintentional injuries, were excluded.

The figure shows that there is variation by health board in this measure. NHSGGC has the second lowest percentage of time spent at home or in a community setting in the last six months of life. This measure is crude and does not include any correction for demographic differences.

This information can be used to make an estimate of the potential reduction in bed days (Table 5) and beds that could occur if NHSGGC were to reduce inpatient hospital stays towards the end of life, for example, by increasing community palliative care services.

Figure 6: Quality outcome measure 10: Percentage of last six months of life spent at home or in a community setting by health board, 2014/15(Source: ISD)

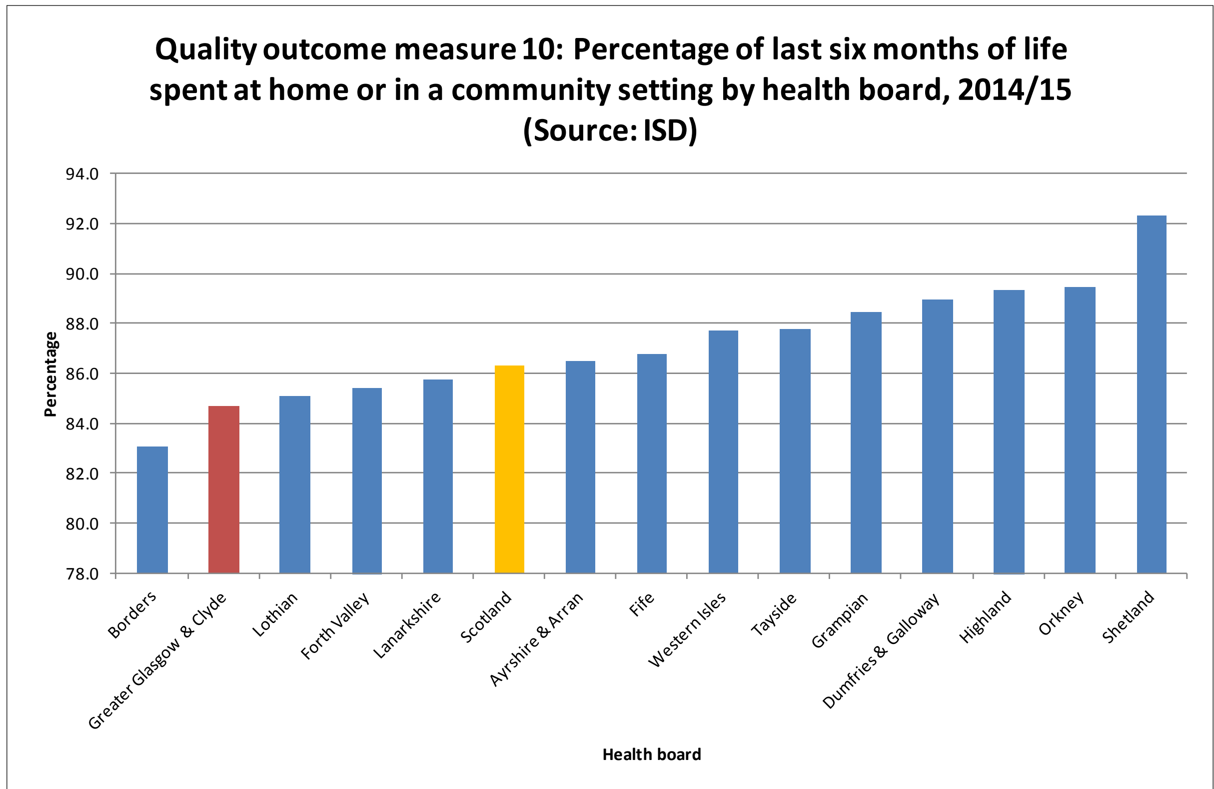


Table 5: Estimate of potential reduction in bed days: NHSGGC vs NHS Tayside

Number of deaths in NHSGGC 2014/15	11,929
Total bed days in hospital in the 6 months prior to death for those people who died within 2014/15	333,154
Total possible bed days (if all people who died spent all of final 6 months of life in hospital)	2,177,043
Average % of time spent in hospital in last 6 months of life in NHSGGC	15.3%
Average % of time spent in hospital in last 6 months of life in NHS Tayside	12.2%
If % in NHSGGC was same as in NHS Tayside...	
Potential reduction in bed days in hospital in the 6 months prior to death	67,307
Potential reduction in beds (adjusted for an 85% occupancy rate)	217

5.10 The calculation outlined above was carried out by multiplying the percentage of time spent in hospital seen in NHS Tayside with the total possible bed days seen in NHSGGC to calculate the number of bed days that would have theoretically been used in NHSGGC. This was then subtracted from the number of bed days that were actually used in NHSGGC. We estimate that 67,307 bed days and 217 beds could be reduced over a year period.

Table 6: Estimated numbers of in-patient beds accounted for by admissions from Care Homes

Partnership	Calculated Beds
East Dunbartonshire	9.0
North East Glasgow	21.9
North West Glasgow	22.7
South Glasgow	18.3
West Dunbartonshire	7.5
East Renfrewshire	6.3
Renfrewshire	11.1
Inverclyde	6.1
Total	**103**

5.11 Table 6 shows estimated numbers of in-patient beds accounted for by admisions from Care Homes. In the year 2015, there were 3,421 emergency admissions to hospital of patents resident in care homes. These patients accounted for 31,951 occupied in-patient bed-days. Assuming an average occupancy level of 85%, this would correspond approximately to about 103 in-patient beds.

Figure 7: UK Day of Care Survey 2012/13 (QuEST)

Table 2. Top three reasons patients were not discharged split by in-hospital/out-of-hospital, for all patients not meeting the Day-of-Care Survey criteria.

Reason not discharged	Number of patients
In-hospital	
Awaiting consultant decision/review	103
Waiting for allied health professional assessment/ treatment	95
Awaiting procedure/investigation/results and not meeting criteria for acute care	64
Total	**262**
Out-of-hospital	
Awaiting community hospital bed	97
Home care support availability/funding	72
Awaiting social work allocation/assessment/ completion of assessment	59
Total	**228**

- The older the patients were, the less likely they were to meet the criteria for acute care.
- The proportion of patients not meeting the criteria increased with length of stay.
- Findings mirrored in RAH survey 2014 and 2015

Table 7: NHSGGC acute beds estimated change with application of Day of Care criteria

NHSGGC Acute beds	Beds			Beds reduction		
	Care of the elderly	Non care of the elderly	Total	Care of the elderly	Non care of the elderly	Total
Current	1344	3633	4977			
50% change	1008	3372	4380	336	261	597
25% change	1176	3502	4678	168	131	299

5.12 Outcomes from Day of Care Survey

- 24% of all acute bed days do not meet acute hospital criteria.
- 50% of bed days in care of the elderly wards do not meet acute hospital criteria (many of these patients would require alternative provision for rehabilitation).
- 10-15% of bed days in non care of the elderly wards do not meet acute hospital criteria.

5.13 In addition these demand examples we have substantially improved delays for patients who need HSCP services to be discharged from acute care but at on any day there will still be around 100 patients in acute hospitals ready for discharge

5.14 We can also cite a number of examples where improving the quality of clinical care would improve patient outcomes and reduce the time spent in hospital; these examples include stroke services and services for patients with heart failure.

5.15 The more detailed, later, sections of this strategy describe how we can change the system of care to reduce demand for acute care and what changes that will mean for the current pattern of services.

5.16 In addtion to this local analysis, the National Clinical strategy has an important theme about realistic medicine and an important part of implementing this strategy as is considering the application of the Medical Royal Colleges “ Choosing Wisely” policy document.

6. A NEW SYSTEM OF CARE

6.1 This section describes the new system and services which are needed to shift the balance of care away from treatment in hospitals, to enable people to be looked after at home or in homely settings. Critical to delivering the transformation of our acute services is change across the whole system of care.

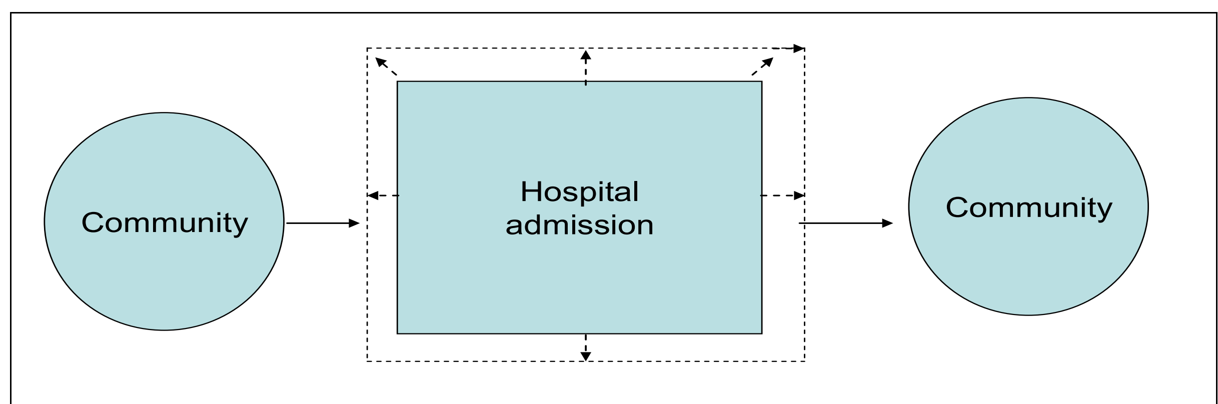
6.2 Integration Joint Boards are now fully in place, four issues are significant in that regard, IJBs are:-

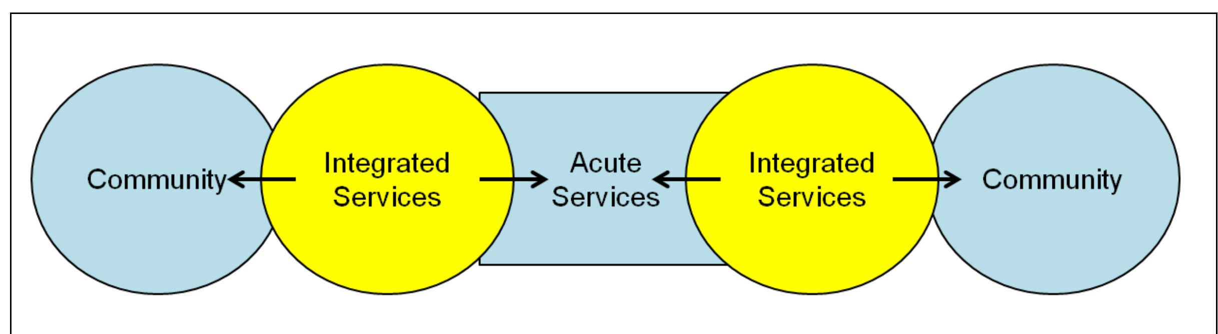
- Developing their commissioning intentions for their acute service responsibilities, these intentions need to direct and enable the reduction in demand for acute care by delivering new and accessible community services.
- Developing their delivery plans for community and primary care services which will enable a shift in the balance of care. We need to ensure the rate and pace of the work enables and integrates with the changes we need to make to acute care.
- Partners in the development of this transformation plan for acute services with a critical leadership role for local engagement and enabling local people to be involved in the shaping of local services.
- Partners in developing the Board's financial plans, we need to change the balance of financing between acute and IJB delivered services to deliver an affordable and effective system of care.

6.3 We need to work with HSCPs to develop further plans to deliver the new system of care which is outlined in the rest of this section.

6.4 **Meeting the challenge across the whole system**

The diagrams below shows the system now and our aim of moving from separate 'hospital' and 'community' services to a system which has services integrated between acute and HSCP services. This system of care is based on strengthened, round the clock community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits. Working differently at the interface will involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.





We have started to develop the integrated acute and HSCPs services which this joined up system of care requires. Examples include:-

- A range of services in care homes, delivered with the support of acute services consultants, enabling early discharge from hospital or direct admission by GPs.
- Development of community rehabilitation teams which enable early discharge from hospital;
- Single point of access to HSCP services enabling GPs to avoid referrals to hospitals;
- HSCP staff working at the front door of acute hospitals to plan HSCP care and avoid admission;

6.5 **Core components of the new system of care:**

This programme of service development and change needs to accelerate to deliver a more extensive and innovative range of community health and social care services which reduce the demand for hospital care and meet the needs of patients who are currently admitted to hospital; while remaining safe and efficient. The overarching aim is to ensure people get care in the right place from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services. The key characteristics of the clinical services required to support this approach are:

- High quality public health services to improve the health of the population.

- A system giving timely access to **high quality primary care** providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:
  - Building on universal access to primary care.
  - The focal point for prevention, anticipatory care and early intervention.
  - Management where possible within a primary care setting.
  - Focus for continuity of care, and co-ordination of care for multiple conditions.

- A comprehensive range of **community services,** integrated across health and social care and working with the third sector to provide increased support at home:
  - Single point of access, accessible 24/7 from acute and community settings.
  - Focused on preventing deterioration and supporting independence.
  - Multi-disciplinary care plans in place to respond in a timely way to crisis.
  - Working as part of a team with primary care providers for a defined patient population.

- Co-Coordinated care at **crisis and transition** points, and for those **most at risk**:
  - Access to specialist advice by phone, in community settings or through rapid access to outpatients.
  - Jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation.
  - Rapid escalation of support, on a 24 / 7 basis.

6.6 This would enable us to transform the delivery of acute services including:-

- **Hospital assessment** which focuses on early comprehensive assessment driving care in the right setting:
  - Senior clinical decision makers at the front door.
  - Specialist care available 24/7 where required.
  - Rapid transfer to appropriate place of care, following assessment.
  - In-patient care for the acute period of care only.
  - Early supported discharge to home or step down care.
  - Early involvement of primary and community care team in planning for discharge.

- **Planned care** which is locally accessible on an outpatient and ambulatory care basis where possible or short stay:-
  - Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
  - Appropriate follow-up.
  - Diagnostic services organised around patient needs.
  - Interventions provided as day case where possible.
  - Rapid access as an alternative to emergency admission or to facilitate discharge.

- **Inpatient hospital care organised** into centres of excellence to provide specialised clinical services for patients whose needs cannot be met elsewhere, with the shortest possible stays and early transfer to reshaped local services delivered by HSCPs.

- **Low volume and high complexity care** provided in defined units equipped to meet the care needs driven by clear evidence of the relationship between volume and outcome.

6.7 The development of more of these services requires:-

- Additional resources and staffing for community services.
- Shared IT systems and records which are accessible to different professionals across the care system.
- Jointly agreed protocols and care pathways, supported by IT tools.
- Effective anticipatory care planning;
- Ensuring that national contractual arrangements with independent contractors support the changes required.

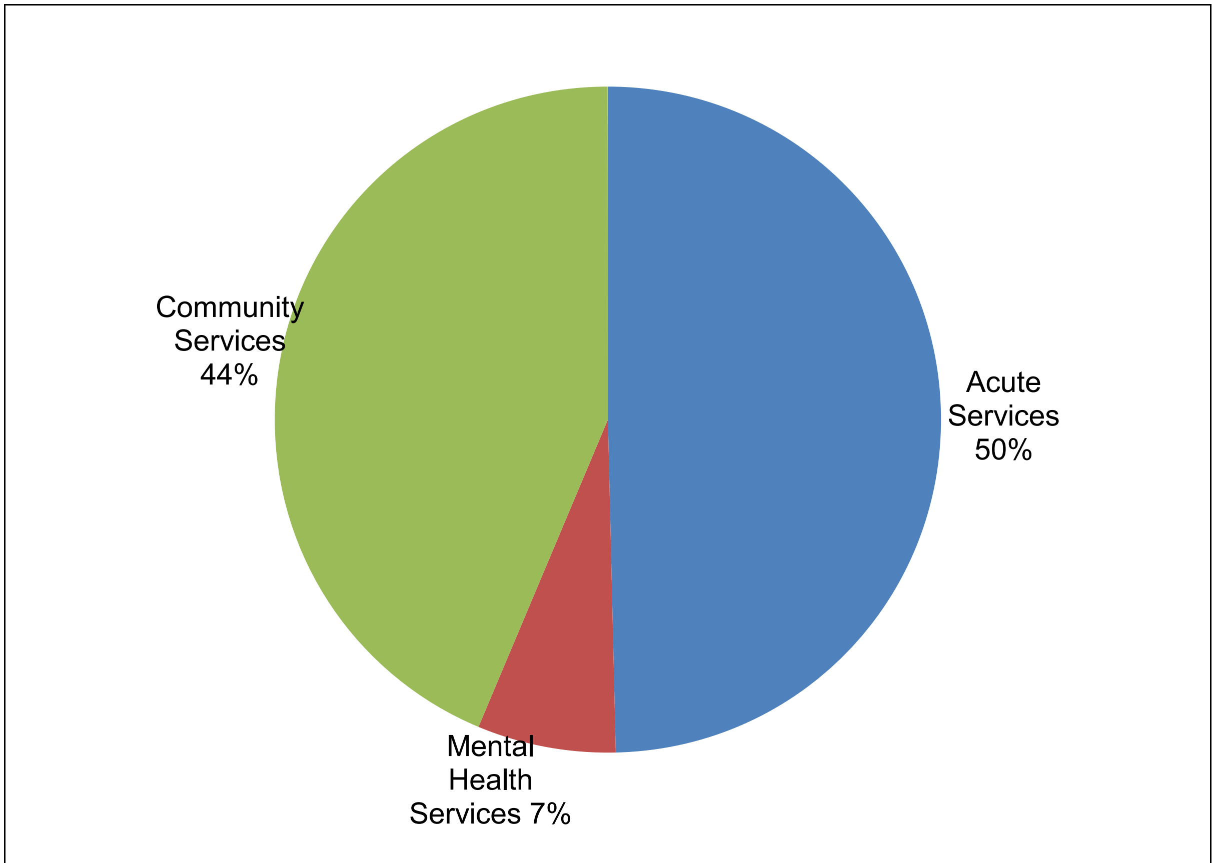
7. RESOURCES FOR ACUTE CARE

7.1 The Audit Scotland report has confirmed the scale of the immediate challenge for Health Boards to manage within available resources. This projection means that we need to provide reduce the costs of delivering care across the whole system, with an imperative to reduce the costs acute by delivering that care in different ways and by reducing the volume of care delivered.

7.2 We are developing our medium term financial plan but we know the headlines for the next five years are likely to require the very challenging level of savings set out below as the NHS needs to continue to fund new services and clinical innovations.

		2017/18	**2018/19**	**2019/2020**	**2020/2021**	**2022/23**
	Financial efficiency challenge	**(105.9)**	**(53.7)**	**(55.8)**	**(57.2)**	**(60.5)**

7.3 To finance the transformed services we have described in this paper we also need to reduce the proportion of the Board's resources which are spent on acute services, the chart below is illustrates the current split of the Board's spending.

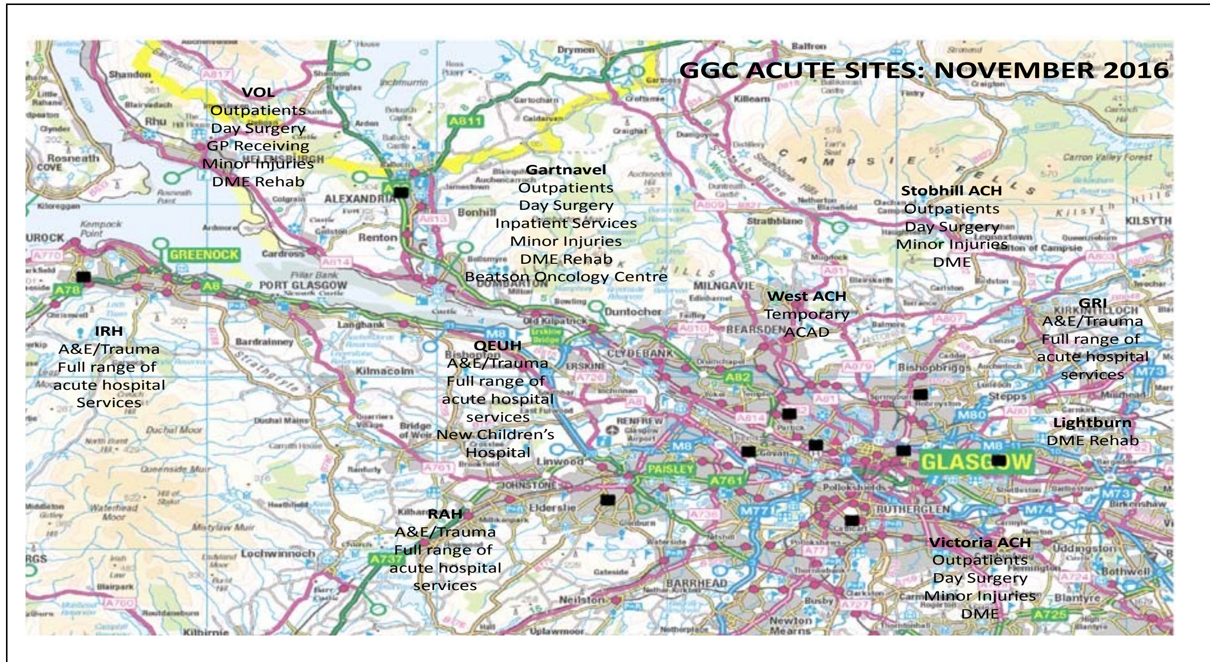


7.4 The continuing pressures on acute services will make this very challenging to deliver but failing to achieve the shift will increase pressures across the system.

8. IMPLICATIONS FOR HOSPITAL SERVICES AND SITES

8.1 This section describes, at a high level how the drivers for change, shifting the balance of care, reducing demand and developing a new system of care will be reflected in how we provide acute services.

8.2 The map below shows the current shape of our acute services.



8.3 The clinical services strategy set out models of care for the following areas:-

- Frail Elderly and Chronic Disease
- Emergency Care and Trauma
- Planned Care
- Cancer services
- Children's services
- Maternity Services

8.4 Since the strategy was published that clinical planning has been developed further. The first phase of delivering this transformation programme will be to translate that planning into proposals for each clinical service and each of our sites. The rest of this section sets out the headline conclusions we can already draw from our clinical services planning and the direction this paper describes:-

- We will deliver acute care with less beds, planning the appropriate and affordable numbers of beds for 2017/18 is already underway;
- Services currently provided in beds will be delivered in ambulatory care settings
- Local HSCP services will provide beds for patients who would previously have been cared for in acute services, meaning we will need less local acute beds;
- Most specialist acute services will be delivered on less sites;
- Our three major acute sites at GRI, QEUH and RAH will remain the major sites for acute care. Those sites will focus on delivering the most acute care, which requires admission and the full range of acute services. All of those sites will require capital investment and the range of services on those sites will change.
- We will plan for the delivery of major trauma, specialist stroke care, specialist cardiac and cancer services around those three acute sites, with most of those services being on a single site;
- The priority for capital investment will be to deliver local ambulatory care for populations who have least good access to other acute care services;

- For populations in and proximate to Glasgow the focus will be on increasing the utilisation of existing, modernised ambulatory care hospitals not further capital developments;
- We will have fewer unscheduled care assessment and admission points as the new system of care we have described begins to take effect.
- We will be delivering higher volumes of specialist care for the rest of the region. This may range from higher volumes of specialist activity to a different shape of general secondary care activity.
- More care for older people will be delivered by HSCPs with acute services focussed only on patients who require full acute care, but acute specialists will have a bigger role in supporting HSCP services.
- Most rehabilitation, for all ages, will be delivered by HSCPs, including specialist care which does not require acute services.
- As we reduce acute capacity from 2017/18 onwards, we need to identify what is the best approach for clinical delivery in the short, medium and longer term around the fixed points of our three major acute sites and two modern ambulatory care hospitals.

9. PUBLIC AND PATIENT ENGAGEMENT

9.1 Effective engagement will be central to the development and delivery of this transformation programme. We know that people are anxious about changes to their local acute hospitals; we need to work with HSCPs to explain the issues set out in the paper and work to ensure that we enable people to see that our proposals will improve care.

9.2 We know from the clinical services review that people have a number of issues which we need to respond to in the way we deliver services:

- Concern about lack of joined up care, particularly for those with multiple conditions receiving support from different teams across primary care, community services and hospital outpatients and/or inpatients.
- Lack of communication between teams and with patients.
- A desire to be able to manage their own conditions better, with appropriate support.
- The need for patients and carers to be valued as partners in care.
- The importance of access to services, in terms of both time and physical location.
- A broad range of issues impacting on people’s health and ability to benefit from services, including the impact of the recession and welfare reform.
- The challenge of ensuring that changes to services add up to real benefits for individual patients.

9.3 The next phase of engagement will include:

- A substantial programme of engagement across the Board area.
- A detailed communication plan to actively promote the strategy and the key messages within it.
- HSCPs will be at the centre of this as the engagement, which needs to be joined up with their local service delivery and planning.
- A core part of this work will be establishing a dialogue with patients about what is important to them in service delivery so that we shape our change proposals to aim to take account of patient’s perspectives.

10. CONCLUSION

This paper has described the range of population, service and financial challenges we face in delivering high quality acute care. Working together to develop our transformation programme will enable to meet those challenges and high quality care to the patients we serve.