Report To:	**Inverclyde Integration Joint Board**	**Date:**	**23 June 2020**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/44/2020/LL**	
Contact Officer:	**Chief Financial Officer Inverclyde Health & Social Care Partnership**	**Contact No: 01475 715212**	
Subject:	**UNSCHEDULED CARE COMMISSIONING PLAN**		

1.0 PURPOSE

1.1   The purpose of this report is to update the IJB on progress in developing the strategic commissioning plan for unscheduled care.

2.0 SUMMARY

2.1   Progress has been made by all six HSCPs, the Acute Services Division and the NHS Board to develop a GG&C-wide strategic commissioning plan as part of the Moving Forward Together programme. This report updates the IJB on the development of the draft plan.

2.2   The draft Unscheduled Commissioning Plan will be presented to all six IJBs for consideration, recognising that further work is required on key aspects as outlined below.

2.3   The Unscheduled Care programme contributes to all nine National Health and Wellbeing Outcomes and in particular is fundamental to the delivery of Outcome 9: that resources are used effectively and efficiently in the provision of health and social care services.

2.4   One key aspect of the Unscheduled Care work is learning from the pandemic, during which we have seen a fall in unscheduled care activity. While the bulk of the draft Plan is still relevant, the learning from what has worked well during the pandemic will be incorporated in the key actions in the final version. This learning is outlined in Section 6.

3.0 RECOMMENDATIONS

3.1   The Integration Joint Board is asked to:

a) accept the attached draft Unscheduled Care Commissioning Plan for NHS Greater Glasgow & Clyde;

b) note the further work underway to finalise the plan including the planned engagement process, and

c) note that a further update and a finalised plan will be brought to the IJB later in the year.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 Further work has been undertaken by all six HSCPs in GG&C to develop a system-wide strategic commissioning plan in partnership with the NHS Board and Acute Services Division and in line with the IJB's Strategic Plan. The draft plan attached builds on the GG&C Board-wide Unscheduled Care Improvement Programme (http://www.nhsggc.org.uk/media/245268/10-   unscheduled-care-update.pdf.) and is integral to the Board-wide Moving Forward Together programme (https://www.nhsggc.org.uk/media/251904/item-10a-paper- 18_60-mft-update.pdf).

4.2 A draft plan is presented to the IJB for consideration recognising that further work is required on key aspects as outlined below.

5.0 DRAFT UNSCHEDULED CARE COMMISSIONING PLAN

5.1 The purpose of the plan is to outline how we aim to respond to the continuing pressures on health and social care services in GG&C and meet future demand. The draft explains that with an ageing population and changes in how and when people chose to access services, we need to change services so that we can meet patients' needs in different ways with services that are more clearly integrated and the public understanding better how to use them.

5.2 The draft plan explains that simply providing more of what we currently have (e.g. more emergency departments) is not possible within the resources we have, nor does this fit with our longer term ambition of providing care closer to where patients live and reducing our reliance on hospitals. The direction of travel is to meet people's needs in community settings with primary care as the corner stone of the health and social care system.

5.3 The draft outlines how we plan to support people better in the community and develop alternatives to hospital care so that we can safely reduce the over-reliance on unscheduled care services. The draft describes the delivery of an integrated system of health and social care services that we believe will better meet patients' needs. While this is a strategic plan outlining improvements for patients to be implemented over the next five years, the plan also includes some immediate actions that can be delivered in the short term in response to current imperatives.

5.4 The programme outlined in the plan is based on evidence of what works and our estimate of patient needs in GG&C. The programme is focused on three key themes:

Early intervention and prevention of admission to hospital to better support people in the community and includes actions on:

- implementing anticipatory care plans within specific patient groups; e.g. COPD, residential care home clients etc.;
- working with GPs through the national frailty collaborative to better manage frailty within the community;
- working with care homes to reduce hospital admissions;
- working with the Scottish Ambulance Service (SAS) to reduce the number of falls conveyed to hospital as part of a wider falls prevention strategy;
- continuing to develop the palliative care fast track service; and,
- extending the community respiratory service to provide a service over weekends.

Improving the interface between primary and secondary services to ensure our health and social care systems work smoothly and efficiently in the patients

interests:

- improved information sharing
- reducing emergency department attendances
- understanding public attitudes to A&E
- focus on right service right place through improved patient advice
- further development of minor injuries units
- focus on frequent attenders
- standardised approach to mental health A&E presentations
- GP assessment units at each main hospital site located close to emergency departments

Improving hospital discharge and better supporting people to transfer from acute care to community supports and includes actions on:

- expansion of the hospital discharge team;
- intermediate care improvement programme designed to reduce length of stay and improve the number of people returning home;
- additional intermediate care capacity introduced as part of the winter planning arrangements;
- additional Red Cross transport capacity purchased to assist with hospital discharge; and,
- continued robust performance management of delays.

5.5 The changes proposed will not take effect immediately or all at the same time. Some need testing first and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is to change to respond to current and future demand, it is also to maintain the direction outlined in the plan over the longer term so that we can better meet the needs of the people we serve.

5.6 We also need to communicate more directly with patients and the general public to ensure people know what service is best for them and can access the right service at the right time and in the right place.

5.7 Progress on these actions is reported regularly to the HSCP Unscheduled Care Planning Group and performance is reported in the quarterly performance reports to the IJB and the IJB Finance, Audit and Scrutiny Committee.

6.0 LEARNING FROM THE PANDEMIC

6.1 Unscheduled care services have seen dramatic changes as a result of the COVID-19 pandemic. As well as an unprecedented drop in A&E attendances, emergency admissions and delays, there have also been significant changes in primary and secondary care services. These changes include the opening of COVID-19 Assessment Centres, GPs operating by telephone triage, and new COVID-19 pathways introduced in secondary care. These changes, together with lockdown measures and a strong public messaging and information campaign, have impacted on unscheduled care activity. It is important, therefore, going forward that we learn lessons from what has worked well during the pandemic and might be followed through as part of our system-wide approach to improving patient services and managing demand effectively.

6.2 Examples of what has worked well and, subject to further testing, could be included in our Unscheduled Care Commissioning Plan include:

➢ the introduction of the Greater Glasgow and Clyde-wide community respiratory service to improve the management of COPD in the community and reduce hospital admissions.

➢ building on our approach to Shielding to improve community support to vulnerable patients with specific conditions, including working with the third

sector, and integrating this with our approach to Anticipatory Care Plans
- ➢ embedding actions to improve delays so this becomes standard practice across Greater Glasgow and Clyde.
- ➢ learning from the operation of the Community Assessment Centres to introduce an appointment-based model in GP assessment units with same day and next day appointments.
- ➢ aligned to this, accelerating the introduction of appointment based 'hot clinics' for specific conditions as part of an integrated primary/ secondary care pathway.
- ➢ refreshing and updating our re-direction protocol to coincide with the re-opening of Minor Injury Units and a wider public awareness-raising campaign on Unscheduled Care services.

6.3 These and other actions will also be included in the NHS Board's Turnaround Plan as part of the performance escalation reporting process with the Scottish Government.

7.0 NEXT STEPS

7.1 Key next steps include:

- engagement on the draft with key partners and stakeholders;
- further work to finalise the in-scope Acute beds plan and financial
- framework; and,
- the key impact measures to be used in reporting on progress.

7.2 The plan will be subject to a period of **engagement** with key stakeholders and clinicians in primary and secondary care over the coming months. Key stakeholders include SAS, NHS24, the third and independent sectors, GPs and other primary care contractors, acute clinicians and staff and neighbouring HSCPs/NHS Boards. The draft will be discussed at various events and fora across GG&C. The engagement process will take place while the draft is being considered by the six IJBs in GG&C and by the Moving Forward Together programme. A period of public / patient engagement is planned in late summer and will be co-ordinated with other public engagement exercises to ensure a joined up and consistent message is given publicly.

7.3 Further work is also required on the **financial framework** to support delivery of the plan – see section 8 of the draft. The draft identifies a number of key actions that could require financial investment to deliver. A finalised financial plan will be incorporated in the final plan to be reported to the IJB in September 2020. Until this is complete, only aspects of the plan which can be funded within existing budgets will be progressed.

7.4 Work is also in hand on the key **impact measures** to be used to demonstrate improvements in performance – see section 9 of the draft. Among the indicators to be used will be:

- emergency admissions;
- acute unscheduled hospital bed days;
- A&E attendances; and,
- bed days lost due to delayed discharges.

8.0 IMPLICATIONS

8.1 **FINANCE**

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	Other Comments
N/A					

8.2 The IJB's budget for 2020/21 includes a "set aside" amount for the commissioning of acute hospital services within scope (e.g. accident & emergency services). This is currently budgeted to be £23.956m for Inverclyde.

8.3 The draft plan includes a financial framework (section 8) to support delivery of the proposals in the plan. Work to identify the annual investment over the life of the plan is in hand. A finalised financial plan will be incorporated in the final plan to be reported to the IJB in September 2020.

8.4 Until this is complete only aspects of the plan which can be funded within existing budgets will be progressed.

LEGAL

8.5 The integration scheme for the IJB includes specific responsibilities for the strategic planning of certain acute hospital services.

HUMAN RESOURCES

8.6 There no specific human resources implications arising from this report.

EQUALITIES

8.7 Has an Equality Impact Assessment been carried out?

	YES
X	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.

8.7.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	None

Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

8.8 There no clinical or care governance implications arising from this report.

8.9 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None
Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	None

9.0 DIRECTIONS

9.1	**Direction Required to Council, Health Board or Both**	Direction to:	
		1. No Direction Required	
		2. Inverclyde Council	
		3. NHS Greater Glasgow & Clyde (GG&C)	
		4. Inverclyde Council and NHS GG&C	X

10.0 CONSULTATION

10.1 The report has been prepared following consultation across the 6 GG&C IJBs and NHS GG&C and after due consideration with relevant senior officers in the HSCP.

11.0 BACKGROUND PAPERS

11.1 None.

NHS GREATER GLASGOW AND CLYDE
HEALTH AND SOCIAL CARE PARTNERSHIPS

D R A F T

Moving Forward Together.

The challenge is change

D R A F T

Strategic Commissioning Plan for
Unscheduled Care Services in Greater Glasgow & Clyde
2020-2025

March 2020

SUMMARY

- **Unscheduled care services in Greater Glasgow & Clyde are facing an unprecedented level of demand**
- **The wider health and social care system, including primary and social care, has not seen such consistently high levels of demand before**
- **While we are performing well compared to other health and social care systems nationally, and the system is relatively efficient in managing high levels of demand we are struggling to meet key targets consistently and deliver the high standards of care we aspire to**
- **We need major change if we are to meet the challenge of rising demand**
- **This draft plan charts a way forward over the next five years to 2025**
- **Essentially it aspires to patients being seen by the right person at the right time and in the right place**
- **For hospitals that means ensuring their resources are directed only towards people that require hospital-level care**
- **At present, an unsustainable number of people are accessing hospital resources on an unplanned basis when their needs can and should be met in a different way**
- **Therefore the emphasis in this strategy 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 public awareness campaign so that people know what services to access when, where and how**
- **We will work with patients to ensure they get the right care at the right time**
- **Analysis shows that a significant number of patients who currently attend emergency departments could be seen appropriately and safely by other services. A number of services could be better utilised by patients**
- **We also need to change and improve a range of services to better meet patients' needs**
- **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. That is why this is a long term plan with some short term actions we need to take soon**
- **The challenge is change**
- **A summary of the key actions in this plan and timescales are shown on the next page. Work to measure the overall impact of the programme is in hand**

KEY ACTIONS

Below is a summary of the key actions in the plan and the timescale for implementation.

Key Actions	Timescale
Communications plan (page 26)	
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 anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.	**Through 2020/21 and updated for future years**
Prevention & early intervention (pages 30-37)	
2) We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions	**2020/21**
3) We will work with the Scottish Ambulance Service (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.	**2020/21**
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.	**2021/22**
5) We will increase support to carers as part of implementation of the Carer's Act	**2020/21 and ongoing**
6) We will increase the number of community links workers working with primary care to 50 by the end of 2020/21	**2020/21**
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	**By end 2020**
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.	**By end 2020**
9) We will further pilot access to "step-up" services for GPs as an alternative to hospital admission.	**By end 2020**
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.	**2020/21**
11) We will explore extending the care home local enhanced service to provide more GP support to care homes	**By end 2020**
Primary and Secondary care interface (pages 38-52)	
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.	**2020/21**

Key Actions	Timescale
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.	**2020/21**
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.	**2020/21**
15) We will incentivise patients to attend MIUs rather than A&E with non-emergencies through the testing of a 2 hour treatment targets	**2020/21**
16) We will explore extending MIU hours of operation to better match pattern of demand	**2020/21**
17) We will assess the feasibility of opening an MIU on the Gartnavel site	**By the end of 2020**
18) We will continue to improve urgent access to mental health services	**2020/21**
19) 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	**2020/21**
20) We will reduce the number of people discharged in 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.	**2020/21**
21) 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 risk of admission to hospital. Specific populations will be prioritised, including care home residents and people living with frailty.	**2020/21**
Improving hospital discharge (pages 53-61)	
22) We will work with acute services to increase by 10% the number of hospital discharges the number of discharges occurring before 12.00 noon and at weekends and during peak holiday seasons, including public holidays.	**By end of 2020**
23) 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	**2020 / 21**
24) We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement services in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.	**2020/21**
25) We will reduce delayed discharges so that the level of delays accounts for approximately 2.5%-3.00% of total acute beds, and bed days lost to delays is maintained within the range of 37,000 – 40,000 per year.	**2020/21**

CONTENTS

List of tables and figures

1. INTRODUCTION

1.1   The health and social care system in Greater Glasgow & Clyde (GG&C) – the largest in Scotland – is facing unprecedented levels of demand. Demand for acute hospital services continues to rise and has increased by 4.3% since 2017/18 and shows no sign of reducing. Whilst the whole system is working hard to deliver more quality care to people than ever before, our performance against some key performance targets has deteriorated in line with this increased demand for example, the percentage of patents seen within 4 hours at emergency departments at currently at 90%, and bed days lost due to delayed discharges has increased by 9,323 since 2017/18. There is also evidence that people are using A&E services more now than they used to in the past.

1.2   Despite this the health and social care system in GG&C performs well compared to other systems nationally, and is relatively efficient in managing high levels of demand and dealing with complexity. However, an over-reliance on unscheduled care services can indicate that a health and social care system is not performing optimally in helping people to know where to go to for help.

1.3   The health and social care system can be confusing for patients, and complicated to navigate for clinicians, staff and the general public. It is often not clear to patients and families which service should be accessed for different needs, how and when. This is an inherent challenge when there are such a broad range of needs, specialisms, professional groups and varying levels of health literacy amongst the general population.

1.4   We must adapt our service model in response to an ageing population, and changes in how and when people choose to access services, so that we can meet patients' needs in different ways, ensure services are more clearly integrated and that the public understand better how to use them. The challenge is change.

1.5   Providing more of what we currently have (e.g. more emergency departments) is neither possible within the resources we have nor does it fit with our longer term ambitions of providing care closer to where patients live, and reducing our reliance on hospitals. We believe people's needs should be met in community settings whenever possible with primary care as the corner-stone of the health and social care system.

1.6   This draft strategy outlines how we as Health and Social Care Partnerships (HSCPs) in Greater Glasgow & Clyde, in partnership with secondary care colleagues and other partners plan to support people better in the community, developing alternatives to hospital care that ensure hospitals are utilised only by those that require that level of medical care. This plan describes the delivery of an integrated system of health and social care services that we believe will better meet patients' needs. While this is a strategic plan outlining improvements for patients to be implemented over the next five years, we also include some immediate actions that can be delivered in the short term in response to current imperatives.

1.7 We will require patients and the wider public to share responsibility for achieving the improvement in service performance and experience we all want to see over the next 5 years. A key element of that will be working with the public to increase general knowledge and understanding of which services to access for what and when.

1.8 In developing this strategy we recognise that the health and social care system operates in a wider social and economic context which often drives demand for health and care support. This plan has been developed at a time when significant changes are taking place in the population we serve, and in society as a whole, that will have an impact on health and social care services. According to the National Records Office "In recent years … increases in life expectancy have stalled"[1], and the Institute for Fiscal Studies has reported that "average household income [in the UK] growth stalled in 2017-18 and is still only 6% above its pre-recession levels"[2].

1.9 Both these factors, and others, will influence the shape and pattern of demand over the next few years. Therefore whilst we make estimates of the potential impact of our programme, it is impossible to provide guarantees of future impact. There are many complex and unpredictable factors involved in being able to predict future impacts with certainty, particularly into the long term. The estimates of potential impact should therefore be viewed with this qualification in mind.

What is unscheduled care?

1.10 Unscheduled care has been defined as:

"… any unplanned contact with health and / or social work services by a person requiring or seeking help, care or advice. Such demand can occur at any time, and services must be available to meet this demand 24 hours a day. Unscheduled care includes urgent care and acute hospital emergency care."[3]

Integration Joint Boards' responsibilities

1.11 As part of the legislation on health and social care integration, Integration Joint Boards were given a statutory duty for the strategic planning of unscheduled care services. The integration scheme for Integration Joint Boards includes the following statement and which forms the statutory basis for our strategic planning responsibilities:

> *"The Integration Joint Board will assume lead responsibility jointly with the five other Health and Social Care Partnerships within the Greater Glasgow and Clyde area for the strategic planning of the following:*
>
> *- accident and emergency services provided in a hospital.*

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[1] Life Expectancy in Local Areas 2015-17, National Records for Scotland, December 2018,

[2] Institute for Fiscal Studies, March 2019, Briefing note: No growth in household incomes in the last year – for only the fourth time in the last 30 years

[3] *Commissioning a new delivery model for unscheduled care in London,* Healthcare for London, 2016

> *- in-patient hospital services relating to the following branches of medicine:*
> > *i. general medicine;*
> > *ii. geriatric medicine;*
> > *iii. rehabilitation medicine;*
> > *iv. respiratory medicine; and*
> *- palliative care services provided in a hospital."*

National picture

1.12 Audit Scotland in their recent report on the NHS in Scotland stated that:

> "*The healthcare system faces increasing pressure from rising demand and costs, and it has difficulty meeting key waiting times standards. Without reform, the Scottish Government predicts that there could be a £1.8 billion shortfall in the projected funding for health and social care of £18.8 billion by 2023/24. So far, the pace of change to address this, particularly through the integration of health and social care, has been too slow.*"[4]

1.13 Audit Scotland recommended that the Scottish Government in partnership with health boards and integration authorities should:

> "*develop a new national health and social care strategy to run from 2020 that supports large-scale, system-wide reform, with clear priorities that identify the improvement activities most likely to achieve the reform needed*"[5]

1.14 In 2015 Scotland's Deputy First Minister in his budget speech stated that:

> "*The nature and scale of the challenges facing our NHS – in particular the challenge of an ageing population – mean that additional money alone will not equip it properly for the future. To be blunt, if all we do is fund our NHS to deliver more of the same, it will not cope with the pressures it faces. To really protect our NHS, we need to do more than just give it extra money - we need to use that money to deliver fundamental reform and change the way our NHS delivers care.*"[6]

This draft plan

1.15 The purpose of this draft plan is to set out the six NHSGG&C HSCPs' collective response to Audit Scotland's recommendation, and how we aim to fulfil the statutory requirement for strategic planning of unscheduled care services laid down in Integration Joint Boards' integration schemes.

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[4] NHS IN Scotland 2019, Audit Scotland
[5] Op cit
[6] John Swinney, MSP, Deputy First Minister, Budget Speech, December 2015

1.16   The draft plan looks at where we are now, assesses the demographics and needs of our population, and current trends in unscheduled care activity in Greater Glasgow & Clyde. We then move on outline our vision for unscheduled care services to respond to the pressures and demands within the health and social care system. We go on to outline specific changes we wish to introduce working with acute colleagues, GPs and others and the estimated impact these changes might have, together with the benefits for patients. Finally we outline the resource framework that will support this work and the implementation arrangements to ensure success.

1.17   This plan should be read together with other plans being taken forward by the NHS Board and Health and Social Care Partnerships including:

- the wider Moving Forward Together programme[7];
- our digital and eHealth programme[8];
- our local primary care improvement plans[9];
- our Board-wide adult mental health strategy and older people's mental health strategy [in development];
- our redesign of out of hours services[10];
- our wider programme of integration of health and social care services[11]; and,
- our partners' plans such as the Scottish Ambulance Service, NHS24, Strategic Housing Investment Plans and Community Planning plans.

1.18   Before we move on we need to clarify who we are serving when describing the changes we want to see. HSCPs are responsible for delivering health and social care services for their resident populations. Acute services in GG&C however serve a much larger population than those who live in GG&C – approximately 10% of the total acute service activity in GG&C comes from out with the Board area. So while some changes in this plan will affect the wider population e.g. minor injury services, others will only affect HSCPs' resident population e.g. anticipatory care plans. In the main we use Health Board data as it relates to our resident population and where we use data that relates to the totality of activity in GG&C serving the wider catchment population we will explain this in the appropriate section. For any national comparisons that are used we will use national data.

1.19   This plan is a draft because we want to hear your views. We will outline separately how comments may be made as part of our engagement process.

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[7]   https://www.movingforwardtogetherggc.org/

[8] https://www.nhsggc.org.uk/about-us/digital-as-usual/digital-strategy-outlook-2018-2022/

[9] https://www.nhsggc.org.uk/media/250803/item-12-primary-care-improvement-plans-18-49.pdf

[10]

https://glasgowcity.hscp.scot/sites/default/files/publications/IJB%2026%2004%202017%20Item%20No%2011%20-%20Out%20of%20Hours%20Reform%20Update.pdf

[11] https://glasgowcity.hscp.scot/strategic-and-locality-plans

2. WHY WE NEED CHANGE

Introduction

2.1 In this section we look at where we are now, current and projected needs and demand for unscheduled care services. A comprehensive needs analysis was undertaken to inform NHSGG&C's *Moving Forward Together* programme, including a literature search of the available evidence on best practice and system wide change. This analysis is not repeated here and can be found at[12] .

Changes in Demand

2.2 The health and social care system in Greater Glasgow & Clyde is experiencing a period of sustained high demand. The reasons for this are considered to be changes in patient expectations and behaviour (see page 46 below), and changes in our population with an increase in the number of people aged over 75 (see page 13 below) and increases in levels of deprivation[13]. Some of this demand is also due to advances in treatments and technology. A key factor in looking at the pattern of demand in GG&C appears to be an over-reliance by some patients on emergency departments (EDs) for non-urgent conditions. This is sometimes associated with adverse life circumstances and ageing.

2.3 At a headline level in 2018/19 there was:

- a continued growth in emergency department attendances at all main acute sites (a 4.3% increase on 2017/18);
- which creates difficulties in meeting the national 4 hour waiting time target on a consistent basis (at the time of writing performance was at 80.9%[14]). During 2018/19 in emergency departments in GG&C the percentage of patents seen within 4 hours at main sites was 88% compared to the national value of 90%;
- a slight decrease in GP referrals to assessment units year on year (-1.3%) with no change in the percentage of patients discharged on the same day (45%-48%);
- a slight increase emergency admissions (0.5%) and a decrease in emergency admission bed days (-1.2%);
- an increase in delayed discharges with, in 2018/19, 36,968 acute hospital bed days lost due to delays; and,
- heightened levels of activity in all services over the winter period and on public holidays.

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[12] https://www.movingforwardtogetherggc.org/media/248682/mft-top-100-transformational-articles.pdf

[13] https://www.gov.scot/publications/scottish-index-multiple-deprivation-2020/
[14]   https://www.nhsperforms.scot/hospital-data?hospitalid=20

Changes in our population

2.4   Coupled with these changes in demand we have also seen changes in our population. We are now seeing for the first time a reversal in the increase in life expectancy for women and men; due it is thought to social and economic reasons[15] . People are still living longer than they were but when looking at healthy life expectancy (life expectancy adjusted to take account of health) we see that for many this is significantly lower than life expectancy (see figure 1)[16].

Figure 1: Male life expectancy and healthy life expectancy at birth 2009-2013
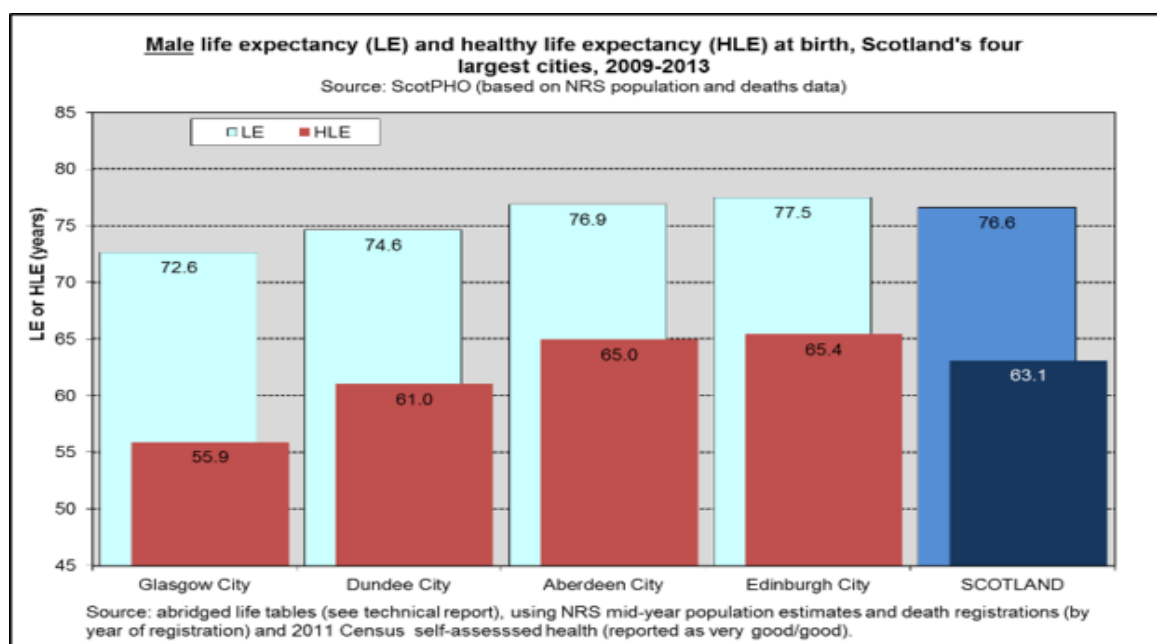
2.5   In addition it is projected that over the next ten years to 2030 in Greater Glasgow & Clyde we will see a 24% increase in the number of people aged over 65 and a 32% increase in the number of people aged over 90. There are also more immediate increases over the next five year with a projected 11% increase in those aged over 75 (see figure 2 below).

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[15] *Mortality and Life Expectancy trends in the UK: stalling progress,* The Health Foundation, November 2019
https://www.health.org.uk/publications/reports/mortality-and-life-expectancy-trends-in-the-uk
[16]

http://www.understandingglasgow.com/indicators/health/trends/male_healthy_life_expectancy/scottish_cities/males

Figure 2: Projected GG&C population change 2019 to 2025
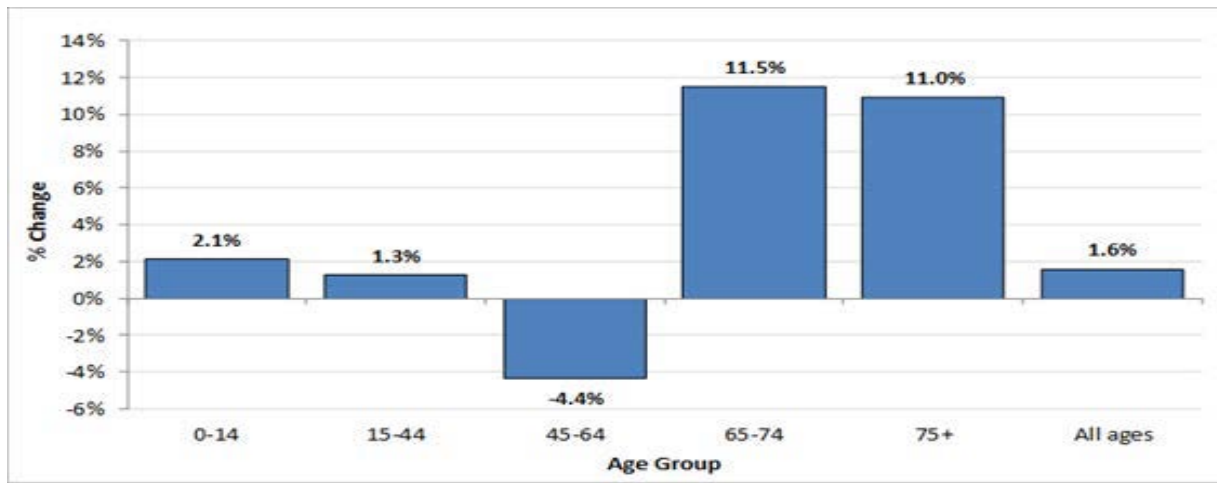
2.6   We can also look at the profile of disease in our population and while this shows considerable changes in the causes of ill health from ten years ago, it also shows differences within our population. The figure 3 below shows the burden of chronic illness and disability in the population as a whole in Scotland and figure 4 shows the picture for the poorest 10% of the population.

Figure 3 – Chronic illness and disability all Scotland
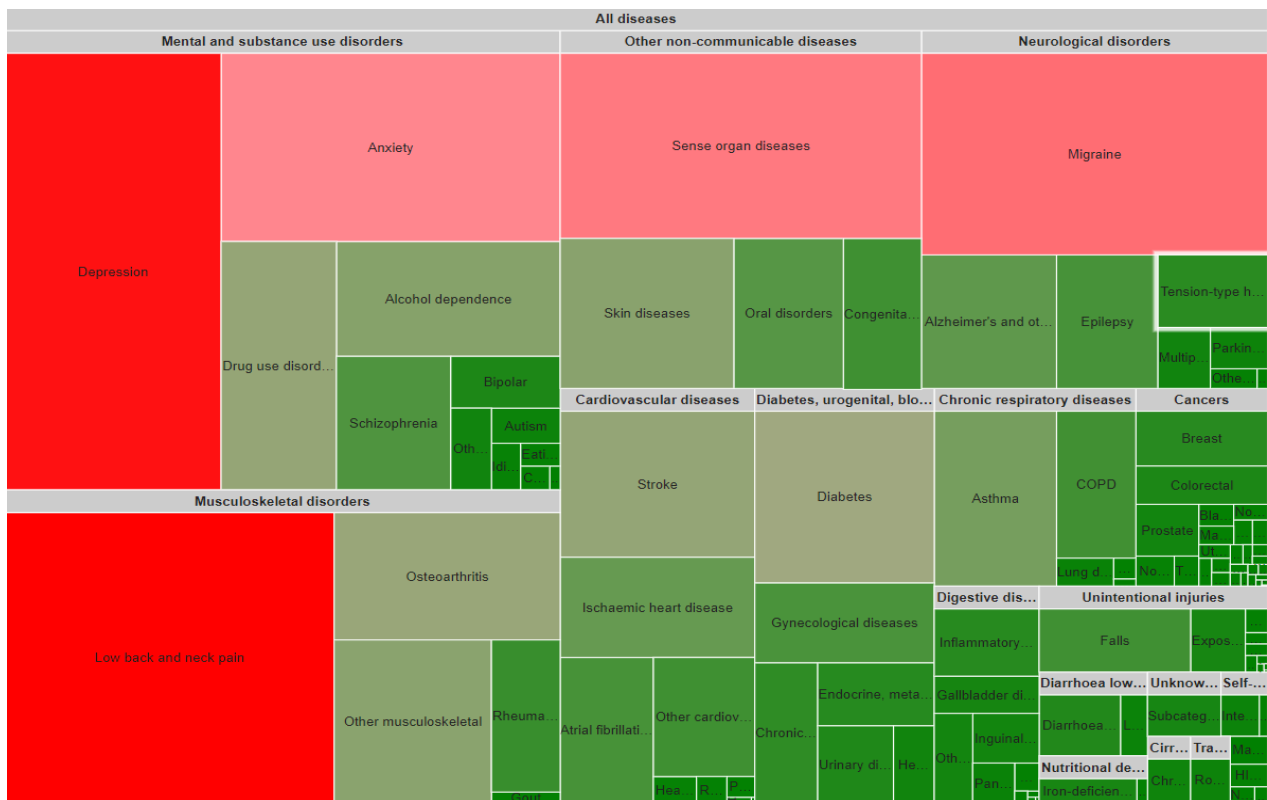
Source: ISD

Figure 4 – Chronic disease and disability Scotland poorest 10%
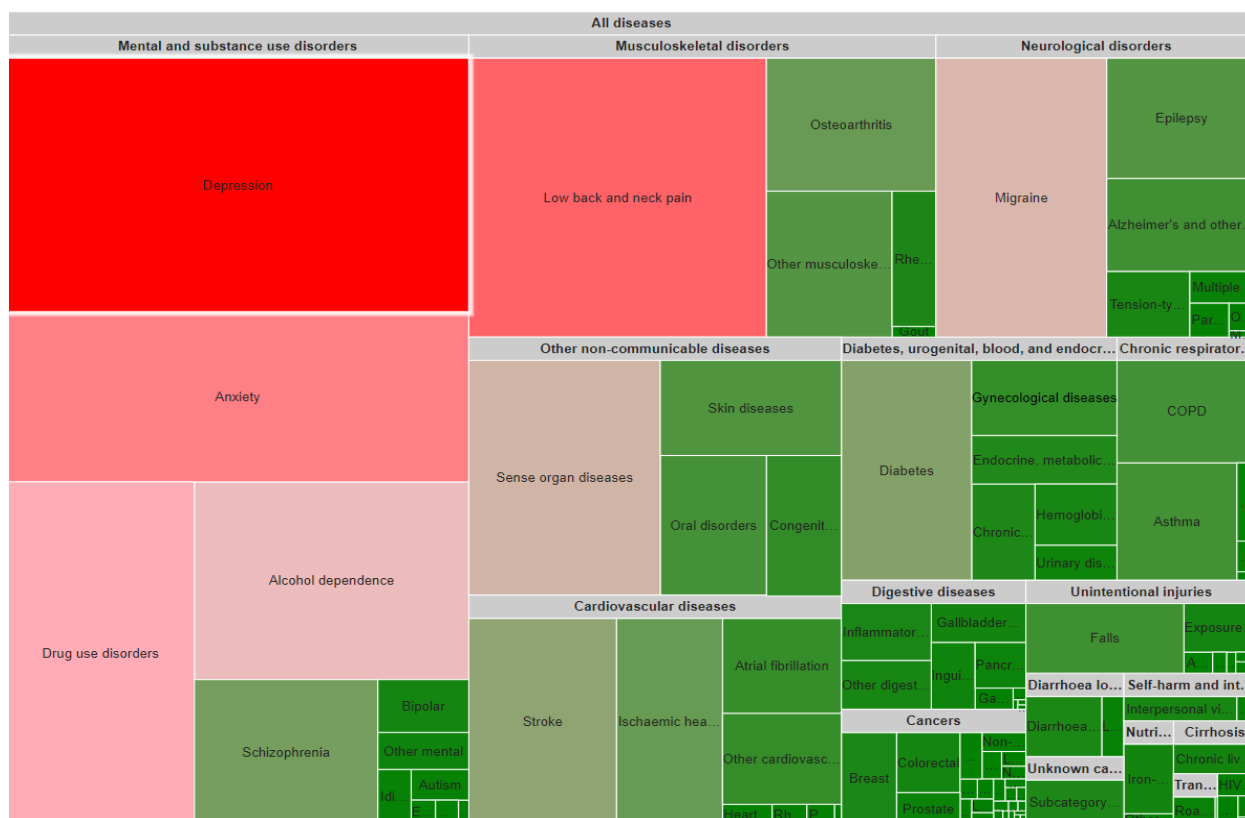
Source: ISD

2.7   For more information on the health population of Greater Glasgow & Clyde
       see https://www.nhsggc.org.uk/your-health/public-health/the-director-of-public-
       health- report/dph-report-2017-2019/

Understanding Current Trends[17]

2.8   The current levels of unscheduled care activity in GG&C are unprecedented, and have
       been driven by demographic changes and the health of our population.

2.9   In 2018/19 there were a total of 517,730 unscheduled care attendances in secondary
       care. This includes attendances at emergency departments (EDs), GP assessment units
       (AUs) and minor injury units (MIU). This is a 4.3% increase on total attendances in
       2017/18. Of these attendances 448,803 were GG&C residents (87%). The overall
       attendance rate per 1,000 residents for GGC was 338.2 compared to 285.7 nationally.
       The rate of attendance varies greatly by age, with higher rates among the young and
       older age groups. Furthermore attendance rates are higher for those who live in the most
       deprived areas when compared with the least deprived (see figures 5a and 5b below).

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[17] Thanks to John O'Dowd for most of this analysis

This pattern is similar to other parts of the UK but is a particular factor in NHSGGC given the relatively high levels of deprivation in our communities.

Figure 5a. Rates of unscheduled care at hospitals for males and females by age-band. (2018/19). 5b. Rates of unscheduled care for males and females by SIMD quintile for deprivation, (2018/19), where 1 is most socio-economically deprived.
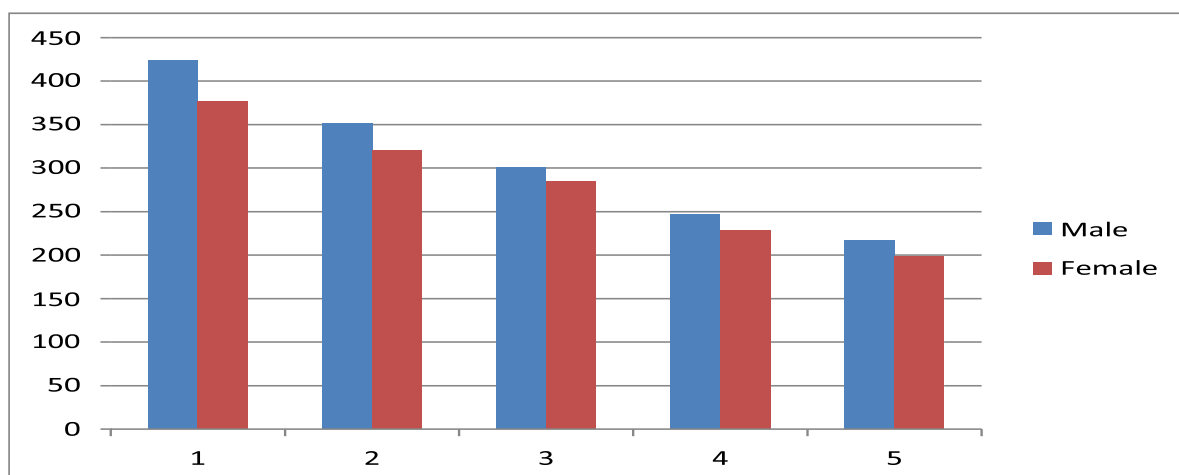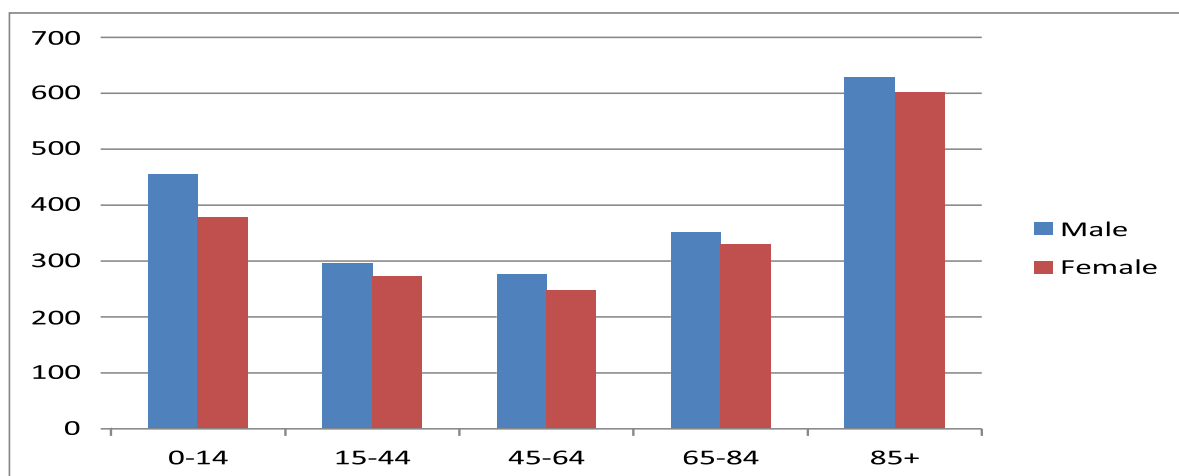
2.10 Of the total number of acute hospital attendances the proportion that requires admission is relatively low at 24% of all hospital attendances. When analysed by source of referral, this varies from 55% of attendances coming via 999 calls, to 37% from GP out of hour's calls, 15% from NHS24 calls, and 11% of patients who self-refer. Of unscheduled care attendances the majority of patients who attend self-refer (66% of all attendances). Of those who do attend emergency departments in GG&C analysis has shown that a significant number could been safely seen and treated elsewhere.

2.11 Based on current trends, and using ISD data, if nothing else changes we can expect a 14.6% increase in ED attendances (see figure 6 below) and a 4.8% increase in emergency admissions over the next five years (see figure 7 below) – this is essentially a do minimum option as it does not take into account the impact of population changes.

Figure 6: Projected total number of emergency department attendances 2020/21 to 2025/26
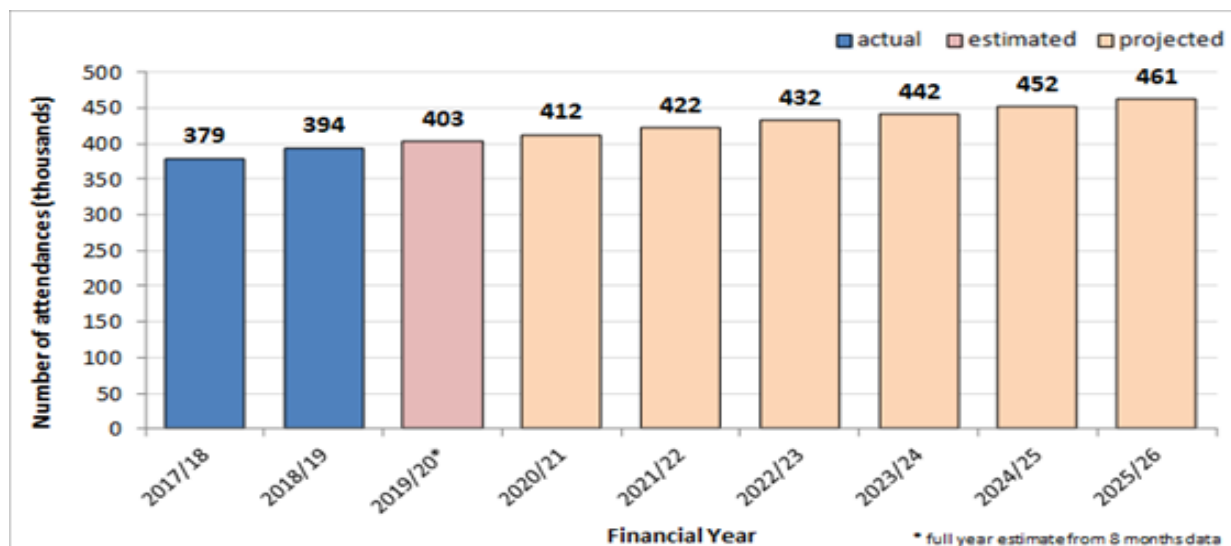
Figure 7: Projected percentage increase in emergency admissions from latest year 2018/19
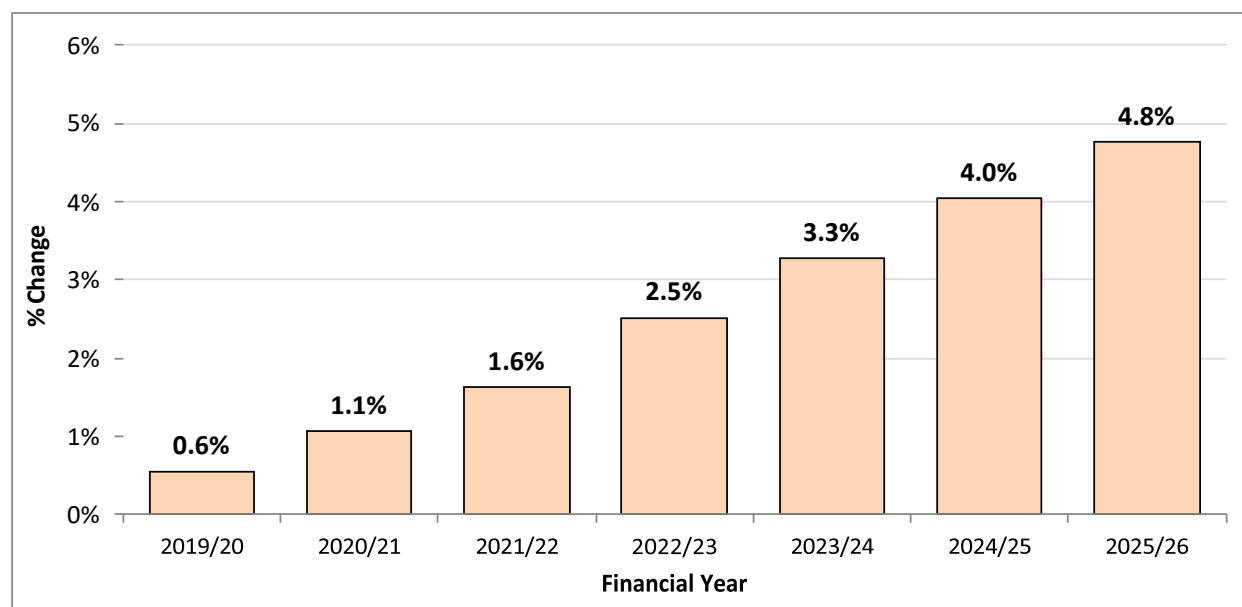
2.12 Unscheduled care is not just a secondary or acute care issue. Unscheduled care attendances also occur within primary care although data on this is not as readily available. We do however have data on GP out of hours activity (OOH). In 2018/19 there were 219,985 OOH consultations, at a rate of 187.2 per 1,000 residents. In hours

consultations can be estimated using English data[18], which shows consultation rates vary from 3.64 to 9.88 consultations per patient per annum nationally. This equates to a range of 4.69 to 12.74 million consultations per annum. The most reliable estimate is considered to be 6.33 million consultations per year. A significant proportion of this in hours work will also be urgent, though it is not yet possible to ascertain the proportion. Most GP practices will have provision for urgent same day appointments, and GPs will be called out to attend patients urgently at home. The Primary Care Improvement Plans have proposals to provide support to unscheduled care in primary care such as advanced practice based physiotherapy and advanced nurse practitioners.

Unscheduled care system

2.13   As explained in the introduction, the current unscheduled care health and social care system is complex (see figure 8). There are many entry and exit points and many interacting services provided by different organisations but all serving the patient. It is also clear that there is a wide range primary care and community based services actively working to support patients.

Figure 8 – Greater Glasgow & Clyde unscheduled care system
[19]

Greater Glasgow & Clyde unscheduled care system
Created by Living Well in Communities, i-Hub, Healthcare Improvement Scotland.

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[18] https://www.kingsfund.org.uk/publications/pressures-in-general-practice
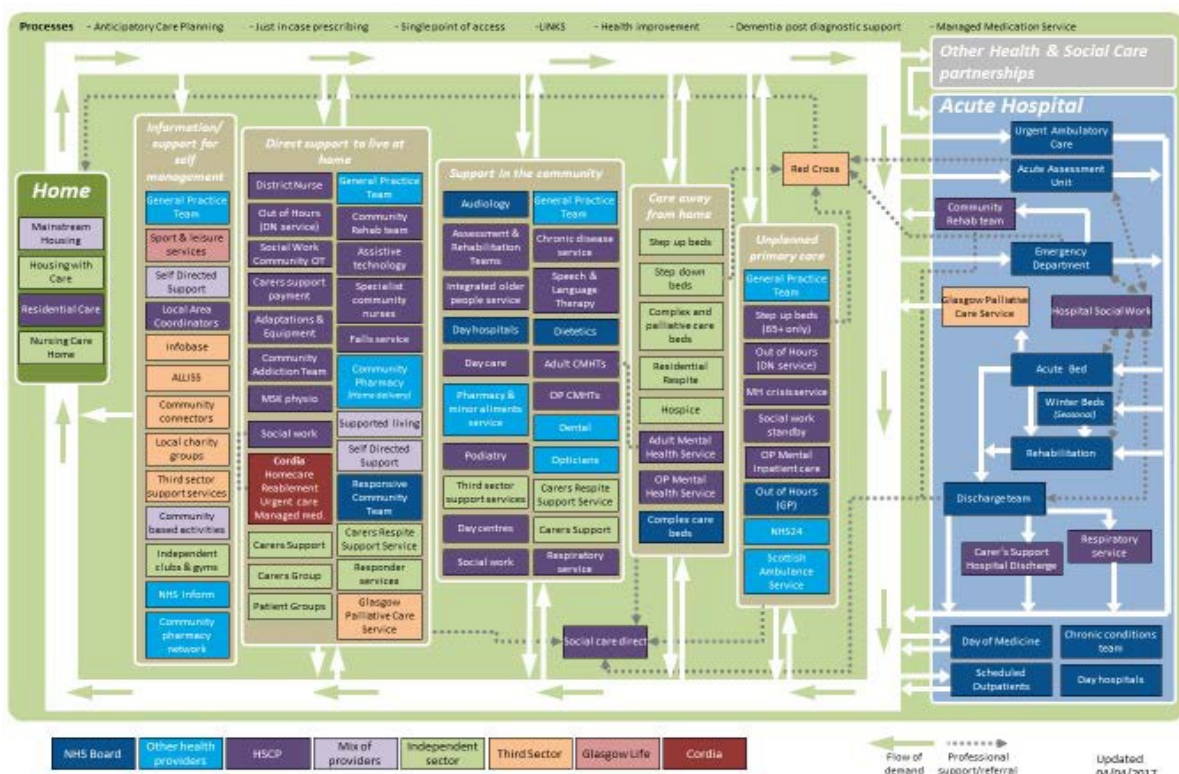
[19] Chart produced by iHub and reproduced with thanks

2.14 Our ambition is to change this so that this complex system operates in a more integrated way, supported by new technology. We aim to make it a more straight forward system to navigate for patients and clinicians alike. We will plan a major public awareness campaign to support patients access the right service for their needs, and which enables people to use services wisely. We also plan a co-ordinated approach to health and healthcare literacy skills as this will help people make informed choices about their care.

Primary Care

2.15 Significant changes are taking place in primary care too. GPs have a new contract that came into force in 2018/19 and aims to substantially improve patient care by maintaining and developing the role of primary care as the 'cornerstone of the NHS system'. The essence of the contract is to create conditions that enable GPs to operate as expert medical generalists by diverting from them work that is capable of being carried out by others, thereby allowing GPs more time to spend on more complex care for vulnerable patients and as senior clinical leaders of extended primary care teams.

2.16 The new contract outlines a range of changes that should take place between now and 2021. In the first phase the key priorities include changes in:

- vaccination services;
- pharmacotherapy services;
- community treatment and care services;
- urgent care services;
- additional professional services, including acute musculoskeletal physiotherapy services, community mental health services; and,
- community link worker services.

2.17 While there is limited data on activity within primary care, analysis in GG&C has estimated that there were 3.77 million face to face consultations with GPs and 1.77 million consultations with practice nurses, or 5.55 million face to face consultations in general practice in 2012/13 (the year the analysis was done). The King's Fund has reported a 13% increase in face to face contacts within general practice over the past five years[20]. If this change is reflected across Scotland, and applies equally to GPs and practice nurses, this equates to 4.26 million contacts with GPs and 2.0 million contacts with practice nurses, a total of 6.26 million face to face contacts per annum.

2.18 Changes are taking place in community pharmacy services too with the introduction of pharmacy first[21]. The new NHS Pharmacy First Service will be available from all community pharmacies in Scotland from April 2020. The service will promote community pharmacies as the first port of call for patients seeking care and support on self-limiting

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[20] https://www.kingsfund.org.uk/publications/pressures-in-general-practice

[21] https://www.nhsggc.org.uk/patients-and-visitors/know-who-to-turn-to/pharmacist/pharmacy-first/

illnesses and stable long term conditions utilising the ease of access to clinical expertise within this setting available over extended hours of opening.

2.19   Pharmacy First has the potential to become an integral part of the local service provision as the first point of entry to health and social care provision for the majority of residents within a locality. Changes are required to be developed within the community pharmacy network to allow the service to progress due to new ways of working. This service development will lay the foundations for further extensions to local and potential national services and could lead to delivery of other services e.g. treatment of common clinical conditions, shingles, COPD, skin infections etc. It will be important to align these future developments with the demand coming from the GP practices, out of hours, emergency departments etc. to assist with identifying unscheduled care requirements

Out of Hours Redesign

2.20   Following the publication of the Professor Lewis Ritchie report[22] a local review of health and social care out of hour's provision was agreed by all six NHSGG&C Health and Social Care Partnerships, led by Glasgow City HSCP. The Review commenced in September 2017 and was completed in June 2019. A key output of the review process was that an Urgent Care Resource Hub (UCRH) model would be developed to facilitate integrated, person-centred, sustainable, efficient and co-ordinated health and social OOHs services throughout GG&C.

2.21   We plan to implement an Urgent Care Resource Hub model in the summer of 2020 in Springburn, Glasgow. Other hubs in GG&C will follow in a phased approach. This will enable a whole system approach to the provision of scheduled (where planned needs change and require something beyond what the service can provide) and unscheduled (where a patient / service user contacts NHS 24) Health and Social Care. The UCRH will provide a vehicle to enhance and develop integration and co-ordination across a wide range of services. The hub will also have a role to improve and co-ordinate the connection of contacts back into day time services and vice versa. The UCRH provides a single point of access across the health and social care system to support co-ordinated support from multiple services based on need.

2.22   There are currently many access points to out of hour's services including NHS 24, SAS and GPs. The UCRH will provide a whole system response via a single point of access.

2.23   Following the implementation of the UCRH model for the OOHs period we will evaluate the impact of the resource and determine which further opportunities could be considered to support the system, e.g. expand the hours of operation of the UCRH to cover daytime hours.

GP Out of Hours (OOHs)

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[22] https://www.gov.scot/publications/main-report-national-review-primary-care-out-hours-services/pages/0/

2.24   GP OOHs services in Greater Glasgow and Clyde are currently facing a number of challenges which impact on delivering a sustainable service. These include:

- ensuring that that there are appropriate levels of GPs and other staffing across the service to respond safely to current demand;
- recruiting and retaining staff to work in the OOHs period;
- current workload and demand pressures in day time practice adversely impact on recruitment to work in OOHs;
- ensuring that the public are aware of how and when to use the service; and,
- reinforcing that GP OOHs is not an extension of in-hours general practice when patients are struggling to / do not attempt to obtain an appointment.

2.25   The service sees a significant number of patients every year in eight primary care emergency centres in GG&C and a home visiting service is also provided for patients who are unable to come to a centre – this is usually frail older people or people at the end of their lives. Centres are closed when the service has insufficient staff and patients are directed by NHS 24 to their nearest available centre. A home visiting service is always provided and transport is provided if people do not clinically require a home visit and do not have transport.

2.26   During 2017/18 and 2018/19 a series of key stakeholder engagement events, were undertaken which included a wide ranging exploration of the challenges faced by the service and identification of the opportunities which helped to shape a programme of work. The key changes are outlined below:

- **developing a sustainable workforce** – ongoing recruitment of GPs (including salaried GPs, ANPs and Primary Care Nurses to support the service);
- **developing professional to professional support** – another health professional working in the out of hours period, who required to speak directly to a GP who is working in the out of hours service require to contact via NHS 24. District Nurses can now contact the GP OOHs service direct during weekend days. There are plans, when resources allow, to extend this facility to cover the OOHs period.
- **frequent attenders** - it is recognised that there are people who frequently attend the GP OOH service. Some of these may also attend in hour's services and the Emergency Departments. Others may have made no effort to contact their GP or NHS 24. Details of these patients are provided to the HSCPs to incorporate into their work on people who frequently attend Emergency Departments.
- **self-referrals** - the service has always seen patients who arrive at a centre even if they have not called NHS 24 – self referrals or "walk-ins". Services elsewhere in Scotland do not provide this option. An element of this will be appropriate – patients who are experts in their own condition, who recognise their deterioration and know that it needs action. However, some could be given advice from NHS 24 and do not needed to not be seen, some could wait to see their own GP the next day and some could be seen by another service such as community pharmacy, dentistry or optometry. An implementation plan to support people to call NHS 24 has been

Page 21

developed with the aim that the service will not see people unless they have called NHS 24 or have been directed by another heath professional such as the Emergency Department or Community Pharmacy.

2.27   The impact of this work will lead to a revised profile of demand on the service. Therefore further development work has been identified to:

- determine the number and location of centres from which GP out of hours urgent care is available. The hours of operation of these centres and the implementation of an appointment system to support the management of patient flow to the service. The workforce model of the GP OOHs service also needs to be considered as part of this work. This work will also describe the links to the Urgent Care Resource Hub (UCRH) through which links to other out of hours health and social care services may be available. The patient transport service should also be considered as part of this work;
- the changes that will be delivered in the six HSCP Primary Care Implementation Plans through to March 2021 and beyond will bring a clear focus on ensuring the use of day time, planned care services are maximised;
- develop a communication and engagement strategy which supports the recommendations of the site options appraisal and the service re-branding;
- develop a risk management framework, as part of a site options appraisal which considers all possible consequences of reconfiguration of GP OOHs services, e.g. increased attendances at Emergency Departments and work in partnerships with services across the system to describe and establish appropriate mitigation actions; and,
- work collaboratively with neighbouring NHS Boards/HSCPs to better understand how to reduce demand for Greater Glasgow and Clyde GP OOHs service from outside NHSGG&C.

Public Health Strategy

2.28   The Public Health strategy *"Turning the Tide through Prevention"*[23] sets the strategic direction for public health in Greater Glasgow and Clyde to improve public health outcomes through collaboration. The aim of the strategy is that NHS Greater Glasgow and Clyde (GGC) "becomes an exemplar public health system which means there would be a clear and effective focus on the prevention of ill-health and on the improvement of well-being in order to increase the healthy life expectancy of the whole population and to reduce health inequalities". The aim of the strategy is that by 2028, NHSGGC healthy life expectancy (HLE) should be equal to the rest of Scotland with a narrowing of the inequality in life expectancy within GGC.

2.29   The strategic objectives of the strategy are to:

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[23] https://www.nhsggc.org.uk/media/251914/item-8-paper-18_59-update-on-turning-the-tide-through-prevention-board-paper-final-version.pdf

- reduce the burden of disease through health improvement programmes and a measureable shift to prevention;
- reduce health inequalities through advocacy and community planning;
- ensure the best start for children with a focus on early years to prevent ill-health in later life;
- promote good mental health and wellbeing at all ages;
- use data better to inform service planning and public health interventions; and,
- strengthen the Board and the Scottish Government's ability to be Public Health Leaders

Summary

2.30 The key points from this section are:

- there has been a continued growth in attendances at emergency departments in GG&C in recent years;
- we have also seen changes in our population with a projected increase of 11% in those aged over 75 over the next five years;
- if we do nothing it is projected that emergency admissions will increase by 4.8% over this period;
- our unscheduled care system is complicated to navigate both for patients and clinicians, and we need to change this so it is more integrated and straight forward;
- unscheduled care is not just an acute hospital issue as primary care and community services are facing increased demand too;
- changes are planned in GP services, community pharmacy and out of hours services to better meet patients' needs; and.
- our public health strategy aims to address the longer term issues of healthy life expectancy, tackling inequalities and reducing the burden of disease.

3. OUR VISION

3.1   Our ambition is to improve the health of our population, and meet people's health and social care needs better, by improving access to health and social care support when and where they need it. In order to do this we must transform the way we deliver health and social care services and work collaboratively with key partners in the third and independent sectors, SAS, NHS24, housing, GPs and other primary care contractors, our staff, and users and carers. Each Partnership has published a strategic plan that describes the specific programmes we plan to take forward to realise these ambitions over the next three years.

3.2   The *Moving Forward Together* programme[24] was launched in 2017 as a wide range transformation programme in response to changes in needs and demands, advances in technology and changes in the way health care is delivered. The programme culminated in a report published in June 2018 that set out a strategic direction for health and care services over to next five to eight years. That report stated that in respect of unscheduled care:

> *"Our approach ... should ensure people are admitted to hospital only when it is not possible or appropriate to treat them in the community. Admissions should be reduced whenever alternatives could provide better outcomes and experiences.*
>
> *We should develop our system wide approach to unscheduled care in which:*
>
> - *people have access to a range of alternatives to attendance at their GP surgery or local hospital emergency department;*
> - *care is better coordinated between community and hospital services at crisis/transition points;*
> - *services are tiered to provide an appropriate level of care;*
> - *some specialist services are provided on fewer sites in order to achieve a higher volume of cases and better outcomes;*
> - *local access to emergency care is at a level that is clinically safe and sustainable;*
> - *the enhancement of community-based services provide a more appropriate alternative to hospital care;*
> - *IT systems enable the rapid exchange of up-to-date information between services and support integrated working;*
> - *ambulatory care services reach out into the community-based networks with jointly designed and delivered pathways across the whole system with specialist support and diagnostic services provided when required;*
> - *there is better connectivity with community services and participation in agreed ambulatory care pathways across the whole system, involving also NHS 24, GP out of hours services and the [Scottish Ambulance Service, to ensure the*

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[24]   https://www.movingforwardtogetherggc.org/

most appropriate care for individuals by the most appropriate person or service at the right time and in the right place."

3.3   This can be illustrated in the model shown below.

Figure 9 – Moving Forward Together tired model

12,980
Hours of home
care provided

55,716
Elective
admissions

120,256
SAS* contacts

157,734
Emergency admissions

166,386
Day cases

206,212
GP Out of hours

301,633
NHS 24 contacts

373,354
Emergency Department/Minor Injuries Unit attendances

1,190,122
Outpatient attendances

7,457,117
GP appointments

24,390,000
Prescriptions

*Scottish Ambulance Service
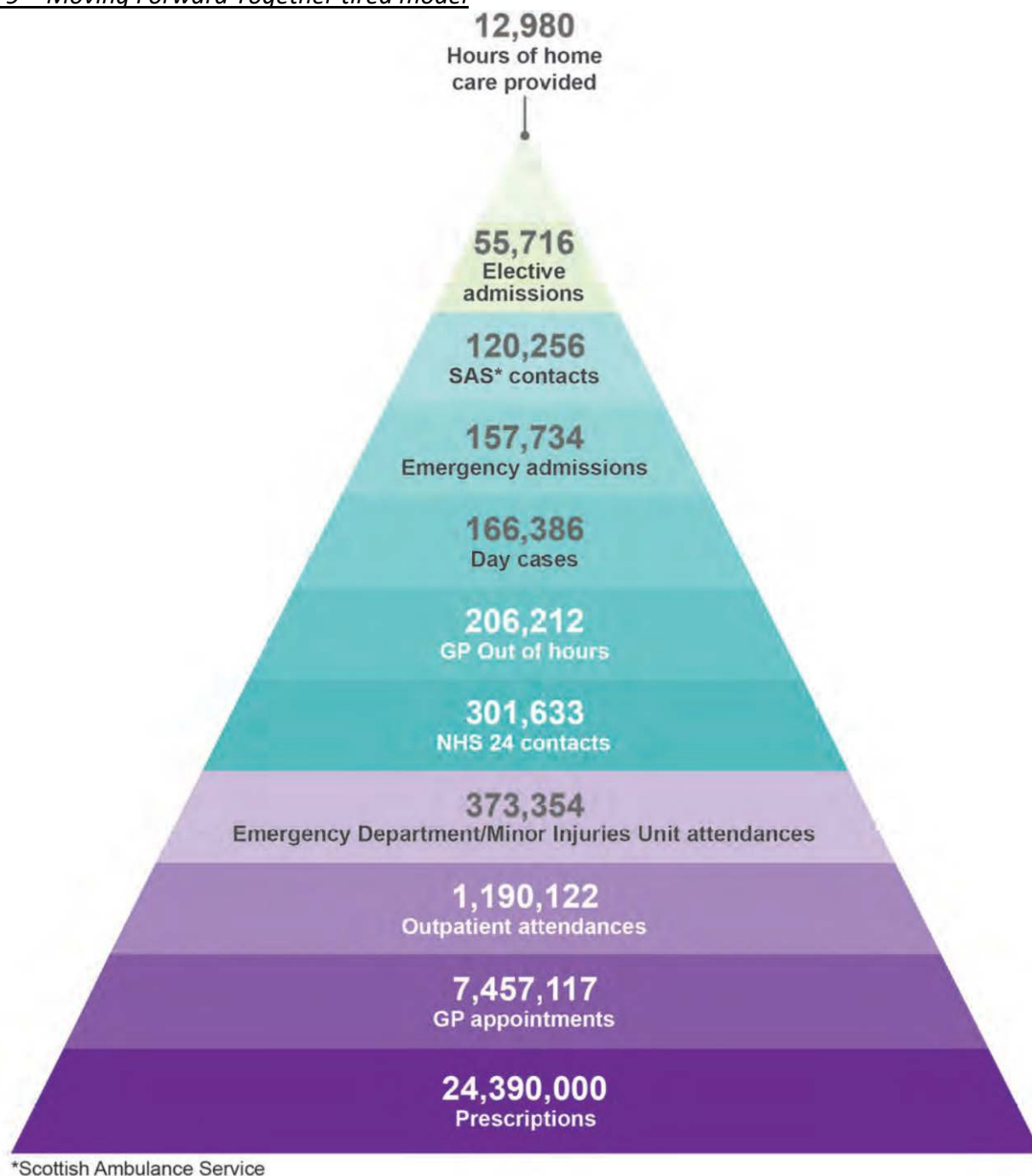
3.4   In step with this approach is the maximising independence programme being developed by Glasgow City HSCP which has echoes in approaches by other HSCPs for example compassionate Inverclyde. The maximising independence programme proposes a step change in individual, family and community independence from statutory support, a focus

on prevention and early intervention approaches in partnership with local community organisations and third, independent and housing sector partners. This assets based approach is in recognition that the tolerance of the health and social care system to absorb increasing demand is limited and change is needed[25]

3.5   Our vision is that self-care and prevention is prioritised, so that a greater proportion of needs are met in a planned way. This approach involves a number of elements working together to maximum effect including:

- health education and promotion at both a population level and individual level;
- strengthened community-based services to respond to urgent care needs in-hours and out of hours; and
- a sophisticated ongoing public awareness campaign advising patients which service to turn to when.

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[25] https://glasgowcity.hscp.scot/publication/item-no-19-maximising-independence-glasgow-city

4. CHANGING THE BALANCE OF CARE

Introduction

4.1   If we are to respond to the current increases in demand and pressures across the health and social care system described above, and to better meet patients' needs, we need to make some changes. In this section we focus on the key improvements we plan to take forward over the next five years.

4.2   In our view it is highly improbable that the health and social care system can absorb continuous year on year increases in demand without making some fundamental key changes. More importantly we would not be acting in patients' best interests, and getting the best from the resources we have available, if we did nothing to change the services we deliver and commission. The challenge is change.

Long term direction

4.3   We need to present these changes as part of a much longer term strategic direction of travel for the whole health and social care system. *Moving Forward Together* [26] describes the strategic direction for health and social care is to move away from hospital based or bed based services to providing more support to patients in community settings. And to work with primary care, NHS24, the Scottish Ambulance Service, the third and independent sectors, including housing, to develop preventative approaches. This is coupled with an approach that seeks to manage patient care so that patients are seen by the right person, in the right place at the right time.

4.4   This means that each part of the health and social care system should focus on what it does best, and the links and connections between services should be as smooth and efficient as possible so patients receive care when and where they need it. For example emergency departments will function best if they are to focus on accidents and emergencies, and primary care will function best if GPs are supported by other community based professionals to be expert medical generalists.

4.5   There is evidence that a significant proportion of patients may be attending secondary care unnecessarily and could be seen safely and more appropriately elsewhere. For many, their care could be better treated through scheduled care approaches in the community or through supported self-care or care and treatment as outpatients. A number of different explanations for the use of unscheduled care for non-urgent problems have been identified in the literature. These relate to lack of knowledge of healthcare use or confidence in accessing this in the community, and barriers to using in hours care due to work or stigma.

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[26]   https://www.movingforwardtogetherggc.org/

4.6   To achieve such changes means that we must develop both short term and longer term responses, and test new approaches on the way to see what might work best. In order to support these changes we will develop a major public awareness campaign the purpose of which will be to inform patients and professionals on how best to access the right service at the right time. A consistent message we receive when we engage with the public is that people do not know what service to turn to for what and when. We need to do more to support people become aware of what service to access and when.

Our priorities

4.7   What follows is our plan to do this by focusing on three key areas each with their distinct but linked programmes of activity:

- ***prevention and early intervention*** to better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible;
- so that our health and social care system works more smoothly and efficiently in patients' interest we aim to ***improve the interface between primary and secondary care services***; and,
- for people who are admitted to hospital for whatever reason we aim to ***improve hospital discharge*** and better support people to transfer from acute care to appropriate support in the community.

4.8   This reflects the patient pathway as shown in figure 10, below, and is based on the best available evidence of what works – this is described in the 2017 Nuffield Trust report[27] on shifting the balance of care and is summarised in annex A.

Figure 10 – current system of care

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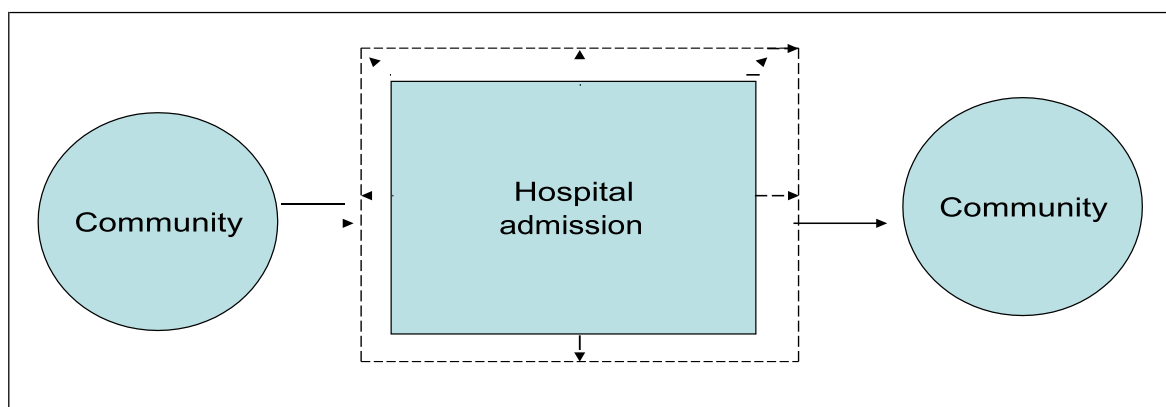
[27] *Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.*

4.9   Prevention and early intervention, and improving hospital discharge, involve programmes that are in the main led by HSCPs working closely with other partners such as GPs, the third and independent sectors and the Scottish Ambulance Service. The primary / secondary care interface programme is a joint endeavour between HSCPs, acute hospitals and clinicians working in primary and secondary care, to test and introduce improvements and will therefore require specific arrangements to take these forward.

4.10   In presenting our programme we have identified the short term actions we intend to take over the period to 2022, in response to current pressures (see section 2 above) and the longer term actions we will work towards up to 2029 to fulfil our vision and the ambitions set out in *Moving Forward Together*. Examples are given of where some of these initiatives are already underway in GG&C or elsewhere.

4.11   In section eight we outline the financial framework to support these changes, and in section nine we identify the impact and outcomes of our programme.

5. PREVENTION AND EARLY INTERVENTION

Introduction

5.1 In this section we outline the actions we have in place to better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible. We include here our early intervention and prevention strategies and their impact on reducing unscheduled care activity and managing patients in the community. This programme also forms part of the broader early intervention and prevention agenda that is key to delivering the ambitions in the Board's public health strategy outlined in section 2 above.

5.2 The programme is based on the conclusions drawn from a review of the evidence (summarised in annex A), and with reference to the recent iHub review [28] and the framework for community health and social care integrated services published by Health and Social Care Scotland[29]. It is important to note that the reviews of the evidence base are not conclusive about what works in reducing admissions to hospital although they do give us a valuable base from which to plan our programmes. That said the iHub review report stated that:

> *"It is not possible to draw firm conclusions or recommend implementation of specific interventions for NHS Scotland based on this review [of the evidence] but there was at least some moderate evidence of effectiveness relating to broad groups of interventions*."

Anticipatory care planning

5.3 Anticipatory care plans (ACPs) are key to supporting people with specific needs in the community, including those with long term conditions. A national model for ACPs was introduced in 2017 (www.myacp.scot). In GG&C HSCPs have developed a standardised approach to ACPs that involves a summary of the patient led ACP being completed by community teams and shared with GPs (with the patients' consent) so that relevant information can be included in the Key Information Summary (KIS). The KIS is vital information that is seen by out of hours services, SAS and A&E and crucial to support decision making should a patient attend emergency services.

5.4 By 2021/22 we plan that all people in Greater Glasgow and Clyde over 65 with a chronic condition, who would benefit from an ACP because of a high risk of admission to hospital, will have been introduced to anticipatory care planning and asked to consent to a summary of their ACP being shared with their GP and other relevant care providers via Clinical Portal and KIS. There will be a far greater number of people, families and carers who have been introduced to ACPs and may take up an ACP at a later stage. ACPs are still

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[28] https://ihub.scot/improvement-programmes/evidence-and-evaluation-for-improvement/review-of-literature-and-evidence-summaries/reducing-unplanned-admission-to-hospital-of-community-dwelling-adults/

[29] https://hscscotland.scot/resources/

a new concept for the most people and it will take time for the message about the benefits of ACPs to be widely understood. ACPs will be promoted as part of our wider communications strategy to support this plan.

5.5 Through this programme we estimate that over a number of years the take up of ACPs will contribute to a reduction in emergency admissions for those aged over 65. In future years we will further extend this programme to other patients groups (e.g. care home residents) targeting those who may be at risk of admission or re-admission.

Example – Glasgow City HSCP
Glasgow City HSCP is leading on the development of an electronic ACP tool in Riverside Residential Care Home and other care homes to support timely information sharing in decision making in residential care settings.

Falls prevention

5.6 In 2018/19 there were 8,948 people aged over 65 who attended hospital because of a fall. There is a strong link between falls and frailty, although not everyone who experiences a fall is frail. Frailty can contribute to falls and result in a person making a slower or poorer recovery following a fall, and a fall can trigger or accelerate the progression of frailty. Most people who attend hospital because of a fall are aged 85 and over.

5.7 The Scottish Government has launched a new draft *"Falls and Fracture Prevention Strategy"*[30]. In Greater Glasgow and Clyde we have taken action to prevent falls working with other agencies such as the Scottish Fire & Rescue Service, housing and leisure services on early risk identification and promotion of positive messages about physical activity and bone health. We support all staff to be aware of the risk factors and where appropriate to assess patients for falls risk or start a conversation with individuals that could identify that risk. We also work with Scottish Care to support care homes in falls prevention strategies and promoting physical activity, reducing sedentary behaviour to improve strength and balance. We also promote strength and balances classes through our rehabilitation teams and by the community falls team*.*

5.8 We also aim to work with the Scottish Ambulance Service to reduce the number of people who have had a fall needing to be conveyed to hospital. Not all falls need to attend hospital as other alternatives are available. We are working 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.

Frailty

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[30] https://www.gov.scot/publications/national-falls-fracture-prevention-strategy-scotland-2019-2024/

5.9   Supporting people living with frailty is an increasingly urgent issue for health and social care services. Approximately 10 per cent of people aged over 65 years, and 25 to 50 per cent of those aged over 85 years, are living with frailty. Frailty (see definition below[31]) is associated with age. Older people living with frailty are often at risk of adverse outcomes following a relatively minor event and often fail to recover to their previous level of health.

5.10   Hospitals admit older people more frequently than other age groups and so an ageing population creates additional demand for health and social care services. These admissions are often unplanned and older people who are frail are more susceptible to healthcare associated infections, falls, delirium and difficulties in maintaining good nutrition, hydration, and skin care. As a result frail older people often have longer hospital stays, higher readmission and mortality rates, and are more likely to be discharged to residential care.

5.11   Frailty identification and management to support people is therefore an important part of our early intervention and prevention strategy. There are 23 GP practices in GG&C who have joined the national frailty collaborative to better identify and support people living with frailty[32]. By the end of 2020/21 we aim to have identified all patients whose frailty score has changed from 'moderate to severe' and develop an ACP with information uploaded onto KIS. As a result we estimate that people who are frail will:

- spend more time living in the community with fewer moments of crisis;
- experience fewer incidents of unplanned care, including GP home visits; and,
- be more involved in decisions about their care through ACPs.

5.12   We will also develop, as part of the collaborative, an integrated frailty pathway with secondary care so that there is a seamless service for those patients who require admission to hospital. We will also manage frailty more proactively for those admitted and to optimise pre hospital management where appropriate for this patient group

Carer support

5.13   Carers play a crucial and important role in supporting people at home or other community settings. Carers are key to any strategy that aims to shift the balance of care towards more support and intervention in the community. It is vital therefore that this plan recognises and supports carers in their caring role. Each Partnership has its own carer's strategy as required by the Carers Act 2017[33]

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[31] "a geriatric syndrome of decreased reserve and resistance to stressors, resulting from cumulative declines across multiple physiologic systems, causing vulnerability to adviser health outcomes including falls, hospitalisation, institutionalisation and mortality" Fried, 2018

[32] https://ihub.scot/news-events/new-living-and-dying-well-with-frailty-collaborative/

[33] https://www2.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016

5.14   In total we estimate that Partnerships will support each year, through one means or another, over 4,000 new carers in their caring role.

Primary care based community links workers

5.15   Links workers support people through strengthening connections between community resources and primary care services. Links workers work with patients to identify issues and personal outcomes and then support patients to overcome barriers to addressing these by linking with local and national support services and activities. Links workers support GP practice teams to become better equipped to match support services to the needs of individuals attending primary care. They will also build relationships between the GP practice and community resources, statutory organisations, other health services and voluntary organisations to better support patients. Links workers can therefore play a vital role in the community based network of support to prevent people needing to access hospital services.

5.16   In Greater Glasgow and Clyde we aim to have over 50 link workers in post by the end of 2020/21 focused on GP practices with the most deprived patient populations. In total we estimate that by the end of 2020/21 links workers will have supported 17,500[34] people registered with GP practices in the most deprived areas of GG&C.

5.17   These new posts will be aligned with other similar roles such as community connectors, Local Area Co-ordinators and the community orientated primary care initiative. Community connectors, Local Area Co-ordinators, and others also help people access community supports to improve well-being.

Avoidable admissions[35]

5.18   Ambulatory Care Sensitive Conditions (ACSCs) also known as Primary Care Sensitive Conditions (PCSCs) have been used as a way of assessing what proportion of hospital admissions could potentially be avoided through other interventions, including stronger community management and early intervention / prevention. The thrust of this plan is to better support people at home or in community settings. So if we can do more to prevent hospital admissions and provide care and treatment in the community we should do so, particularly where there is an evidence base to support such an approach. We need to avoid circumstances where decisions to admit a patient to hospital are taken for largely social reasons rather than clinical reasons

5.19   In 2018/19 in GG&C the main reasons for admission to hospital were:

- COPD & pneumonia
- sepsis
- cerebral infarction

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[34] Calculated on the basis that each worker receives 350 referrals per annum based on caseload in East Ren
[35] Thanks again to John O'Dowd for this analysis

- fracture of femur, and
- other disorders of the unitary system

Table 1 – main reasons for hospital admission 2018/19

2018-19 non elective inpatient activity		
Reason for admission	**Occupied Bed days**	% of Total OBD
Pneumonia	**43,776**	4.5%
Sepsis	**43,742**	4.5%
Cerebral Infarction	**37,102**	3.8%
Fracture of Femur	**36,465**	3.7%
COPD	**34,518**	3.5%
Other Disorders of Urinary System	**33,125**	3.4%
TOTAL	**228,728**	**23.5%**
Notes: 1. Discharges of Non elective IP only 2. Excludes other HSCP 3. Includes all ages		

5.20 Of these COPD & Pneumonia accounts for 8% of total occupied bed days following an emergency admission. We will continue to develop our community respiratory services across GG&C that have proven effective in supporting people with COPD in the community and prevent admission to hospital. In this way we estimate that in 2020/21 we will have avoided a significant percentage of these admissions.

5.21 In 2020/21 we will also introduce a revised model of care for heart failure utilising the skills of the specialty nurse practitioners and other professionals within a multi-disciplinary team construct to develop alternatives to admission.

5.22 For the other conditions we will develop new care pathways with primary care to ensure that wherever possible patients can avoid attending hospital. Our aim will be to start patient pathways in primary care and community services supported by access to diagnostics and secondary care clinical advice as an alternative to an overnight stay in hospital.

Example – Glasgow Community Respiratory Service
The Community Respiratory Team is a nationally unique service that supports the needs of people living with COPD in their own home and is made up of physiotherapists, respiratory nurses, pharmacists, occupational therapists, dieticians and rehabilitation support workers. GPs refer to the service as an alternative to patients going into hospital by accessing the specialist service to support the patient in their own home. The service also facilitates early discharge from hospital by closely linking with secondary care colleagues and providing responsive follow

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up and support.

The ethos of the service is to provide a personalised approach to care, enabling self-management by those affected by COPD including:

- *increasing their own knowledge of their condition.*
- *knowing what to do when they are unwell.*
- *improving knowledge of inhaled therapies.*
- *knowing how to clear secretions from their chest.*
- *increasing their physical activity and independence through the provision of home pulmonary rehabilitation and equipment.*

An evaluation has shown a reduction in the impact of disease, an improvement in quality of life and a reduction in hospital admissions.[36]

Hospital at Home

5.23 Hospital at Home is being promoted as an innovative initiative to support older people with frailty who would ordinarily require admission to hospital to receive treatment in their home[37]. The i hub guidance points out however that while the evidence base identifies potential benefits from this approach there are "areas of uncertainty". Further work is needed to test the benefits of introducing this model in GG&C alongside existing services such as the FIT team in West Dunbartonshire and the Glasgow Community Respiratory Team. Glasgow City HSCP is developing a trial of the Hospital at Home model within a care home in the North East of the City. A number of GP practices in HSCPs are also involved in the frailty collaborative (see above).

Alternatives to admission

5.24 We also need to look at potential alternatives to admission so that GPs have a range of options available to manage patient care in the community. There are five specific measures we wish to test with acute clinicians and GPs to assess the impact on patient care. These are:

- **GP access to consultant advice:** the facility for GPs to obtain direct and timely consultant or senior clinical advice on an individual patient's care has the potential to reduce the need for patients to attend hospital and thus avoid the transport and other arrangements that might need to be put in place in enable this to happen. Consultant Connect piloted at the QEUH has shown some benefits in this respect, and it is now been rolled out to other specialities and hospitals. Experience in Tayside has shown that this also has benefits for emergency departments and GP assessment units. We plan to further test its benefits in

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[36] CRT final evaluation report, 2018
[37] https://ihub.scot/project-toolkits/hospital-at-home/hospital-at-home/

2020/21.

- **GP direct access to diagnostics:** access to diagnostic tests is crucial in determining a patient's treatment and care plan. Currently GPs have to refer patients to GP assessment units or ambulatory care clinics for an acute clinician to then order the appropriate tests and review the results. If GPs had access directly to an agreed range of tests and the results, such as CT and MRI, with the facility to discuss the results with a senior acute clinician if need be, then patients may not need to be referred and care and treatment could be managed within primary care. We wish to test this approach with acute diagnostics and evaluate its potential impact on GP referrals and acute activity.

- **next day outpatient appointments:** GP direct access to next day out patient appointments or "hot clinics" in line with an agreed care pathway, supported by patient transport, would provide GPs with a further alternative to referral to GP assessment units. Here we would be seeking the freeing up of an agreed number of appointments to allow GPs to book these direct instead of referring a patient to an assessment unit and potentially being admitted overnight. Essentially this would move some unscheduled care activity to being dealt with in a more planned way. A test of change to evaluate this should be set up involving acute clinicians on the main acute sites.

- **referral for assessment:** the ability for GPs to refer for assessment via SCI gateway with a view to preventing admission is another potential alternative that could be explored. We will set up a test of change to evaluate the potential for such a facility to be introduced across GG&C.

- **step-up care:** we have piloted step up care in care homes that GPs can access for patients who are unwell and need nursing care and observation but don't need to be admitted to hospital. The GPs who use these beds find them helpful in providing patients with care in a community setting for a short period of time before they go home again. If these beds were not available it is highly likely that such patients would have been admitted to hospital via a GP assessment unit (see below). In 2020/21 we will work with GPs and others to review this service as part of a wider review of intermediate care (see below) to determine if this is something we should develop further.

Example – West Dunbartonshire Focused Intervention Team (FIT)
West Dunbartonshire introduced the FIT team in July 2019 with the aim of providing an integrated community based service to support people to remain at home or homely setting as an alternative to hospital admission. The team provide a rapid response service to avoid admission, a care home liaison service to support care homes and COPD. It is estimated that to date, of the referrals received by the team nearly 60% have avoided a hospital admission.

Reducing admissions from care homes

5.25 In 2017/18 across Greater Glasgow and Clyde care homes accounted for 5,900 emergency admissions – 5% of total emergency admissions. Since then Partnerships have developed programmes with care homes to reduce emergency admissions by:

- providing training;
- support to GP practices covering care homes;
- introducing anticipatory care planning; and
- implementing the red bag scheme to safely transfer patients to and from hospital.

5.26 We have also in our residential care homes in Glasgow introduced advanced nurse practitioners covering approximately 550 beds who have already made an impact on both reducing GP call outs and admissions to Hospital.

5.27 By further developing this whole programme we estimated that by the end of 2020/21 we will have reduced emergency admissions from care homes by 2.5% from the level it was in 2018/19.

Summary

5.28 The aim of our prevention and early intervention programme is to reduce emergency hospital admissions particularly for those aged over 65, and support more patients in the community. Our programme based on the evidence of what works includes:

- extending anticipatory care plans;
- falls prevention strategies;
- work to manage frailty in the community;
- link workers to support GPs;
- support to carers;
- developing more integrated patient care pathways for the top key conditions that result in admission;
- assessing Hospital at Home;
- providing GPs with alternatives to admission and more options and support to manage patient care in the community; and,
- work with care homes to reduce admissions to hospital.

5.29 This is an extensive programme and will take time to be fully implemented in its entirety across GG&C. In section 9 we give an indication of the potential impact of the programme on the system as a whole.

6. PRIMARY AND SECONDARY CARE INTERFACE

Introduction

6.1 The interface between primary care, where most patients are seen, and secondary or acute hospital care, where patients attend for specialist treatment and investigations, is important in delivering a quality service to patients. It is in everyone's interest that the communications and links between primary and secondary care work smoothly and efficiently so that patients receive the right care in the right place at the right time.

6.2 In this section we focus on our priorities to improve the interface between primary and secondary care, including actions to reduce demand on our emergency departments as these have seen a significant growth in attendances in recent months (see section 2 above). Actions to address pressures in primary care are included in each HSCPs' Primary Care Improvement Plan.

6.3 Our proposals here focus on what has emerged from our analysis of the population's health and the balance of care, key issues highlighted by GPs and secondary care clinicians, and are set within the context of the strategic direction outlined in *Moving Forward Together*.

6.4 Patients in Greater Glasgow & Clyde access acute emergency and unscheduled care services at the four main acute hospitals – GRI, IRH, QEUH and the RAH (see figure 11 for location of acute hospital services including other hospitals).

Figure 11 – main acute hospital sites in GG&C
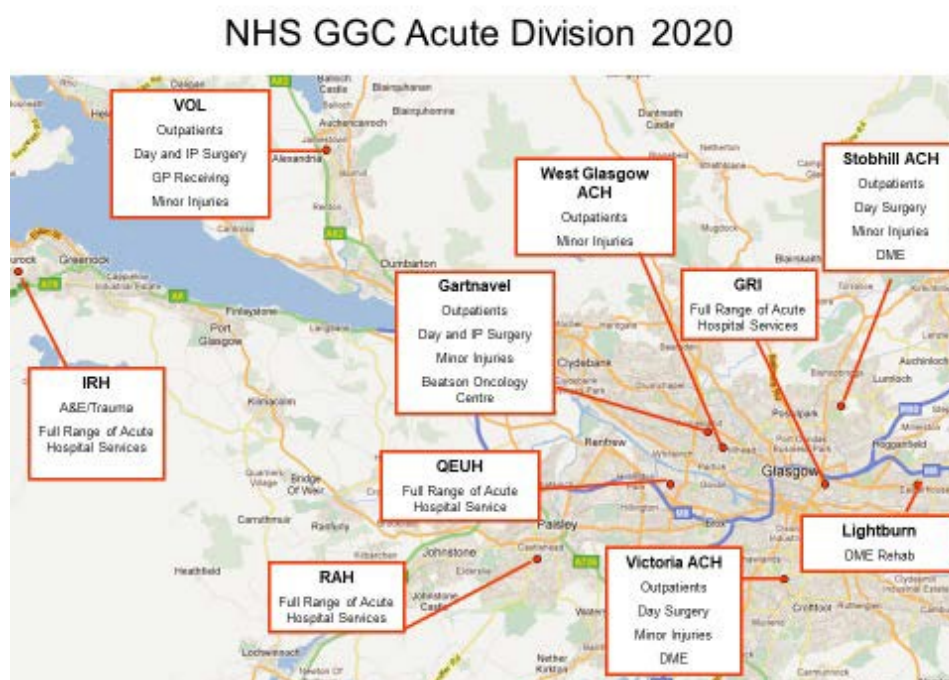
Information sharing

6.5   Information sharing between clinicians and primary and secondary care is vital in reaching decisions about patient care. Great strides have been made in improving information sharing between GPs and secondary care and the eHealth strategy outlines further developments[38] planned in the future. At a micro level improving access to EMIS for secondary care clinicians and the role of ECAN nurses pulling together patient information to inform decision making can make a difference. HSCPs are also encouraging GPs to update the Key Information Summary with summary ACPs to assist managing patients who attend emergency services.

Emergency department attendances

6.6   Emergency department (ED) attendances (see figure 12) have risen steadily in recent years and all EDs in GG&C have struggled recently to achieve the national 95% target for four hour waits (see figure 13).   During 2018/19 in emergency departments in GG&C the percentage of patents seen within 4 hours at main sites was 90% against the national target of 95%.

Figure 12: Percentage change in ED attendances from previous year, 2015/16 to 2019/20

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[38] https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/
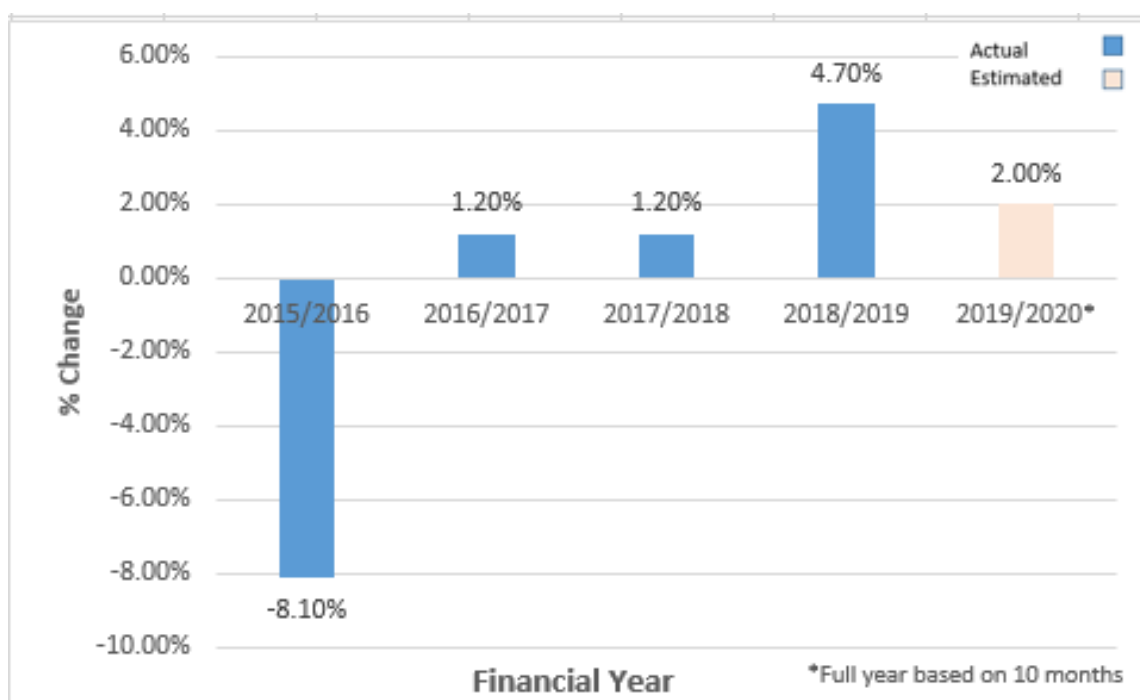
Table 2 – Emergency attendances and 4 hour target – GG&C

Year	% Compliance
2014/2015	87.7%
2015/2016	92.3%
2016/2017	91.9%
2017/2018	89.7%
2018/2019	90.0%
2019/2020 (to February)	85.2%

6.7   Analysis also shows that:

- the highest proportion of emergency department attendances were very young children and those in their twenties;

Figure 13 – ED attendances in GG&C 2018/19 by age
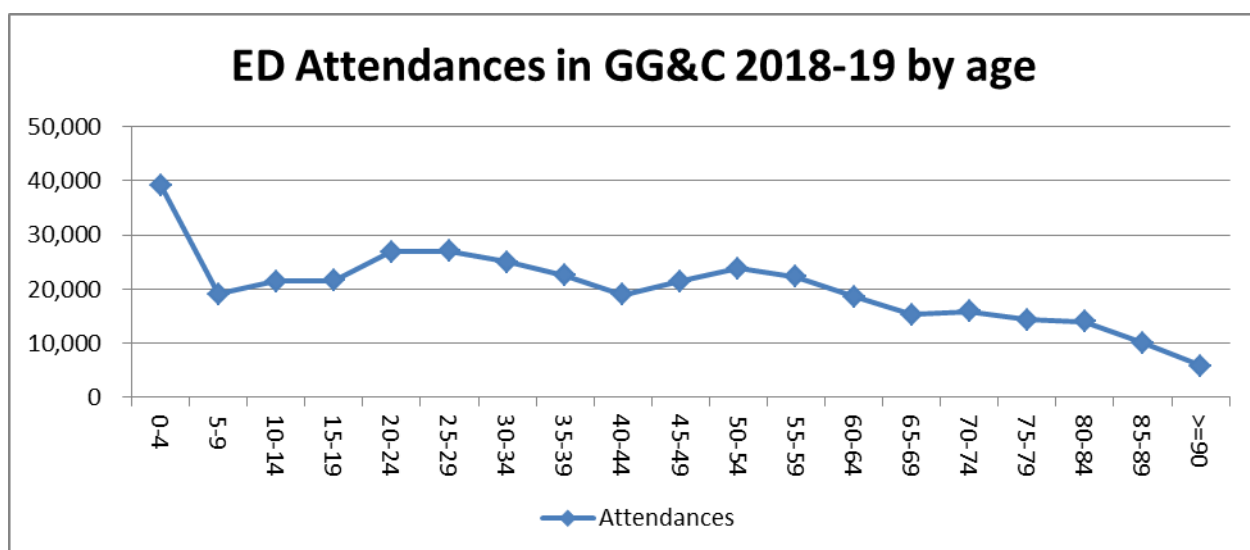
- in 2018/19 there were more than 300 attendances at the four main emergency departments for every 1000 people aged over 65;

Table 3 – Total attendances at 4 major emergency departments in NHS GG&C (2018/19) and rate per 1,000 population

Age	Number of attendances	2018 Population Estimate	Rate per 1,000 population
Age 65+	65,546	181,637	360.9
All attendances	265,514	1,174,980	226.0

- the proportion of attendances for over 65s at the main emergency departments has increased. One in 4 attendances at main emergency departments are over 65;

Table 4 - Attendances at 4 major emergency departments in NHS GG&C (2018/19) by age

Age	Attendances	% attendances
65+	65,546	24.7%
All Attendances	265,514	100.0%

- in 2018/19, on average 58% of attendees referred themselves to ED while 8% were referred by a GP;

Table 5 - Attendances at all emergency departments in NHS GG&C (2018/19) – source of referral

Source of referral	Attendances	% attendances
GP	37,200	8%
Self-referral	256,803	58%
All attendances	440,007	100%

- a patient living in one of the most deprived areas in GG&C is more than six times likely to attend ED than a patient one of the least deprived areas (see figure 14);

Figure 14 - attendances at all emergency departments in NHS GG&C (2018/19) by SIMD
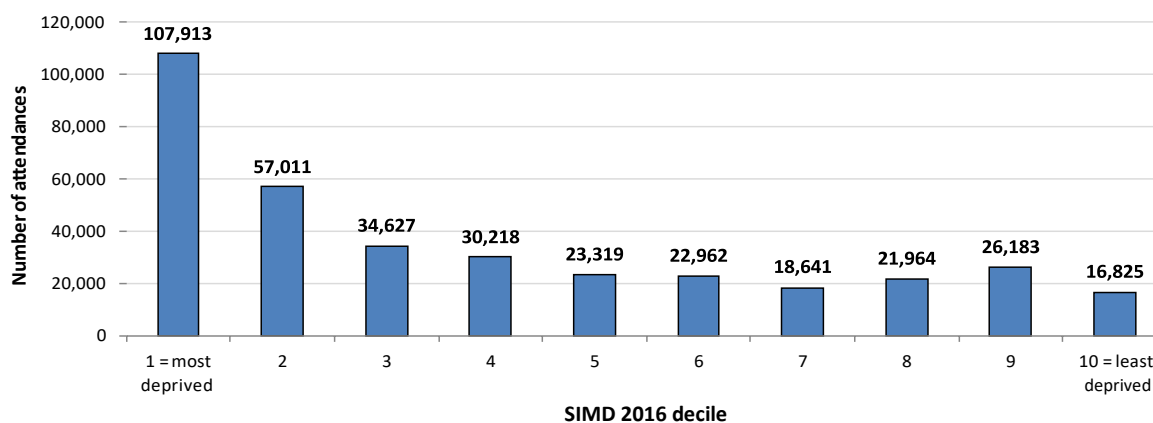
- users of mental health services were more than twice as likely to have attended ED as non-users. They were also likely to attend more frequently;

- the pattern of arrival time by hour of day has remained consistent over the past five years with most attendances occurring between the hours of 10:00 and 18:00 (see figure 17 below);

Figure 15 - attendances at all emergency departments in NHS GG&C by time of day (2018/19)
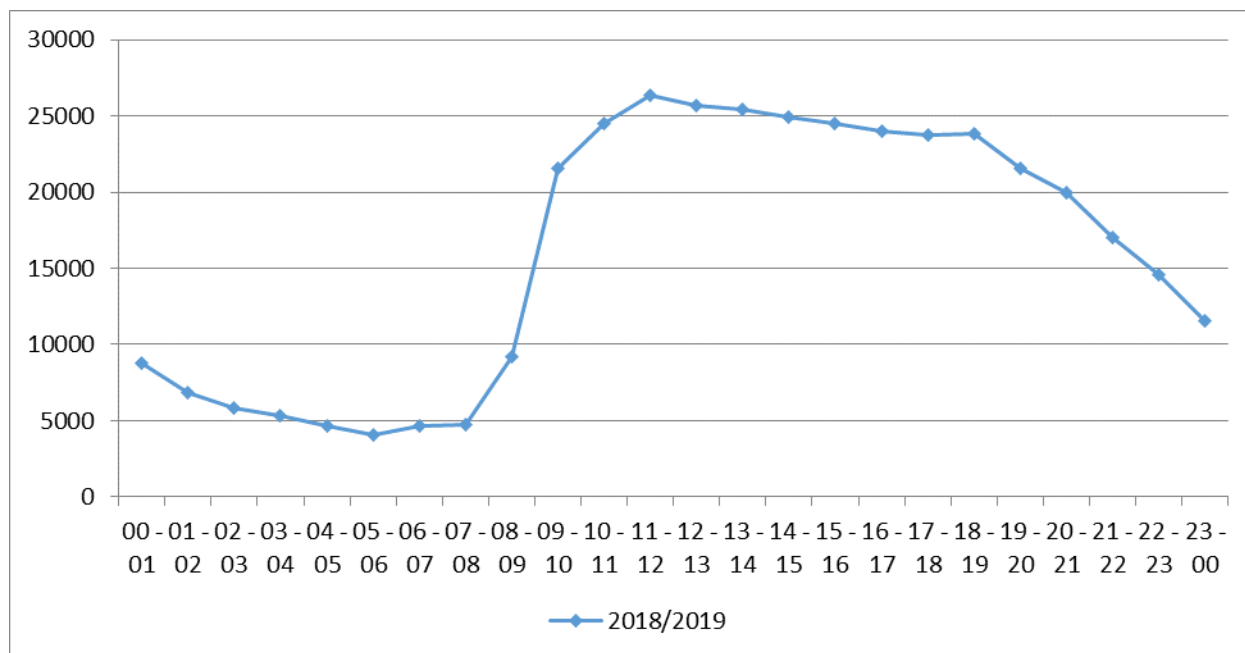
- more than one in four of all ED attendances ended with admission to hospital.

Table 6 - attendances at all emergency departments in NHS GG&C (2018/19) percentage admitted

Discharge Destination	Number of attendances	Proportion of all attendances
Admitted	105,126	28.5%
All attendances	368,993	100%

- over half of all ED attendances for people aged over 65 ended with admission to hospital. Compared to nearly one in three for people aged under 10.

Table 7 - attendances for those aged 65+ at all emergency departments in NHS GG&C (2018/19)

Discharge Destination	Total attendances (all ages)	% of attendances (all ages)	Total attendances (64+)	% of total attendances (64+)
Admitted	87,848	23%	35,250	47%
All attendances	383,298	100%	75,390	100%

Table 8 - attendances for those aged under 10 at all emergency departments in NHS GG&C (2018/19)

Discharge Destination	Number of attendances (65+)	Proportion of all attendances (65+)
Admitted	92,715	31.0%
All attendances	299,540	100%

6.8   Further analysis of attendances also shows that approximately 51% of self-presentations are as a result of a minor illnesses or ailments[39]. It is possible then that a significant proportion of self-presentations at emergency departments could be treated by other services such as primary care, pharmacy or minor injuries units[40]. Currently there are no national or GG&C policies in place to support front line staff to direct patients to other services, therefore all individuals who attend ED are seen and assessed. We wish to develop a policy of re-direction to support patients accessing the right service in the right place at the right time.

Public attitudes to A&E

6.9   In putting such a policy in place we need to understand why some people attend ED instead of other services. Recent research[41] into public attitudes to accident and emergency services found that:

- **People living in deprived areas** are more likely to prefer A&E departments over their GP to get tests done quickly, find it more difficult to get an appointment with their GP and think A&E doctors are more knowledgeable than GPs;
- **Parents with children under 5** are most likely to have used A&E in the last year, to think it is hard to get an appointment with their GP, less likely to trust their GP but are also more likely to use the internet to try to decide what the problem might be; and,
- **Men** are less knowledgeable about how to contact a GP out of office hours and less likely to use the internet to research a health problem.

6.10   The study also found that in the main people believe that A&E is overused, and a clear majority (86%) think that too many people unnecessarily use A&E services. This increases to 94% for people aged 65 to 74 years old and drops to 79% for those aged 18 to 24 years.

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[39] Demand and Capacity Model for NHS Greater Glasgow and Clyde, Final Report and Recommendations, NECS, 2019

[40] Richardson M, Khouja C, Sutcliffe K, Hinds K, Brunton G, Stansfield C, Thomas J (2018). Self-care for minor ailments: systematic reviews of qualitative and quantitative research. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London.
[41] National Centre for Social Research (August 2019)

When asked whether they had actually accessed A&E services in the previous 12 months for themselves or others, 32% of the public and more than half of parents with a child under 5 (54%) report they have done so at least once. 29% of those without young children in the household say they have visited A&Es in the same period.

6.11   Around half (51%) the population agrees that it is hard to get an appointment with a GP. Those with children under 5 (65%) and those living in the most deprived areas (59%) are most likely to agree. While over one third (36%) of the public report that they prefer NHS services where they do not need to make an appointment, those living in the most deprived areas (48%) and those with no educational qualifications (48%) are most inclined to say so. Only 27% of people living in the least deprived areas and 30% of graduates express this sentiment.

6.12   17% prefer A&Es to GPs because they can get tests done quickly. The figure rises to 29% when looking at people in the most deprived areas. This view is held by just 11% of people who live in the least deprived areas. By the same token those with no qualifications are twice as likely (26%) as degree holders to prefer A&Es to GPs to get tests done quickly (13%).

6.13   65% of the total population have confidence in GPs, while 11% state they do not have much confidence. This compares to 18% of those living in the most deprived areas, 16% of people with no qualifications and 20% of parents with a child aged under 5 who do not have much confidence. In contrast, 10% of those without young children and 8% of degree holders and 8% of those living in the least deprived areas feel the same.

6.14   Overall just 19% agree that doctors at A&Es are more knowledgeable than GPs. However, this jumps to a third for those without any qualifications (32% compared with 14% of graduates) and 28% of those in the most deprived areas (compared with 15% living in the least deprived areas).

6.15   58% of people with internet access say they would look online to help understand a health problem, while 47% would use the internet to decide what to do about it. Nevertheless, substantial gaps between demographic groups exist. Young people aged 18 to 24 are twice as likely (62%) to research health problems online than those aged 75 and over (30%). Those without children under 5 (56% compared with 72% of those with young children) and people with no qualifications (42% compared with 71% of graduates) and men (54% compared with 62% of women) are less likely to turn to the internet for health advice.

6.16   When it comes to awareness and confidence to access the right NHS services, most people (90%) report being confident that they know when to see a doctor regarding a health problem. Men (76% compared with 85% of women) and young people (64% compared with 79% of those 75 and over) emerged as the groups least confident in knowing how to contact a GP out of hours. And while 85% of people say they could rely on family and friends to care for them in the case of a non-life-threatening health

problem, this drops to 76% for those in the most deprived areas and rises to 91% for those living in the least deprived areas.

The challenge is change

6.17   So taking public attitudes into account and looking at our performance and recent trends shown above it is clear we need to do two things - change services to meet rising demand and change public awareness and attitudes. The data shows (see figure 6 above) that if emergency departments continue to operate as it stands they will not be able to cope with annually increasing demand[42]. If we do not change either, and ideally both, then primary and secondary care services are going to struggle to keep pace with demand and we will not be able to deliver the best we can for patients.

6.18   We outline our plans to raise public awareness and change attitudes in section 3. The challenge is change.

Patient advice - right service right place

6.19   From the analysis presented above it is possible some patients who are not an accident or an emergency could in theory be seen appropriately by other services rather than having to wait to be seen in A&E. We will test the potential for a service in emergency departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service. This could operate at peak periods and assist in easing pressure on emergency departments and ensuring patients are seen by the most appropriate professional.

6.20   As part of a comprehensive whole-system strategy for unscheduled care, helping patients with minor ailments navigate to alternative sources of support can also be an important change. There is evidence from other health and social care systems that supporting patients who attend A&E and who could more appropriately and safely be seen in primary care can work; e.g. Tayside. Such a policy has been implemented at GRI for certain conditions; e.g. COPD. Patients triaged are provided with information on alternative sources of community support for their condition. The policy has relatively modest aims and follows guidance from the Royal College of Emergency Medicine[43].

6.21   It is important we look at what can be done to guide patients safely and smoothly to alternative services where we can. We wish to work with acute clinicians to test re-direction arrangements at all the main acute sites so that emergency departments can focus on treating patients who need acute care. We will discuss with primary care how this might be done to ensure appointment slots are available timeously for patients re-directed from emergency departments. We estimate the impact of such a policy, supported by a public awareness campaign, the use of Consultant Connect and improved

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[42] Demand and Capacity Model for NHS Greater Glasgow and Clyde, Final Report and Recommendations, NECS, 2019

[43]   https://www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

pathways, could be that potentially in a full year in GG&C 8,000 attendances could be seen within primary care either by GPs or community pharmacies (see table 9). For GP practices this could mean an additional two appointments per week.

Table 9 – potential impact of re-direction

	Total
Non Urgent - 80%	8,711.2
Standard - 10%	9,332.9
Total	**180,44.1**

Note estimate based on 2018/19 data and assumes a reduction of 80% of activity triaged as "non-urgent" and around 10% of "standard" activity.

Minor injuries

6.22   Minor injuries units offer a safe and effective service to patients. The units at Stobhill and the New Victoria see a large number of patients year on year and regularly achieve the four hour waiting time target (see table 10 below). They offer a good model for how we can serve patients better. We think that there should be similar dedicated minor injury units at the main acute hospital sites in addition to those at Stobhill and the New Victoria. Such units would relieve pressure on busy emergency departments and improve the flow within A&E departments and access for patients, separate and distinct MIUs should be established at all main acute sites

Table 10 – MIU attendances

Year	Total attendances	No. under 4 hours	% Compliance
2018/2019	46,575	108	99.8%
2019/2020 (to February)	44,215	129	99.7%

6.23   We will test developing further the MIU service model to deliver shorter waiting times consistently and reliably to increase attendances, and encourage patients to attend MIUs for appropriate cases instead of A&E e.g. patients seen and treated within 2 hours at MIUs versus the 4 hour A&E target. We will also test a change in the hours of operation to better match pattern of demand with MIUs open to 11.00 pm at weekends and Bank Holidays. We also wish to explore the costs and benefits of opening an MIU at Gartnavel.

6.24   If minor injuries were seen in dedicated units rather than being seen in emergency departments we estimate this could significantly reduce A&E attendances with no detrimental impact on patient safety.

Frequent attenders at Emergency Departments

6.25 In 2018/19 there were 1,188 patients who had attended an A&E department in Greater Glasgow and Clyde more than ten times. In total these patients accounted for 17,918 A&E attendances – 3.5% of the total attendances in GG&C. Each Partnership has a programme of work with GPs and other services such as mental health and addictions, to review individual cases to see what early intervention or preventative measures can be taken to support these patients.

6.26 Through this programme we estimated that by the end of 2020/21 the number of A&E attendances accounted for by people who have attended more than ten times in the previous twelve months will have reduced by 2.5%. Through further extension of this programme beyond 2020/21 we estimate will reduce the number of frequent attenders as a percentage of total A&E attendances from the current level to approximately 2%.

> *Example – Inverclyde HSCP*
> Data suggests that in Inverclyde the largest group of frequent attenders either have Alcohol & Drugs issues or poor mental wellbeing. Inverclyde HSCP set a target to reduce number of frequent attenders the aim being to work with individuals on a partnership basis to reduce attendances with the provision of appropriate community services. Alcohol and Drugs Recovery Service implemented a test of change in September 2019, involving an MDT and assessment and care management approach.

Mental Health

6.27 Individuals with mental health problems have been identified nationally to be as likely to breach the four-hour emergency access target as those with any other presentation. Action 13 of the national mental health strategy highlights the unnecessary delays experienced and aims to streamline care pathways irrespective of the patient's mental health problem. The recommended model for all unscheduled care services is one part of the *Moving Forward Together* programme matching demand to a prompt and effective response. 2020 sees the proposed implementation for a more standardised approach to maximise effectiveness and efficiency. The identified actions include:

- psychiatry liaison services – rolling out a single adult mental health liaison service across NHSGGC, with designated teams working into each acute hospital during working hours and a coordinated out of hours response via a single point of access to emergency departments 24/7. Services will operate to defined response and accessibility criteria. The ability to provide a 24 hour timeous response will be coordinated across liaison and out of hours Community Psychiatric Nursing services.
- Acute Psychiatric Liaison for Older People will commence enhancing capacity of older people's liaison services to the acute sector and to care homes. This will be implemented by Liaison Services using a range of low level interventions and support for people suffering with dementia. These will target people who access

services and their families/carers at an earlier stage, help people live longer in the community and reduce attendance at emergency departments.

- Crisis Resolution and Home Treatment - enhanced Board-wide access to crisis resolution and home treatment teams as an alternative to hospital admission. The service will implement intensive home treatment coordinated across Crisis and OOH CPN services, close an identified gap in response to Emergency Departments and will be available from 8am to 11pm, 7 days a week and will offer home-based care visits up to three times daily.

- Out of Hours – Implementing in 2020 a single point of access that will coordinate care across all unscheduled activity arising outside normal working hours. This will include provision of CRHT (Crisis Resolution & Home Treatment Teams) and Liaison Services to Emergency Departments as well providing access for emergency and urgent care assessment for people presenting in distress. A senior clinician will be available to offer telephone advice to referrers and to coordinate responses from Community Mental Health Teams and Crisis Resolution & Home Treatment Teams (CRHTs) as needed.   Access as identified has also been increased to OOH CPNs from 5.00pm to 9.00am which will improve accessibility and be connected to the broader OOH review.

- Mental Health Services and emergency departments have established a standardised response time to EDs from point of referral to Mental Health Services. Both Mental Health Services and EDs are promoting a supportive joint working ethos and shared responsibility to ensure that people with a mental health presentation get the most appropriate care treatment response. The standard target response time is to carry out a face to face mental health assessment within one hour from point of receipt of referral (time of initial telephone call). Prioritisation of all referrals are based on individual patient risk factors, current demand/activity within the service, current risk factors within Emergency Departments, medical fitness, ability to engage in psychiatric assessment due to substance intoxication or availability of interpreting services.

6.28   The focus of implementation during 2020 will be on the following:

- GGC wide approach to Crisis Resolution and Home Treatment (CRHT) service 8am-11pm x 7 days. HT up to 3 x visit/treatment daily;
- Provide single point of Out of Hours access co-ordinated across all unscheduled care services arising outside normal working hours;
- One coordinated single board wide adult mental health liaison service;
- Dedicated liaison teams working in to each of the 5 acute hospital sites GRI; VOL; QEUH; RAH & IRH;
- Coordinated Out of Hours response to 4 x Emergency Departments 24/7;
- Implement an SOP describing input to the EDs and inpatient wards;
- Development in partnership with third sector, a tender for Safe Haven Crisis outreach model to provide an alternative response to people in distress (away from EDs);

- Evaluating pathways and safe response models as an element of a partnership with a commissioned 3rd Sector Safe Haven hub approach across Glasgow City to support distressed people to access care and prevent attendance at accident and Emergency Units; and,
- Test the concept of new health and social care assessment model for older adults.

GP assessment units

6.29 At each main hospital site in GG&C there are assessment units located close to emergency departments where GPs can refer patients to be assessed. Such referrals are usually unplanned and made on the same day when a patient has been seen by a GP, and a decision taken that they need assessment in secondary care. These units provide an essential service to patients and support to GPs and are extremely busy departments. Prior to these units being introduced referrals such as these would be made straight to emergency departments. The current rate of referral to assessment units is shown in table 12.

Table 11 – GP referrals to assessment Units

	2017/2018	**2018/2019**	**2019/2020 (to February)**
GP referrals	13,030	12,587	10,040
Total attendances	55,705	56,709	49,152
% GP referrals	23%	22%	20%

6.30 There is a variation across the main hospital sites in the ratio of attendances at assessment units and the number of admissions. We will work with assessment units and GPs to explore the reasons for this variation with a view to improving overall ratios and in particular reduce the number of people discharged in the same day by the development of care pathways for such conditions such as DVT and abdominal pain (see above). Providing alternatives to admission as described above will assist in achieving such improvements.

Table 12 – GP Assessment Units - ratio of attendance to admission

	2017/2018	**2018/2019**	**2019/2020 (to February)**
Total admissions	31,106	31,022	25,929
Total attendances	55,705	56,709	49,152
% admissions	56%	55%	53%

6.31 A significant proportion (45-48%) of GP referrals to AUs are discharged on the same day and not admitted. Most attendances occur between the 4pm and 6 pm with same day discharges often taking place in the evening. As well as being inconvenient for patients and their families there is a risk that patients are admitted overnight because of

difficulties in getting patients home safely. Work will be undertaken to review same day discharges and what alternatives could be offered to GPs on a planned basis, and what the impact might be if discharge to assess was scaled up. It is also suggested that the contact telephone number of the consultant in charge should be shared to encourage GPs to contact the consultant to seek advice before making a referral.

6.32 We will look at potential alternatives for GPs for this group of patients where advice and or tests are needed and can be managed the next day. The potential here might be we give GPs the ability to book patients directly into next day clinics for advice and treatment. This would alleviate pressure on assessment units and give patients and GPs assurance that they will be seen quickly and on a more planned basis.

6.33 Initial analysis indicates that the effect of such a programme could be a significant reduction in admissions from assessment units although clearly some of this activity would be converted into planned activity in other services such as diagnostics.

Advice to secondary care clinicians

6.34 In seeing patients who attend emergency departments it is important secondary care clinicians can access support and advice in order to make decisions about the next steps. Currently emergency departments can access advice from CPNs, community rehab, hospital discharge teams and others for support in managing patients. HSCPs will review these arrangements with acute clinicians to see what improvements can be made to respond to an increase in the numbers attending. We are conscious that in a busy ED department when decisions about a patient need to be taken quickly it can be confusing to know who to turn to in HSCPs for advice and support.

Day of care survey

6.35 A national Day of Care survey was carried in October and May 2019 out to provide an overview of in-patient bed utilisation across NHS Scotland. In GG&C the survey involved 3,038 patients in 3,216 beds and an overall occupancy level of 94.7%. The results of the survey were that:

- 13.8% of in-patients did not meet survey criteria for acute hospital care;
- the main three reasons identified for patients not being discharged were:
  - awaiting social work allocation/assessment/completion of assessment;
  - awaiting consultant decision/review; or,
  - legal or financial reasons.

6.36 The audit also concluded that the older the patients were, the less likely they were to meet the criteria for acute care.

6.37 These numbers compare well with previous audits although the number of patients and beds surveyed, and occupancy levels were higher than in May 2019 when the last survey was conducted.

6.38 HSCPs are keen to work with the NHS Board and the acute division to take forward the results of the survey. Our programme to improve discharge and our proposals to provide GPs with alternatives to admission should positively impact on these results going forward. We would wish to see an improvement in performance from current 14% of bed days not meeting the acute care criteria to 10% in 2022/23.

Length of stay

6.39 One area highlighted in the day of care survey that impacts on patient flow within the acute hospital system is the length of time patients spend in a hospital bed. There are variations in length of stay across specialties and hospital sites. When comparing GG&C hospitals performance there is significant variation (see table 9 below).

Table 13 – length of stay by specialty by hospital compared with Scotland – general, geriatric & respiratory medicine 2018/19

Hospital	All specialties	General Medicine	Geriatric Medicine	Respiratory Medicine
Glasgow Royal Infirmary	5.2	3.3	10.8	7.4
Inverclyde Royal Hospital	7.2	5.9	20.6	*2.6
Queen Elizabeth University Hospital	6.3	5.1	12.2	5.9
Royal Alexandra Hospital	6.1	6.1	16.1	*1.9
Vale of Leven General Hospital	6.6	4.5	14.7	*1.1
NHS Greater Glasgow & Clyde	**6.2**	**4.9**	**15.5**	**6.1**
NHS Scotland	**6.3**	**4.9**	**16.7**	**5.9**

* - denotes small number of spells
Source: NSS Discovery dashboard
Notes:
Description: Analysis of the variation in LOS based on Total LOS and number of spells
Numerator: Total LOS (days)
Denominator: Number of spells

6.40 There is a need for fast access to investigation, diagnostic services and pharmacy services to shorten lengths of stay and prevent potentially avoidable admissions. We need also to optimise bed use given demand pressures generated by scheduled and unscheduled care needs, and delivery of waiting time targets. Implementation of the NHS Board's 2017 unscheduled care improvement programme is key to this and the following should contribute to delivering these improvements for patients.

Consultant geriatricians and GPs

6.41 Considerable progress has been made in joint working between HSCPs, GPs and consultant geriatricians. Further development of these links is desirable to better support patients in the community. Particular areas of focus for the next stage of this work would be:

- geriatrician support to GPs who cover care homes potentially utilising Attend Anywhere for MDTs;
- defining the geriatrician's role in anticipatory care planning, the management of complex cases and involvement in MDTs;
- introducing telephone or virtual clinics between GPs and geriatricians including advising GPs before referrals to AUs;
- considering the role of day hospitals in the provision of community based older people's services including the potential for the urgent / rapid review of patients referred by GPs; and,
- improving the management of frailty in the community as part of the frailty collaborative and the development of an integrated primary / secondary care frailty pathway.

6.42 Consultant geriatricians currently undertake a number of sessions in the community at a day hospital or other community setting. These sessions are important in supporting patients in the community after discharge or preventing potential future hospital admission and providing integrated care with community based services including GPs. As part of this plan we would like to explore the potential for more community sessions as part of developing an integrated approach to managing frailty within community settings, working with the third and independent sectors, including housing. We will work with consultant geriatricians to explore the opportunities to take further steps to develop more integrated care pathways.

<u>Summary</u>

6.43 In this section we have focused on our priorities to improve the interface between primary and secondary care, including actions to reduce demand on our emergency departments. This programme requires a whole system approach to make progress, and further discussion particularly at a clinical level between GPs and secondary care clinicians to move these proposals forward. Improving links between primary and secondary care is a long term agenda recognising the changes taking place within general practice and the scale and size of the health and social care system in GG&C. Nevertheless some important key steps can be made early to impact on emergency care such as:

- introducing dedicated minor injury units at each emergency department to improve flow and performance against the four hour target;
- introducing a re-direction policy to support patients access appropriate emergency services;
- reducing the number of frequent attenders at A&E;
- improving the proportion of patients seen on a planned basis as an alternative to attendance at GP assessment units;
- improving length of stay; and,
- improving links between GPs and consultant geriatricians.

7.   IMPROVING HOSPITAL DISCHARGE

Introduction

7.1   The plan is about taking a 'whole system approach' to unscheduled care and outlines a range of community alternatives to hospital admission. We recognise that hospitals provide valued and essential assessment, treatment and care and patients are often admitted because the necessary care and treatment they need cannot be provided safely and effectively at home or in the community. It is important that all potential options are explored with patients and their carers before a decision is taken to admit someone to hospital. Anticipatory care plans have a role to play here.

7.2   A prolonged stay in hospital however is often not associated with a good outcome so we must do as much as we can to speed up the discharge process. Being in hospital can disconnect people from their family, friends and social network and can result in a sense of isolation, loss of confidence and depression. Visiting hospital for a long period may heighten an already stressful situation for family carers. Older people experience functional decline as early as 72 hours after admission and are more likely to have an episode of delirium or infection. The risk of a poor outcome increases every time a frail patient is moved from ward to ward.

7.3   Every unnecessary day in hospital increases the risk of an adverse outcome for the individual, drives up the demand for institutional care and reduces the level of investment that is available for community support.

Improving discharge

7.4   Achieving safe, timely and person centred discharge from hospital to home is therefore an important indicator of quality and a key measure of effective and integrated care. Once a patient is fit for discharge it is in their best interest that this takes place as quickly as possible so that they can settle safely and comfortably at home or other appropriate setting. For those patients who need further support in the community from health and / or social care it will often be the HSCPs' discharge teams that make sure that support is in place. For most patients discharge will be followed up by community services and / or their GP. We want to ensure that people get back into their home or community environment as soon as appropriate and with minimal risk of re-admission to hospital.

7.5   On a typical day there are over 250 discharges from acute hospitals in GG&C. Most of these discharges occur during the hours of 14.00 and 17.00. The pattern of discharges varies during the week with most discharges occurring towards the end of the week. Ideally we would like to see this pattern spread more evenly throughout the week, including weekends, and increase the number of discharges occurring before 12.00 noon and at weekends as this easies pressure on home care, community services and others who follow up patients in the community.

7.6 We will aim to routinely discharge patients home from hospital in days not weeks. We believe that when a patient no longer requires to remain in hospital, they should be discharged home and their post hospital rehabilitation, care and support needs met by the local community services. If return home is not possible in the short term, they should transfer to a step down bed in the community for a period of Intermediate care and rehabilitation.

Example - Home for Me, East Dunbartonshire
In East Dunbartonshire Home for Me is working closely with orthopaedics to support early discharge with follow up rehabilitation and home care re-ablement

Example – Home First, Inverclyde
In Inverclyde Home First tracks patients in hospital and once a discharge date is agreed early referral is made so patients can be discharged to assess with an appropriate risk assessment. The Home1st team brings together ACM, reablement, in reach team and discharge team to move the emphasis of discharge planning from hospital to community provision. Discharge planning begins in the community and assessments completed in the service users home. The discharge to assess approach, when an individual is medically fit to be discharged they return home where an assessment for future needs is completed by the Home 1st (Reablement) Team. In this way Inverclyde ensure a smooth patient pathway, early referral for social care assessment and reduce duplication. Care Home Liaison Nurses are also involved in supporting care homes to maintain residents in community and avoid hospital admission

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Discharge process

7.7 We will begin care planning as soon as possible after a patient is admitted to hospital and involve the appropriate members of the multi-professional team at the earliest opportunity. Planning for discharge with clear dates and times reduces a patient's length of stay, potential re-admission and therefore pressure on acute hospital beds. The multi-disciplinary team should meet ideally within 12 hours of a patient's admission to consider the patient's discharge plan so that patients can be discharged safely onto the next appropriate area of care.

7.8 Key to a successful discharge is:

- specifying an estimated date and/or time of discharge and discharge planned from the point of admission (or before) with the norm being discharge within hours and days of readiness rather than weeks;
- identifying early what a patient's discharge needs are and how they will be met;
- taking a personal outcomes approach that tackles every delay, every day and uses data to examine performance and challenge causes of variation;
- active participation by patients and their carers ensuring that they understand and are able to contribute as appropriate to care delivery and discharge planning;

- identifying a named person with responsibility for co-ordinating all stages of discharge planning throughout the patient's journey including engagement with housing where appropriate;
- an acute hospital bed is not the best place for assessing an individual's need for long term care and support so, unless unavoidable, no-one should move directly from an acute bed to a long-term care home placement; and,
- most importantly we will adopt of a culture of 'Home First' as a default position - wherever possible and safe, patients should return to the home they were admitted from and only explore alternatives if this is not possible.

Discharges before 12.00 noon

7.9   This plan proposes more discharges before 12.00 noon – currently less than 10% of discharges are before midday. Earlier in the day discharges would be better for patients allowing them time to settle beck at home or other setting, and also ease pressure on wards. We propose an improvement of 10% over the next 12 months.

Intermediate care

7.10   Intermediate care acts as a bridge between hospital and home for those deemed medically fit for discharge but who are delayed in hospital. In this way it ensures that acute hospital capacity is used appropriately and individuals achieve their optimal outcome and has been shown to be effective[44].

7.11   There are a number of intermediate care places in GG&C commissioned by HSCPs from the independent care sector. The function of this service is to create a stable non-acute environment where individuals being discharged from hospital with enduring complex care needs can have their long-term social care assessments undertaken.

7.12   Most intermediate care resources are of this 'step down' type of provision for patients transferred from an acute hospital. However, the model also lends itself to 'step up' intermediate care where a patient might be referred to avoid a potential hospital admission. This aspect of the model needs further development and has the potential to offer GPs another option for patients even in an emergency or urgent situation. We will explore this further with GPs and the independent care sector and how this service might operate.

Adults with Incapacity (AWI)

7.13   At the time of writing there were 57 patients in acute hospital beds who have been identified as AWI patients within the definition of the Act[45]. AWI patients typically have a

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[44]Implementing a step down intermediate care service, Kate A. Levin, Martine A. Miller, Marion Henderson, Emilia Crighton, Journal of Integrated Care, ISSN: 1476-9018, 10 October 2019

[45] https://beta.isdsscotland.org/find-publications-and-data/health-and-social-care/delayed-discharges/delayed-discharges-in-nhsscotland-monthly/

longer length of stay than other patients and therefore consume more acute bed days than other patients. In 2018/19 AWI patients accounted for 10,037 bed days in GG&C – over a quarter of all bed days. HSCPs will bring a dedicated focus and resources to monitoring and expediting guardianship process as far as their authority extends

7.14 Following a legal challenge to the Health Board policy on AWI by the Equalities and Human Rights Commission we have ceased admitting AWI patients to specific care home places. Currently alternative pathways are being explored. In the interim the number of AWI delays in acute hospital beds is likely to rise.
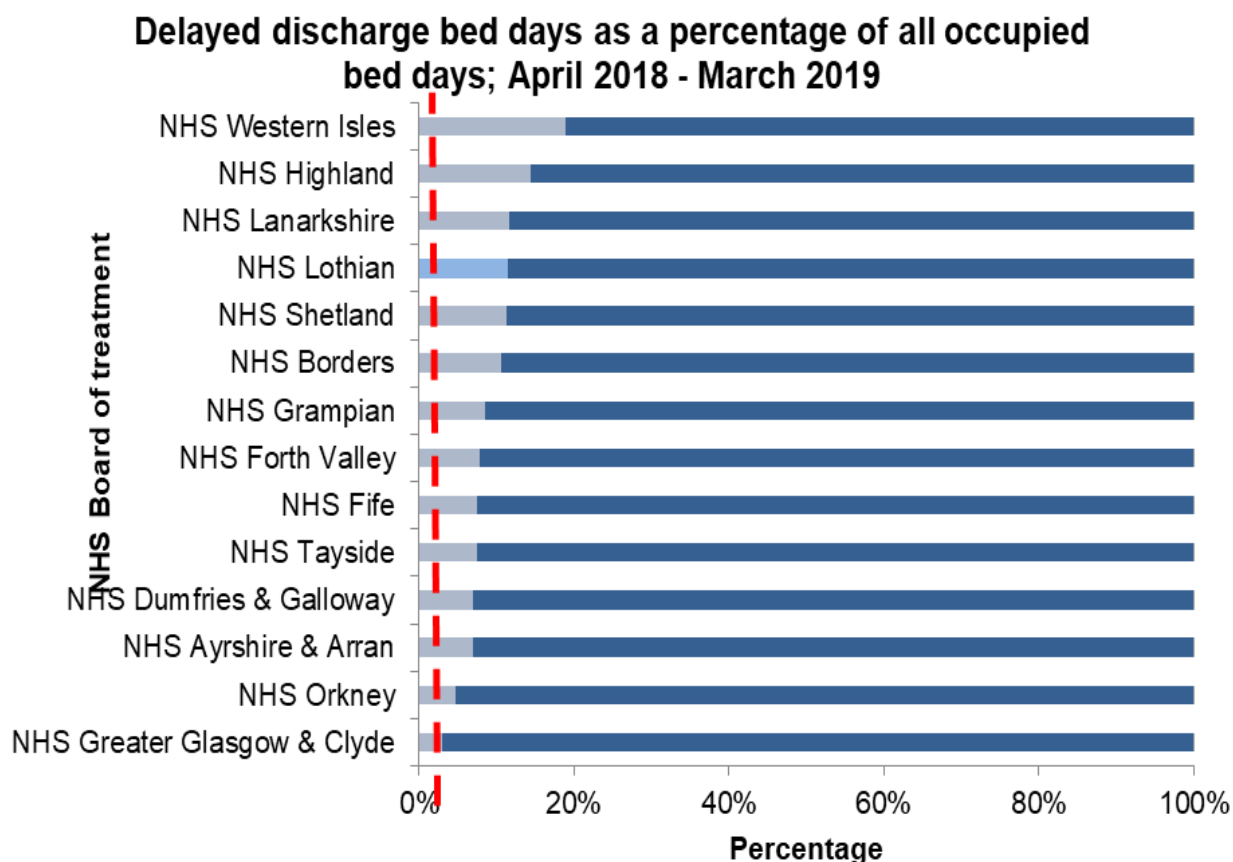
Improving Delayed Discharges

7.15 HSCPs have performed well in recent years in managing delayed discharges which have been on a downward trajectory since 2016. However, reflecting pressures in the wider health and social care system our performance has declined over the past 12 months. While this mirrors a trend nationally, GG&C performance as a whole continues to compare favourably with other Health Boards. HSCPs and the Acute Services Division have robust processes in place to manage delays on a day-to-day basis, and a range of actions are currently being implemented designed to improve hospital discharge arrangements and patient outcomes.

7.16 It is widely acknowledged that delays in patients being discharged from hospital can be detrimental to patient care. No patient ideally wants to remain in hospital any longer than they need to. A long delay can often lead to a patient falling ill again, or losing vital life skills, independence or mobility. It could ultimately result in the patient having to be admitted to a care home due to the deterioration in their health and mobility. There is clear evidence that an unnecessary, prolonged stay in hospital can be detrimental to a person's physical and mental wellbeing.

7.17 In GGC acute patients who are declared fit for discharge are immediately recorded as such and "the clock starts ticking" with reports generated daily on the number of delayed patients in the health and social care system and into which category they fall e.g. AWI, mental health etc. The discharge planning process will begin much before this date, and this is now further improved with the introduction of the Estimated Date of Discharge on admission to an acute ward, and availability to HSCPs of inpatient data via dashboards.

7.18 The current rate of delays (i.e. all delays) for all patients aged 75 plus per head of population by HSCP for 2018/19 is shown in figure 24 below and illustrates that the performance of GG&C HSCPs compares favourably with other HSCPs nationally.

Figure 16 – Delayed discharges per 1,000 population aged over 75 by HSCP – April 2018 to March 2019

Local authority of residence

Rate per 1,000 population, aged 75+
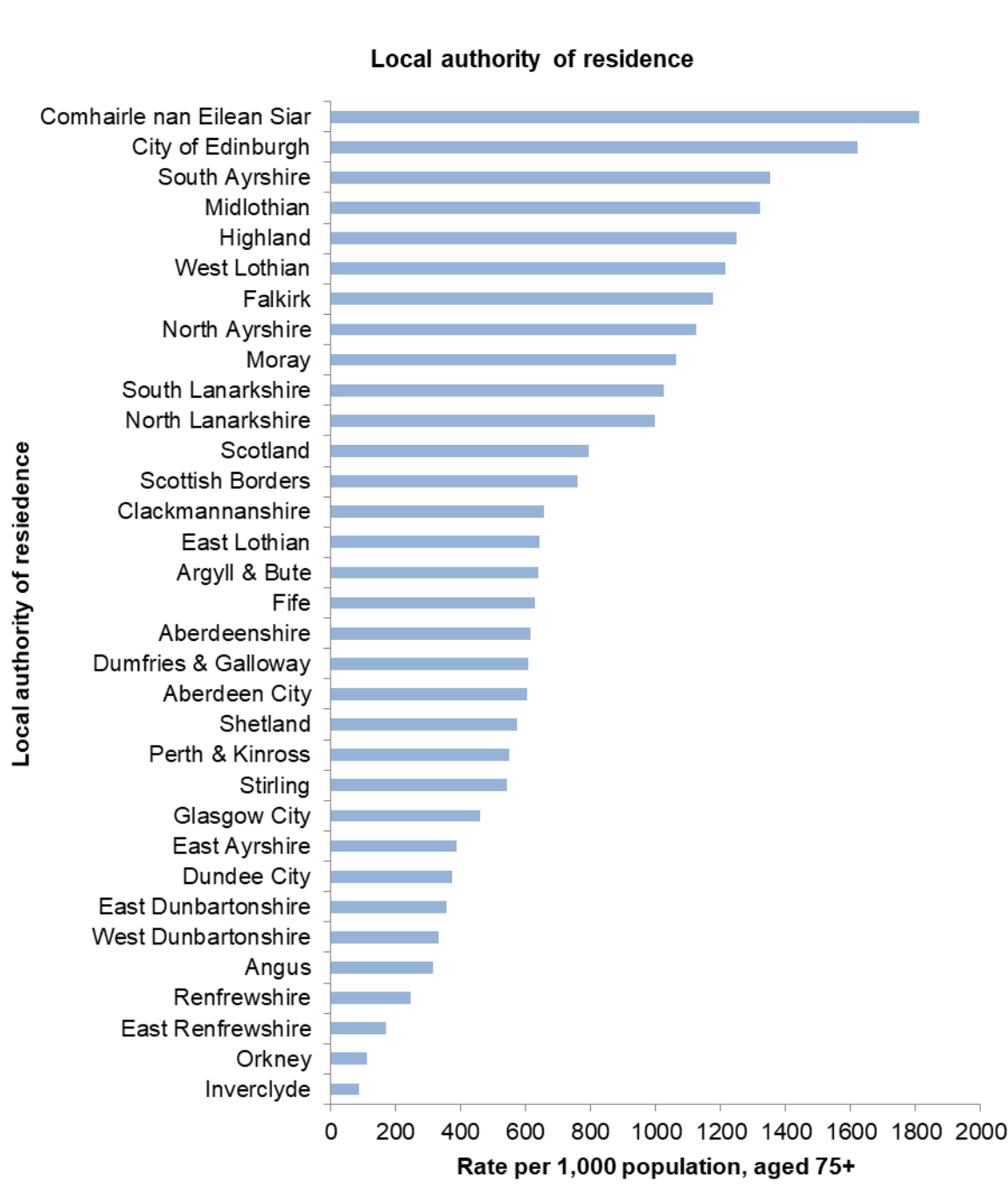
7.19 This is further illustrated when considering the percentage of acute beds in GG&C (3.1%) occupied by people who were delayed in their discharge (see figure 17 below);

Figure 17 – delays as a percentage of acute beds – 2018/19

Delayed discharge bed days as a percentage of all occupied bed days; April 2018 - March 2019

7.20 The number of delayed discharges in GG&C and the associated bed days due to delays has increased in recent months:

- the number of acute delays for patients aged over 65 in GG&C has risen from 352 in January 2019 to 472 in January 2020 – the highest since 2012/13;
- total acute delays for all ages in GG&C has risen from 342 in September 2018 to 527 in January 2020 (this is the highest it has been for some years);
- in 2018/19 there were 36,968 bed days occupied by people delayed in their discharge, and of these 29,072 were occupied by people aged 65 years and over (see figure 26 below); and,
- there has been an increase of 9,323 in delayed discharge bed days between 2017/18 and 2018/19.

Figure 18 – Acute hospital bed days lost due to delays – over 65 – AWI and none AWI - April 2012 to February 2020
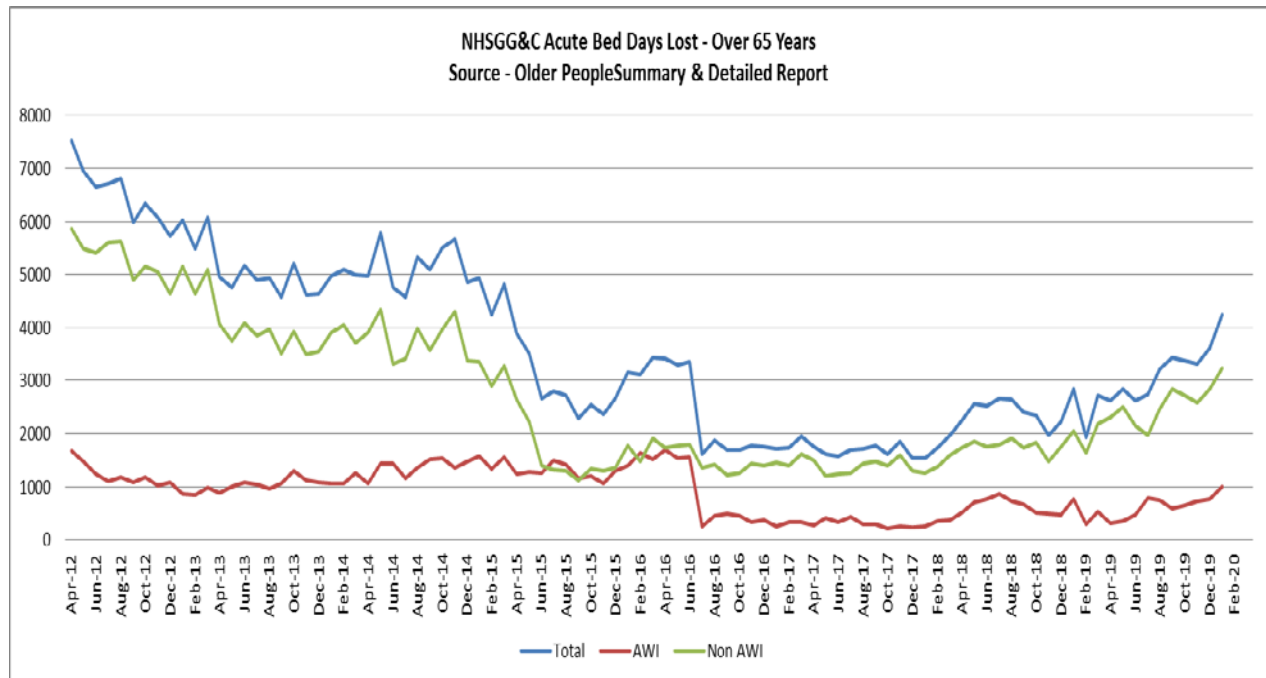
7.21 The main reasons for delay in GG&C are:

- o awaiting place availability (28.4%);
- o awaiting completion of care arrangements (22.4%);
- o complex delay reasons (21.5%);
- o awaiting community care assessment (20.6%); and,
- o other reasons including funding, transport, patient and family related reasons (6.8%).

7.22 Recent analysis has shown that there is a significant variation across hospital sites in the timing of referrals to social work services as part of the discharge process. This variation creates an added challenge to respond effectively to the assessment of individuals in a time sensitive manner. There is a clear relationship between early referral to social work and a reduction in delays. Where referral occurs earlier in the patient pathway, the data shows that delays are mitigated or reduced. The average delay following same day referral to social work for those who become delayed discharges is eight days. A third of referrals were made with less than three days of the patient being reported as 'Ready for Discharge' (RFD). The average length of stay for those referred on the same day was 26 days at the point of referral. This would suggest that for many people, there could be opportunities for earlier signposting of patients in areas of high activity in advance of referral and for referrals to be made earlier in the patient stay.

7.23 All HSCPs have action plans in place to reduce delays (see annex B). Additional staffing is being recruited to Glasgow City HSCP's hospital discharge team. East Dunbartonshire

have substantiated the Social work resource within the Home for Me service to improve relationships, communication and consistency within the wards. Inverclyde HSCP has additional assessment staff for the Home1st Assessment and Rehabilitation Service. West Dunbartonshire HSCP are re-aligning staff within the Hospital Discharge Team to place greater emphasis on in-reach/ early assessment. In addition, West Dunbartonshire's new Focussed Intervention Team is responding to referral where a hospital admission is being considered, and through intense support, avoid these admission in 60% of cases.

7.24   The aim of these actions at a GG&C level is to reduce delays so that they account for approximately 2.5% to 3% of total acute beds, and that bed days lost due to delays (non AWI patients) are maintained within the range of 37,000 to 40,000 per year. In summary these actions include:

- increased intermediate care capacity;
- discharge teams linked more closely to acute wards;
- estimated date of discharge planning;
- direct access to home care or same day response to care packages;
- increased support within hospital discharge teams; and,
- improvements to the process for managing AWI patients

Managing capacity at peak times – seasonal planning

7.25   The health and social care system experiences peaks of demand at certain periods during the year usually over the winter period and at bank holidays, and also when conditions such as flu affect large sections of the population. It is essential that we review the capacity of the system to meet these peaks in demand and ensure patients continue to receive a consistently high quality service throughout the year. We must plan additional supports during these key points of the year, and scale up services quickly where we need to. In doing so we will be guided by our strategic direction to manage patient care in the community and avoid the need for hospital admission. Each year we will develop a capacity plan informed by the latest projections of future demand.

7.26   We also need to consider managing services on a 52 week annual cycle. At present we scale services down for several days over annual holiday periods. As demand is 24/7 all year round we do put strain on the system by managing 52 weeks demand over a 51-50 week year. We fully recognise that staff need a break and are entitled to annual leave, but we do need to look at ways we can deliver services throughout 52 weeks of the year.

7.27   Our aim is that we have a coherent system wide plan capable of adapting to seasonal or system pressures so we can flex capacity and service responses as needed. Traditionally our response has been to open additional beds over the winter period the consequence of which is to place additional demands on other parts of the health and social care system. Our aim starting in 2020/21 will be not to open any additional beds in line with our overall approach in this plan to prevent admission and build capacity within community services. As part of our seasonal planning we will continue to:

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- proactively manage a flu immunisation campaign both to staff and the general public to encourage increased uptake, including capitalising on the role of community pharmacies;
- proactively deliver a public awareness campaign on what services to access for what over the holiday period and alternatives to accident and emergency such as minor injuries;
- implementation of the re-direction protocol in emergency departments to advise patients on appropriate services;
- seven day working to support improving weekend discharges and discharges earlier in the day;
- introducing "hot clinics" for quick access for GPs for specific conditions such as abdominal pain; and,
- take forward actions to improve communication between GPs and secondary care clinicians e.g. consultant connect for GP to consultant advice

Summary

7.28 In this section we have outlined our priorities for improvements in unscheduled care services to ensure patients receive the right care in the right location and at the right time. We have outlined proposals we intend to test with secondary care clinicians and primary care to provide GPs with alternatives to admission and other actions that can be taken to better respond the changes in demand that can yield further improvements in our health and care system.

7.29 In summary the key actions to improve the discharge process planned are:

- take a personal outcomes approach and encourage the active participation by patients and their carers in the discharge planning process;
- identify a named person with responsibility for co-ordinating all stages of discharge planning;
- as early as possible following admission, including agreeing an estimate date of discharge;
- adopt a home first default position;
- better managing community capacity by increasing the number of discharges earlier in the week, before 12.00 noon and at weekends;
- improving our management of delays; and,
- better manage capacity over the winter period and at other times of the year.

8. RESOURCING THE CHANGES

Introduction

8.1 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.

Financial Framework

8.2 This commissioning plan represents the first step in moving towards delegated hospital budgets and set aside arrangements within Greater Glasgow and Clyde. In 2019/20 unscheduled care is estimated to cost Greater Glasgow and Clyde £438.7m. With a budget of £409.3m identified by Greater Glasgow and Clyde Health Board. This is a shortfall in funding of £29.4m and represents a significant financial risk to Greater Glasgow and Clyde Health Board and the six IJB's with strategic responsibility for this area.

8.3 This budget shortfall impacts on the IJB's ability to strategically plan for unscheduled care. Nationally there is an expectation that IJB's, 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[46] which assumes that 50% of savings released from the hospital sector will be redirected to investment in primary, community and social care service provision. The ability to achieve this in Greater Glasgow and Clyde is hindered by the existing financial position outlined at 8.3 above.

8.5 The commissioning plan identifies a number of key actions and investments which require financial investment to deliver. Work is in hand with all HSCPs and the acute division to identify the level of resource needed across the life of the plan. Until this is complete only projects which can be funded within existing resources will be progressed.

Acute Inpatient Beds Plan

8.6 There is a requirement that this Commissioning Plan outlines an inpatients beds plan for the specialities included in the set aside arrangements (see 1.11 above). Annex C shows the changes in inpatient beds across the main acute hospital sites in GG&C since 2010. These numbers show that the potential to significantly reduce further acute beds capacity in NHSGGC is limited given the current and projected future demand for acute hospital care.

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[46] https://www.gov.scot/publications/scotlands-fiscal-outlook-scottish-governments-medium-term-financial-strategy-2019/

8.7 Further the acute system in NHSGGC already benchmarks favourably with the rest of Scotland in terms of its efficiency KPIs, reflected in average length of stay (ALOS) and day of care audit data (see table 14).

Table 14 – acute inpatient beds benchmarks 2019

Indicator	Pan-Scotland Acute (28 Sites) Oct 2019	Pan-Scotland Acute (29 sites) May 2019	NHSGG&C Oct 2019	NHSGG&C May 2019
Bed Occupancy %	**96%**	95%	94.7	96.29
Day of Care - criteria not met %	**19%**	21%	13.8	14.12

8.8 NHSGGC has also given effect to the Scottish Government's Hospital Based Complex Clinical Care (HBCCC) guidance from May 2015, which saw all acute continuing care capacity in the Board area phased out over the past 3 years (see annex c).

8.9 As the scope to deliver a further significant reduction in future acute inpatient bed capacity is limited we will take action to support the acute hospital system to manage growing demand without having to expand bed capacity (the thrust of the actions in section 5) and specifically we will work with the acute system to reduce the requirement to open additional winter beds over the winter period to zero over the lifetime of this plan (see annex D).

8.10 As per the set aside arrangements, this would require funds to be directed towards community alternatives to hospital, in line with the programme detailed in this plan. The ability to do this will be dependent on the level of funds available for investment over the life of the plan and represents a risk to delivery.

9. MEASURING IMPACT AND PROGRESS

Introduction

9.1 In this section we look at the potential impact of the programme outlined in this draft plan and the key measures we will use to monitor progress.

9.2 In a large and complex system such as GG&C with many moving parts estimating and forecasting the impact of specific interventions is not an exact science. There are many external factors that can influence the impact of any given intervention – some of which are not in our control. Forecasting or estimating impact is even more difficult when looking into future years. The numbers presented below should therefore be viewed with caution and should not be considered as a firm guarantee of future impact; they are a guide and our best estimate based on what the evidence says and our knowledge of the health and social care system in GG&C. These numbers will also need regular review and updating following implementation.

Key Measures

9.3 The key indicators we propose to use to measure the impact of our programme are:

- emergency departments attendances:
    - delivery of the four hour target
    - total attendances by age, sex and deprivation
    - total attendances per head of population
    - rates of admissions and discharges
    - frequent attenders
- minor injury units attendances:
    - delivery of the four hour target
    - total attendances by age, sex and deprivation
    - total attendances per head of population
    - rates of admissions and discharges
- GP assessment units attendances:
    - total attendances by age, sex and deprivation
    - total attendances per head of population e.g. 65-74, 75+
    - rates of admissions and discharges
    - GP referral rates
- emergency hospital admissions:
    - admissions by age, sex and deprivation
    - rates per head of population e.g. 65-74, 75+
    - length of stay
    - rates per GP practice
- acute unscheduled care bed days
    - rates per head of population e.g. 65-74, 75+
- acute bed days lost due to delayed discharges

  o rates by age e.g. e.g. 65-74, 75+
  o AWI and non AWI rates
  o bed days lost as % of total acute beds

9.4 In assessing the impact of the programme outlined in section 5 to prevent admissions, and based on current rates of admission per head of population and for different age groups (e.g. 65-74, 75 plus) we estimate that the full implementation of this programme will likely result in a reduction in the rate of emergency admissions for over 65s by 4.9% by 20205 (see figure 19 below). This estimate takes into account the demographic changes forecast over this period.

Figure 19 – projected percentage change in emergency admissions (based on 2018/19 data)
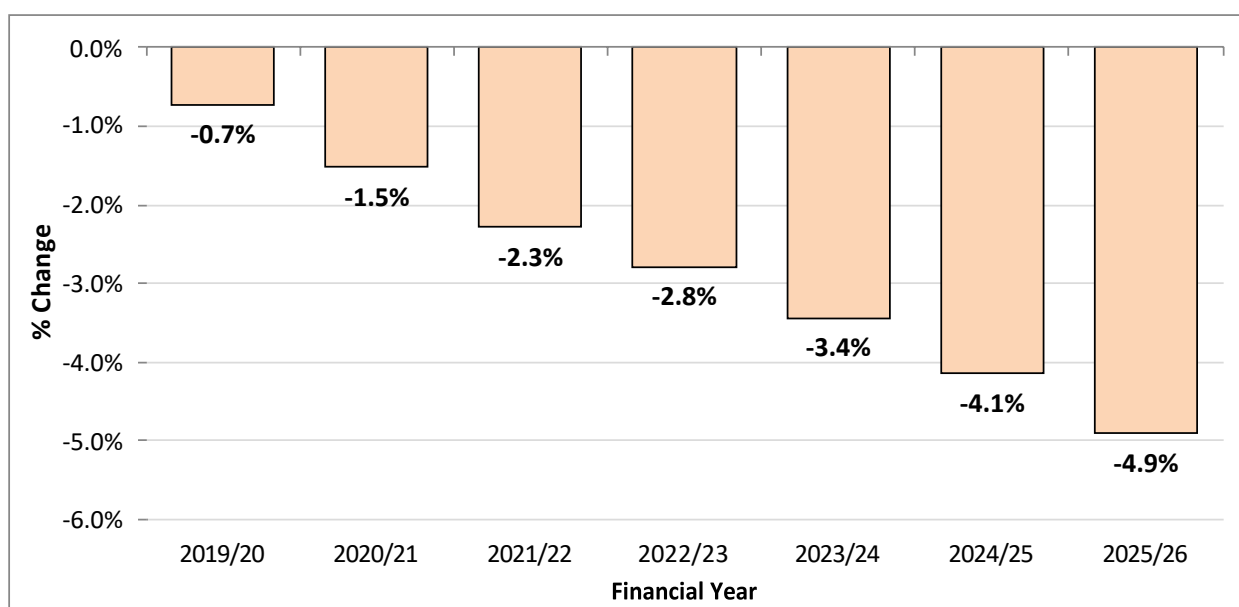
9.5 An important caveat to these projections is that other changes in the population e.g. changes in life expectancy, wider society and the economy highlighted in section 1, will affect these numbers in ways that are difficult to predict at the present time.

9.6 Work is underway to identify the potential impact of all the actions outlined in this draft plan. Through this further work we aim to demonstrate that if plans are delivered in full by 2021/22 as envisaged this will not only enable increases in demand anticipated from changes in our population to be met, it will also result in a reduction in current costs.

10. CONCLUSION

10.1 The purpose of this plan is to outline how the six NHSGG&C HSCPs in partnership with Acute Division and other partners aim to respond to the continuing pressures on health and social care services in Scotland's largest Health Board. For a number of reasons health and social care services are stretched and we are struggling to meet key targets. In a large system such as GG&C a large number of patients are seen by health and social care professionals in a variety of different settings on a daily basis. When looking to the future we can see that demand will increase as the number of people aged over 75 is forecast to rise over the next five years. We need to change therefore if we are to both meet current and future demand.

10.2 The challenge is change. We need to do somethings differently (e.g. out of hours services) and we need to change some services (e.g. mental health services) to respond better to patients. We need to scale up some of what we are already doing (e.g. anticipatory care planning) and we need to try new things (e.g. "hot clinics" for GPs). We also need to look at putting new additional services in place (e.g. minor injury units) and changing how emergency departments operate more effectively.

10.3 We also need to communicate more directly with patients and the general public to ensure people know what service is best for them and can access the right service at the right time and in the right place.

10.4 The programme outlined in this plan is based on evidence from elsewhere of what works and our estimate of patient needs in GG&C. We believe it is the right way forward. The changes proposed will not take effect immediately or all at the same time. Some need testing and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is change to respond to current and future demand, the challenge is also maintaining the direction outlined in this plan over the longer term so that we can better meet the needs of the people we serve.

Annex A

SUMMARY OF THE EVIDENCE[47]

Redesigning elective care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Improved GP access to specialist expertise
Mixed evidence, particularly on overall cost reduction	• Peer review and audit of GP referrals • Shared decision-making to support treatment choices • Shared care models for the management of chronic disease • Direct access to diagnostics for GPs
Evidence of potential to increase overall costs	▯ Consultant clinics in the community ▯ Specialist support from a GP with a special interest ▯ Referral management centres

Redesigning urgent and emergency care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Ambulance/paramedic triage to the community
Emerging positive evidence	• Patients experiencing GP continuity of care
Evidence of potential to increase overall costs	• Extending GP opening hours • NHS 111 (NHS24 in Scotland) • Urgent care centres including minor injury units (not co-located with A&E)

Avoiding hospital admission and accelerating discharge

Relative strength of evidence of reduction in activity and whole-system costs	Initiative

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[47] *Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.*

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence Emerging positive evidence	⬚ Condition-specific rehabilitation ⬚ Senior assessment in A&E ⬚ Rapid access clinics for urgent specialist assessment
Mixed evidence, particularly on overall cost reduction	• Intermediate care: rapid response services • Intermediate care: bed-based services • Hospital at Home

Managing 'at risk' populations

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Additional clinical support to people in nursing and care homes • Improved end-of-life care in the community • Remote monitoring of people with certain long-term conditions
Emerging positive evidence	• Extensive model of care for high risk patients
Mixed evidence, particularly on overall cost reduction	⬚ Case management and care coordination ⬚ Virtual ward

Support for patients to care for themselves and access community resources

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Support for self-care
Emerging positive evidence	• Social prescribing

Annex B

HSCP DELAYED DISCHARGE ACTION PLANS
SUMMARY

Each HSCP, working closely with the acute services division, has a number of actions in train to improve outcomes for patients and current performance. Progress on actions plans and performance is routinely reported to IJBs. Key actions being taken by HSCPs are summarised below.

East Dunbartonshire:

- Linked Mental Health Officer to Hospital Assessment Team to lead improvement in relation to AWI focusing on timeous completion of reports, local authority guardianship applications etc.;
- Dedicated Intermediate Care Unit;
- Palliative and Complex Care beds;
- Hospital attached Social Workers linked to wards who proactively engage with discharge co-ordinators and MDT discussions;
- Proactive use of unplanned inpatient activity dashboard to identify those who have been inpatient for 10 days+ and those with an EDD of 1 month+ to facilitate early referral and allocation of case;
- Same day response to care packages

East Renfrewshire:

- continued use of the inpatient dashboard to identify at earliest point East Renfrewshire residents in acute wards to support early referral;
- continue to strengthen relationships between our Hospital to Home Social Work Assistants aligned to acute sites, staff in acute wards and discharge co-ordinators;
- Proactive planning by Hospital to Home multidisciplinary team to support safe, early discharge collaborating with Care @ Home services and wider RES team;
- Further development of Intermediate bed capacity model as a result of Local Authority Care Home refurbishment over the winter period;
- Unscheduled Care daily huddles to identify those at risk of admission and planned discharges; and,
- Implementation of pan Greater Glasgow & Clyde AWI approach.

Glasgow City:

- a continuing programme of improvement in relation to intermediate care with a focus on reducing average length of stay;
- additional capacity recruited to the HSCP hospital social work team;
- for under 65s, a named Adult Service Manager in each locality to hold accountability and ensure progress with complex adult delays daily;

- improved links with complex wards to improve early referral and effective communication;
- the sharing of estimated day of discharge information to a give early indication of potential future discharges; and,
- a management focus on everyday activities, including:
  - o a reduction in same day (as fit for discharge) referrals from Acute – which automatically generate delays;
  - o more assiduous prioritisation of delays by HSCP community staff – these are marginal, as most cases are held by the hospital-facing Home Is Best team; and,
  - o improved communication arrangements between ward staff and the hospital discharge team around individual patients i.e. single points of contact, more effective networks.

Inverclyde:

- 7 Day Service - we will continue to work in partnership with local Care Homes to accept safe weekend and evening discharges for new admissions;
- Following last Winter's successful Pilot we wish to again increase capacity in our Home care Service to cover 175 hours per week to focus upon evening and weekend discharges for new service users as well as restarting existing packages;
- Test of Change Care Coordination - Coordination of Emergency Department Frequent Re-Attenders will utilise existing Locality Meetings to identify people at risk of hospital re-attendance and implement review and development of appropriate support to address unnecessary presentation. This will be across Health and community Care (including OPMHT) and have similar process in place to address frequent attendances of people known to Alcohol and Drugs Service and Community Mental Health Team;
- Day Care Services - a further Test of Change is to utilise Day Care Services to prevent Unscheduled Attendance's at Hospital This will identify 10 Frailty Day Places which will help to address Isolation and Anxiety amongst Older People which we have identified as a factor for some attendance's and admissions. These will be short term placements with clear link to reablement and accessing community supports;
- Assessment and Care Coordination at Emergency Department - we also intend to support the strengthening decision making at Emergency Department with greater knowledge of community resources and services to allow safe return home rather than admit. To support this we are requesting funding for 6 months to cover a Care Management post who would link directly to IRH Emergency Department complete assessments and return people home with necessary support thus avoiding unnecessary admissions;
- Choose the right Service - we have also extended our local Choose the Right Service campaign to cover attendance at emergency department and families with children.
- Purchase of step up beds on call off basis to prevent inappropriate admissions and also short term placements to facilitate discharge as required.

Renfrewshire:

- Discharge Coordinator post created from November 2019. This dedicated role solely focuses on working with Families, Acute and HSCP Services to manage the discharge process;
- when available, beds at Hunterhill Care Home are used for the reablement of delayed discharged patients;
- Hospital discharge protocol to be finalised and implemented;
- Acute and HSCP meet 3 times a day to discuss discharge planning and review active cases/delayed discharges and agree appropriate actions;
- Hospital Social Work Team attending daily huddle including bank holidays; and
- Weekly meetings with the Care at Home Service Delivery Team Manager; Acute; and the Royal Alexandra Hospital Social Work Team to discuss delayed discharges

West Dunbartonshire:

- Full use of inpatient dashboard to identify patients with admissions of 10 days+
- Dedicated early assessment cohort (Social Care, Nursing, OT) undertaking assertive in reach in wards
- Continuing programme of robust review in relation to use of s13za for AW patients.
- Refresh of hospital discharge homeless policy in conjunction with WDC Housing to ensure streamlined approach
- Refinement of engagement by colleagues in mental health and learning disability services to support safe and timely discharge

Acute Inpatient Beds Totals by Hospital site 2010-2025

2010	Beds	2015	Beds	2020	Beds	Projected 2025	Beds
Southern General	900	QEUH campus	1450	QEUH campus	1400	QEUH campus	1400
Victoria Infirmary	370	New Victoria	60	New Victoria	60	New Victoria	60
Western Infirmary	500						
Stobhill Hospital	440	Stobhill ACH	60	Stobhill ACH	60	Stobhill ACH	60
Glasgow Royal	930	Glasgow Royal	910	Glasgow Royal	870	Glasgow Royal	870
Gartnavel General	450	Gartnavel G	360	Gartnavel G	360	Gartnavel G	360
RHSC Yorkhill	230	RHC	215	RHC	215	RHC	215
RAH	650	RAH	550	RAH	550	RAH	550
IRH	320	IRH	300	IRH	300	IRH	300
VOL	90	VOL	80	VOL	80	VOL	80
Total	4880		3985		3895		3895

2008 – publication of QEUH business case

2015 – opening of QEUH/ closure of Victoria Infirmary, Southern General Hospital, Western Infirmary, conversion of Stobhill Hospital to ACH

2020 – year 1 of Joint Unscheduled Care Commissioning Strategy – figures include additional winter beds

2025 – year 5 of Joint Unscheduled Care Commissioning Strategy (will be the same as 2020 minus the winter beds)

Notes:

All numbers are rough estimates. Bed numbers fluctuate seasonally and for other operational pressures

2010 figures include total bed numbers in the catchments of each hospital, including continuing care beds, e.g. Drumchapel, Blawarthill, etc.

QEUH campus includes QEUH, Institute of Neurological Sciences, Maternity & Gynaecology, and the Langlands building. RHC shown separately

GRI numbers exclude Lightburn

Gartnavel campus is GGH and BWOSCC only

Annex D

Proposed Reduction of Use of Additional Winter Beds

	2019/20	2020/21	2021/22	2022/23	2024/25	2025/26
South	88					
North	51					
Clyde	89					
Total GG&C	228	200	175	100	75	0