

Greater Glasgow NHS Board

Board Meeting

Tuesday 18 February 2003

Board Paper No. 2003/9a

Director of Planning and Community Care

ACUTE ADMISSIONS REVIEW: INITIAL REPORT

Recommendation:

Members are asked to:

- Note this report and consider emerging issues.

1 BACKGROUND AND PURPOSE

1.1 The Board approved a review of acute admissions on 27 June 2002. That decision responded to a number of factors:

- Widespread evidence of severe strain on current emergency care arrangements.
- The need to underpin strategic decisions on the shape of emergency care arrangements with credible, detailed planning work.
- The impact of current and increasing emergencies on the configuration, capacity and resources of services.
- Workforce issues and pressures.

1.2 The Board set the following remit for the Review:

- Refine and agree, on the basis of work already done, the number of patients with acute medical problems for whom we will need to plan services over the next decade. This work needs to be done against the background of an already agreed strategy that sees acute medical receiving being based at Gartnavel General, the Southern General and the Glasgow Royal Infirmary sites by the end of the coming decade.
- Review different models of acute medical receiving as they are currently to be found elsewhere in the United Kingdom and, where appropriate, in major centres elsewhere.
- To agree the most appropriate pattern of service delivery that would achieve efficient patient-centred care of all patients presenting as an emergency to Glasgow's hospitals. This model of care must ensure that patients are dealt with quickly, that their needs are accurately established and that adequate infrastructure is available within each service to manage their care effectively.
- The review should make recommendations as to the necessary infrastructure in terms of imaging capacity, other investigational facilities and in-patient beds required to deliver the agreed model of care.
- A manpower planning model to be established to ensure that the capital investment being made in Glasgow's hospital infrastructure over the coming years is matched by numbers of appropriate staff.
- In light of the work necessary to deliver the final configuration of hospitals within the City, the review should make recommendations on the interim moves necessary to protect the medical receiving service on 5 existing sites until the capacity has been established on the 3 long term sites to take over.

EMBARGOED UNTIL MEETING

- A critical feature of efficient acute medical care is rapid and effective communication between the secondary care sector and primary care. The review should consider how best to work with primary care in order to ensure efficient transfer of information between the sectors and continuity of care for patients moving between them.
- The review should consider the implications of the work for the Ambulance services and for NHS 24 who will be major partners in developing an effective and comprehensive emergency care service for the City

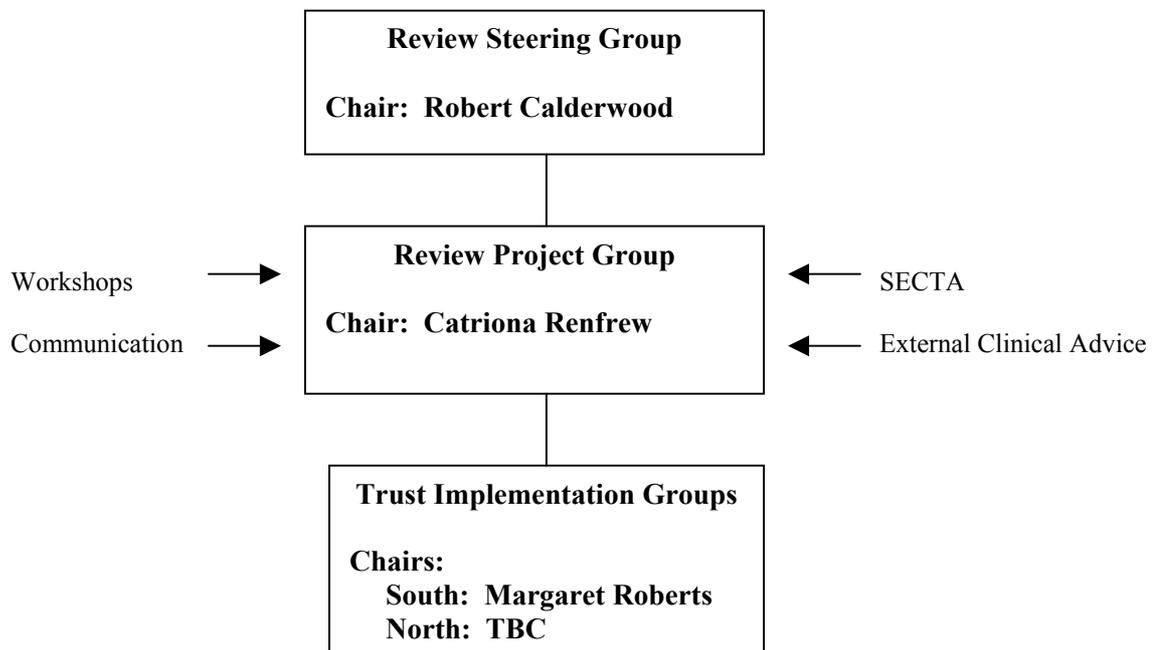
1.3 The purpose of this paper is to provide the Board with an initial report on this initial programme of work – in the context of an overview of progress on implementing the Acute Services Review as a whole.

The following sections cover:

- 2 **Review Structure**
- 3 **Diagnosing the Problem**
- 4 **Current Position and Work Plan**
- 5 **Further Issues**
- 6 **Conclusion**

2 REVIEW STRUCTURE

2.1 This section briefly describes the structure of the review process. There are 3 groups in place to deliver the required outcomes. These are shown diagrammatically below, followed by information on the role and membership of each group.



2.2 **Review Steering Group:**

The function of this group is to achieve the input of a wide range of key interests into the Review and to support the work of the Project Group. Membership includes:

- Area Medical Committee nominees, including primary care.
- The Local Health Council
- Chief Executives
- Divisional Clinical Chairs

2.3 **Review Project Group:**

The core of this group is formed by the Project Team which comprises 3 senior nurses and 2 consultants, seconded from the North and South Trusts.

In addition the group includes Medical Divisional General Managers and SECTA consulting, whose role is described in more detail in a later section of this report. This group is the engine room of the review process, charged with ensuring work programme outlined in Section D is completed and, with TIGs, ensuring that the overall review objectives are met.

2.4 **Trust Implementation Groups (TIGs)**

The Review process will generate a whole series of recommendations for change and development – both short term operational issues and more significant medium and long term proposals. The purpose of these groups is to ensure there is clear corporate ownership and leadership to deliver implementation of the agreed programmes of change. We have recommended to Trust Chief Executives that these groups – which the Project Team will work closely with – should include an identified lead for emergency care, across the Trust. This is a similar approach to the English NHS where all Trusts are required to identify a senior lead with corporate accountability for the emergency care system. We will need to identify additional resources as part of the overall acute service implementation costs to enable Trusts to ensure they have the capacity necessary for what will be a major challenge.

2.5 The overall structure of the Review is intended to ensure all interests are able to connect to the process, that we are able to comprehensively identify and address the critical issues and implement change, as rapidly as possible in the context of the physical, workforce and financial constraints within which we operate.

2.6 We are in discussion with the Primary Care NHS Trust to strengthen linkages to clinical staff in primary care, who are critical to prevention, pre and post hospital care.

3 DIAGNOSING THE PROBLEM

3.1 The first phase of the Review has focussed on developing a clear diagnosis of the issues we need to address. This diagnostic phase has had a number of elements:

3.2 **SECTA's Report**

Following a competitive tendering process to select external, expert support, SECTA Consulting were engaged to produce descriptive and numeric analysis of current services, supported by detailed briefing on service models and experience elsewhere in the UK. SECTA's detailed report is being finalised and will be circulated to Board members and more widely.

This section includes a brief summary of its key findings. The report is based on a programme of visits to each hospital site, interviews with key staff, analysis of data provided by Trusts and SECTA's experience from work elsewhere. SECTA will continue to provide support to the Project Team, will undertake similar analysis for other major specialty groups and will complete detailed work on capacity planning as we finalise the service system which is to be implemented.

3.3 **Staff Open Sessions:**

We ran a session open to all frontline staff, in each hospital, at the start of the Review process – to launch it and to hear staff views. This has provided a site specific perspective and information on issues which are relevant across Glasgow.

3.4 **Workshops:**

Two workshops have taken place, organised by SECTA and the Project Team. These brought together a broad range of clinical and managerial staff. The first focussed on coming to a clear consensus about the problem – the second, held at the end of January 2003, contributed to testing the emerging service model and more detailed work on a number of the key issues, including the construct of assessment units, specialist versus generalist care and developing rehabilitation.

3.5 **Website:**

The review has a dedicated page of the GGNHSB website – including all relevant papers and reports and with a facility to email in comments and suggestions.

All of the activity outlined above has enabled us to arrive at a degree of clarity on the key components of the problem – the process to address those issues is set out in section 5.

3.6 The rest of this section summarises the conclusions from the diagnostic activity outlined above.

- Many medical patients, including those who have been seen by a GP, are assessed in Accident and Emergency (A&E). Those who A&E staff deem to require admission are assessed again in A&E by the junior staff of the admitting team.
- Linked to this point, there are very limited facilities for any more detailed assessment of patients – for example, including diagnostic tests – prior to admission.
- There is highly variable consultant input to medical receiving – consultant physicians do not consistently have dedicated time for this important function. Consultant receiving commitments vary significantly between the North and the South.
- Beds in the admission ward, or correct speciality, are often not available, leading to medical patients being admitted to non medical wards or speciality patients to acute medical wards.

EMBARGOED UNTIL MEETING

- There are perceived delays in accessing primary care appointments resulting in hospital attendances.
- Limited shared protocols between primary and secondary care, including GEMS and A&E.
- Variable and limited services to provide alternatives to admission, including specialist outreach.
- Significant numbers of attendances related to alcohol, IV drug use and homelessness with significant problems in achieving discharge.
- The provision of clinical support services does not reflect the pattern of acute activity.
- On call diagnostics rather than shift arrangements delay investigation and diagnosis.
- Bed occupancy levels are too high, particularly in admissions wards, causing backlogs into A&E although stays in the admission facilities are longer than necessary resulting from insufficient capacity in speciality wards.
- Many patients within specialty wards do not require an acute bed and have long lengths of stay linked with delays, accessible diagnostics.
- Pressure on beds requires significant staff effort focussed on juggling capacity rather than solving the root causes of problem.
- Different lengths of consultant receiving duties – most only a 24 hour commitment, potentially disrupting continuity of care and creating unscheduled ward rounds.
- Perceived understaffing and poor environments on acute admission wards.
- Heavy use of bank and agency staff due to recruitment problems and beds closed by staff shortages.
- Limited use of care pathways – which should define consistent approaches to the treatment routes of patients with common conditions. There are variant approaches to the management of similar medical problems even within the same hospitals.
- Lack of consistency on which patients receive specialist care from medical sub specialties.
- Physical constraints, in terms of admission ward facilities and spatial relationships between key functions.
- Delays in the assessment and discharge of significant numbers of older people.
- Waiting times for equipment and adaptations preventing discharge.
- Inadequate rehabilitation capacity.
- Patients being admitted because out-patient and investigation delays are excessive.
- Failures of information transfer – manual systems and differing IT systems.

Subsequent sections of this paper outline how solutions to these problems will be identified.

4 CURRENT POSITION AND WORK PLAN

4.1 Based on the problem diagnosis set out in Section C, and their own clinical experience, the project Group has drafted a detailed Project Plan which identifies a series of strands of work which are summarised below. This work programme, including timescales, will be signed off at the next Steering Group meeting, in early March 2003. It will also be informed by a programme of visits to other UK services which is already underway and external clinical advice.

4.2 Work Plan

- A Assessment and Admission**
- Proposals for assessment arrangements and generalist/specialist medical model with workforce requirements.
 - Review bed management.
 - Review organisation of required clinical interventions.
- B Discharge:**
- Confirm critical internal and external blockages.
 - Deliver integrated hospital discharge teams.
 - Short life group on rehabilitation.
 - Proposals to deliver 7 day discharge organisation.

EMBARGOED UNTIL MEETING

- C Clinical Support Services:**
- Short life working group to proposed route to extended opening.
 - Review potential for changes to medical out-patients and investigation facilities to enable urgent access without admission.
- D Workforce:**
- Assess critical areas of staff shortages and potential action.
 - Workforce plan to underpin final service model including medical staffing.
- E Care Pathways:**
- Programme of work to agree and implement care pathways for key conditions and chronic patients.
- F Community Services:**
- Assess chronic disease management programme connection to acute services.
 - Review potential for further interventions in primary and community care.
- G Key Client Groups:**
- **Older People**
 - Test institutional care capacity plan and nursing home support arrangements will address delayed discharge and avoidable admissions.
 - Identify gaps in community services.
 - **Homeless People:**
 - Test new services currently being implemented for acute care impact.
 - Review social work input to discharge.
 - **Addictions People:**
 - Review existing hospital liaison arrangements, specialist support and through care arrangements to community teams.
 - **Head Injuries:**
 - Connect to head injury planning process to ensure acute management and long term care arrangements are durable.
 - **Palliative Care:**
 - Scope alternative models for end of life care.
- H Infrastructure:**
- Review IT Strategy contribution and timing.
 - Review efficiency of transport arrangements with SAS.

4.3 Trust Implementation Groups (TIGs)

Trusts are in the process of establishing their TIGs as described earlier in this paper. These groups are fundamental to delivering real change.

4.4 Communication and Engagement

A further round of communication and staff engagement activity will be developed as the work programme gathers momentum.

4.5 **Capacity Modelling.**

The diagnostic work identified a number of capacity problems in admission wards, excessive bed occupancies and delayed discharges. SECTA will produce a detailed capacity analysis which will include modelling current and future demand, throughput and occupancy assumptions, to arrive at required bed numbers for the final system of care. A particular issue is that in Glasgow, around 15% of our acute bed days relate to patient stays over 30 days – the review’s recommendations to improve process will address this – that can then be reflected in the capacity work as can anticipated growth in admissions. The objective will be that the capacity plan covers the whole system and is linked to workforce and facilities plans.

5 FURTHER ISSUES

5.1 It is worth highlighting 2 other important issues.

The system of emergency care in greater Glasgow has been under significant pressure in recent weeks with a number of long trolley waits for patients in A&E before admission, high numbers of patients admitted to a bed outside the correct speciality and cancellation of elective surgery. This last measure, which remains our in extremis response to bed pressures to ensure we meet our obligations to provide emergency care, is undermining our ability to deliver the level of activity required to meet our waiting list targets.

The planning processes for winter, older people and delayed discharges have included implementation of a number of measures intended to reduce these immediate pressures, including:

- Dedicated GP input to nursing homes
- Funding for additional beds in acute hospitals
- Improved infrastructure, including discharge transport
- Increased bed management capacity.

In the next phase of work of the Review process, we will work with Trusts to identify and address any other short term issues which can improve the current position. However, from the progress the Review has already made, we know that many of the issues set out in Section C are not amenable to quick solutions, but are likely to require significant systemic change, for example to shift patterns of clinical support services, the organisation of consultant time and physical facilities.

5.2 On a related point – the modern system of care which is already emerging from the Review process will require a higher level and different organisation of clinical resources, for example extended and rapid diagnostic services, intensive assessment facilities prior to admission and more dedicated specialist clinical input. We will need to make an in-depth assessment of whether this system is achievable and sustainable – in workforce and resource terms on our current 5 sites.

6 CONCLUSION

6.1 This initial report, which will be supplemented by SECTA’s detailed report, offers the Board an early indication of the key issues and the process to find solutions. Regular updates will be included in further reports on the implementation of the Acute Services Review.