

Greater Glasgow & Clyde Health Board

Board Meeting

Paper No. 12/55

Medical Director

CLINICAL SERVICES FIT FOR THE FUTURE: The Case for Change

Recommendation:

The NHS Board is asked to approve the Case for Change

1. Background

The Clinical Services Fit for the Future programme was launched at the Board meeting in February 2012. The programme aims to look at the shape of clinical services beyond 2015 to make sure we can adapt to future changes, challenges and opportunities¹.

The key aims of designing a new strategy for Greater Glasgow and Clyde are to ensure:

- Care is patient centred with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- Sustainable and affordable clinical services can be delivered across NHSGGC;
- The pressures on hospital, primary care and community services are addressed.

The first stage of our programme has focused on what needs to change in the future to make sure we can achieve this.

The attached paper sets out the 'case for change' – the reasons why we cannot stand still and need to continue to change and develop our services in the future. It recognises the challenges within the current services and systems and presents an overwhelming case for doing things differently in the future. The case for change sets out the key areas to be addressed in developing and improving services going forward to 2020. It also provides a sound basis for future decisions about health services in Greater Glasgow and Clyde.

2. Development

The case for change has been developed through the work of the eight clinically led groups.

- Population Health
- Emergency Care and Trauma
- Planned Care
- Child and Maternal Health
- Older People's Services
- Chronic Disease Management
- Cancer
- Mental Health

The clinical working groups have involved patient representatives and have been supported by wider patient reference groups, involving patients, carers and voluntary groups.

The groups have been focused on:

- Reviewing current services, future changes and possible models of care;
- Looking at evidence from research, good practice and innovation;
- Thinking about what needs to change – and what doesn't;
- Reviewing feedback from the engagement sessions with the patient reference groups.

This work has been supported by extensive literature reviews, activity analysis and population health analysis, and by a wide programme of engagement with key stakeholders. The next stage will consider the future models.

3. Engagement and feedback

During September, October and November 2012 there has been extensive engagement on the case for change, including:

- 8 Patient Reference Groups
- Presentations and discussions at all major sites with groups of clinicians
- Through each of our Directorates in the Acute Division, and all six of our Community Health (and Care) Partnerships
- Discussions with partners including NHS 24, Scottish Ambulance Service, West of Scotland Regional Boards.
- Discussion at joint planning groups with Local Authorities
- Information in StaffNews and through papers available on the intranet
- Discussion with the Area Partnership Forum and Staff Partnership Forums across GGC
- Regular updates to the Area Clinical Forum and advisory committees
- Discussions with GPs through locality groups

The general feedback was that the nine themes in the case for change were felt to accurately reflect the range of pressures and opportunities facing the Board in the future.

A range of issues were raised which respondents felt could be further emphasised or made more specific. These have all been incorporated in this final version of the case for change, and included:

- the need to be clearer on what happens if we 'do nothing' and pressures on services continue to grow
- the role of carers in supporting patients, and the pressures placed on carers when care is at home
- the growing demand across all parts of the system
- a range of issues around palliative and end of life care to ensure patients and their carers are supported in their own homes/community setting where possible
- the need to think about things from a patient point of view, rather than that the artificial barriers created by the way our services are structured
- the importance of getting the basics right to make sure that systems work better – communication, attention to basic administrative issues,
- the need to make much better use of IT infrastructure to share information across all parts of the system
- the importance of looking across the whole population of Greater Glasgow and Clyde
- the need to emphasise workforce pressures across all professions
- the specific challenge posed by changes to medical training
- the critical role of diagnostic services to make sure that patient pathways work effectively
- a set of issues identified in the EQIA including the critical importance of future developments around chronic disease management and multi-morbidity, children's services and mental health and the

need to ensure that sufficient information is being gathered to test the impact of future plans on equalities groups.

- the need to reflect that no specialty or service can change in isolation and the need to take account of how services interact and rely on each other.

4. The Case for Change

Nine key themes have been identified which together make a compelling clinical case for change and which must be addressed to ensure high quality clinical care in the future. These are set out below and discussed further in the next section of this paper:

1. The health needs of our population are significant and changing;
2. We need to do more to support people to manage their own health and prevent crisis;
3. Our services are not always organised in the best way for patients²;
4. We need to do more to make sure that care is always provided in the most appropriate setting;
5. There is growing pressure on primary care and community services;
6. We need to provide the highest quality specialist care³;
7. Increasing specialisation needs to be balanced with the need for co-ordinated care which takes an overview of the patient;
8. Healthcare is changing and we need to keep pace with best practice and standards;
9. We need to support our workforce to meet future changes.

Together these issues paint a picture of health services which need to change to make sure that we can continue to deliver high quality services and improve outcomes. The years ahead will see significant changes to the population and health needs of NHS Greater Glasgow and Clyde, starting from a point where there are already major challenges in terms of poor health outcomes and inequalities. It is clear that not enough focus on prevention and support for people at an early stage in their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages of illness. The growing complexity of need, including multi morbidity and a wide range of care and support needs, mean that users and carers can feel inadequately supported and services can feel complex and fragmented. This poses significant challenges to the way we deliver health services and work with partner agencies, to ensure that our services adapt to these changing needs.

The health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. A more consistent and joined up approach is required across all parts of the system, targeting interventions and support where they are most needed. The case for change tells us that we need to improve outcomes by organising and delivering services differently to prevent ill health in the first place, to support patients with multiple conditions more effectively and to enable older people to live more independently. We also need to change our hospitals to ensure that high quality care is consistently available, that there is timely access for all to specialist care and that we have 24 /7 access to specialised emergency care.

The next section of this document considers each of the 9 themes in more detail and sets out some key messages and specific examples from the clinical groups.

4.1 The Health Needs of our Population are Significant and Changing

People are living longer and major advances have been made in tackling the big 'killer diseases'.

Significant health challenges remain: we need to improve health outcomes for the whole population and in particular the most vulnerable groups.

The complexity of patient needs and the change in age profile will require different approaches and interventions

We need to take a different approach to cope with the increasing levels of demand

- **Life expectancy is increasing and the population is ageing.** NHS GGC's population is expected to increase by 2.4% by 2020, and the over 65s will increase by 12.9%.⁴ Over 65 year olds make up 15% of our population, but account for 41% of emergency admissions and 66% of bed days in hospital. Between 2020 and 2030 the population aged 65+ increases by a further 22%. At current rates of service use, this would require us to open an extra 350 beds every 10 years if we don't do something differently.
- **Chronic Disease** - An increasing number of people will have multiple long term conditions affecting both their physical and mental health. The estimated population within NHS GGC living with a limiting long term condition is 260,000⁵ patients. Around 80% of all consultations at GP practices are for care of long term conditions. Patients with a long term condition or complication of their disease account for 60% of all hospital beds days. While ageing is associated with increasing numbers of long term conditions, absolute numbers of patients with multi-morbidity are higher in those aged less than 65 years.
- **Prevention.** Around 60% of the total burden of disease is preventable, and directly linked to a small group of risk factors including smoking, alcohol use, overweight and lack of exercise. We need ensure that we can support people to make the lifestyle changes necessary to prevent future ill health.
- **Dementia** - there will be significant growth in the numbers of people with dementia: an estimated 18% increase by 2020. One in three people aged over 65 will die with a form of dementia⁶ and one in four hospital inpatients will have dementia.
- **Poverty and vulnerability** continue to be significant drivers of ill health and the way people access services in Greater Glasgow and Clyde – 35.5% of the population live in the most deprived quintile. This may rise with the

Examples from the clinical groups

Cancer: new cancers in NHSGGC are expected to increase by 10% by 2018-22 from 6354 to 7074 cases however survival is improving⁷. More patients are surviving cancer and/or living with cancer as a long term condition which requires adjustment to the current approach to care and ongoing management.

Older People / Chronic Disease. The two main drivers of demand are chronic disease and frailty including cognitive impairment and dementia. The focus tends to be on the very frail elderly patients however the growth in the number of patients over 65 includes a significant number of patients with underlying chronic disease and multiple morbidities who place considerable demand on the service with admission to hospital with either acute problems or an acute exacerbation of a chronic condition.

Mental Health. There are exceptionally high levels of need for mental health and addictions services in Greater Glasgow and Clyde. Life chances, social outcomes, physical health and life expectancy are all markedly poorer for people with mental health problems.

Paediatric and maternity demand is high with complexity and outcomes very strongly linked to deprivation. Rising maternal age

recession and welfare changes. The onset of multi-morbidity occurs 10-15 years earlier in people living in the most deprived areas compared with the least deprived areas

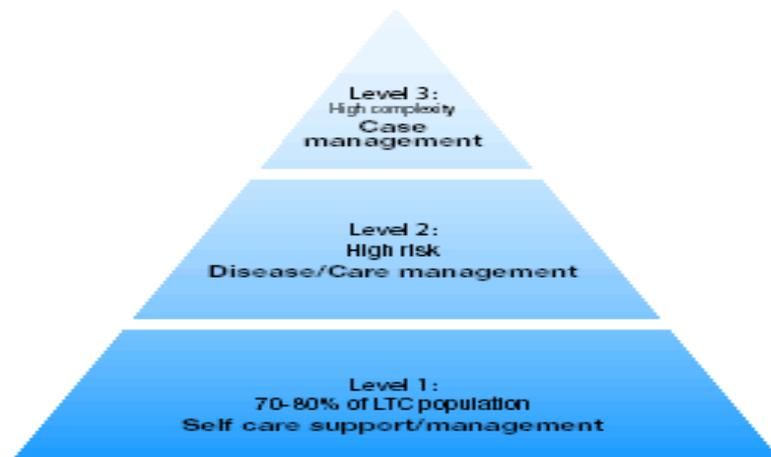
- **Inequalities** -There are stark differences in health and outcomes across different social groups, with significant difference in healthy life expectancy, access to services and clinical outcomes. This challenges the way we organise our services to close the health gap.

and co-morbidities also place a growing challenge on maternity services. Increasing survival of premature babies can increase complex disability and chronic disease.

4.2 We need to do more to support people to manage their own health and prevent crisis

If we don't focus on prevention, early detection and self management, outcomes for patients will not be as good and we will have increasingly treat people at crisis points and as emergencies.

- There is growing recognition of the importance of supporting people to help them manage their own illness / health. The triangle of care below indicates 70-80% of the population are able to manage their own illness with support⁸.



- Early detection and prevention is important to maximise patient health outcomes. Our services are currently largely designed to focus on established illness rather than working to prevent problems arising or intervene early.
- A lot of the ill health in Greater Glasgow and Clyde is preventable: 43% of colorectal cancer disease is preventable by addressing lifestyle factors such as reducing smoking, healthy eating, increasing exercise and reducing alcohol consumption⁹.
- Information on what patients can expect in relation to their condition and involvement in their care planning can empower patient to manage their own illness and health. This information is neither good enough nor consistently available currently and needs to be improved to support people in future to manage all their conditions including mental health. This was a strong message from patients as well as from clinical teams.
- Families and carers have a crucial role in supporting self management: our services are currently designed to respond to individuals.
- There is a lack of direct access to specialist advice, triage or support for alternative management of patients, other than admission, for patients with known long term conditions.
- Good practice models of anticipatory care require multi-professional and multi agency input, with the ability to quickly put in place responsive packages of care, and easy access to specialist advice. We don't do this systematically or consistently across services.
- Care is too focused on episodic care and with limited monitoring between episodes to recognise problems and act early to avoid acute exacerbations and a possible resultant admission to hospital.

4.3 Our services are not always organised in the best way for patients

Failure to co-ordinate care and support patients/ carers can lead to poorer outcomes and greater risk of admission or long term care.

The current system can be frustrating and time consuming to navigate, increasing the risk of patients missing out on important stages in treatment and support.

There is a risk of duplicating services or requiring patients to attend multiple appointments which is not a good use of time or resources for patients and the NHS.

- Services are organised around single disease pathways. Increasingly patients have multiple conditions and problems that do not fit a single pathway. Patients are frequently attending multiple appointments and services in hospital and community with care often provided in a fragmented manner. The strong link between deprivation and multiple morbidity means that this approach risks worsening inequalities in health outcomes.
- Care and setting for care, acute hospital or community, should be based around patient need and not only what suits the service.
- Services are organised in different ways across GGC in both hospitals and in the community. This is complex for patients and also professionals to understand and maximise access to the right services at the right time. Some variation in service is appropriate but there should be more consistent provision of core services.
- Services for physical and mental health needs are delivered separately, while increasing numbers of people have both long term conditions which affect both their physical and mental health. Dementia affects all aspects of care and support at home for older people and cannot be managed in isolation.
- Communities don't always understand why services are configured the way they are and don't understand why there is not effective communication between services with value placed on local support / point of contact to coordinate care.
- There is evidence of the inverse care law in both primary and secondary care.
- Communication and information sharing

Examples from the clinical groups

Emergency Care and Trauma: Where patients require unplanned services they need to be as accessible as possible with better integration and co-ordination between different component parts of the system including GP's, NHS 24, Scottish Ambulance Service and NHS Greater Glasgow and Clyde. This includes better integration between health and social care agencies.

Chronic Disease Management: An increasing number of patients have multiple chronic physical and mental health conditions are in contact with several different services, which don't always communicate with each other and can offer conflicting treatment advice.

Older People's Services: Older People are the most likely to be in touch with a wide range of health and other services. How do we make sure this is all joined up? Information about prior diagnosis of dementia, and about existing community care packages, needs to be available at time of admission. Better, more timely information needs to be available on discharge to enable primary care and community services to support patients effectively.

Planned Care: Referral for planned intervention should consider the overall patient benefit of that intervention. Improved dialogue /communication between primary and secondary care to support patient management without the patient having to be seen in an outpatient clinic, where indicated, would support the provision of specialist advice for GPs on patient management.

Mental Health: There is a lack of coherent pathways and a range of service gaps and overlaps. Service users and carers sometimes experience services as complex, fragmented and variable.

within and between services does not always effectively support patient care. Systems to access advice are limited and can result in the referral to secondary care for advice, support and or admission that could have been provided in other ways.

- Better use of information technology is required to share information and records to support effective shared care models and improve continuity of care.

Child and Maternal Care: Concerns included follow up of DNAs, communication between primary and secondary care, ability to raise concerns and share information across all agencies and communication between the primary care team and midwifery services particularly around vulnerable women and families. The transition of care for patients with complex needs from paediatric to adult services is a particularly vulnerable stage.

4.4 We need to do more to make sure that care is always provided in the most appropriate setting

Patients need to be able to access hospital care when required, but hospital is not always the answer.

Being in the wrong setting impacts on health outcomes including recovery and independence.

Unless we change our approach, the impact of the population changes and health needs will drive increasing demand and expenditure in hospital care and impact on our ability to provide comprehensive community services.

- We have high rates of hospital care with a continuing increase in emergency attendances and admissions. This particularly impacts on the most deprived populations who have the highest rates of emergency care.
- GGC has a higher admission rate than almost all other Scottish Health Boards even when adjusted for age, sex and deprivation¹⁰.
- Some patients stay in hospital too long – ‘delayed discharges’ account for 100,000 bed days a year.
- Alternatives to hospital care are not always as easy to access as hospital care.
- There are high and rising rates of outpatient attendances for some specialties.
- Medical advances mean that most routine surgery is now done in just one day with the majority of patients staying in hospital fewer than 3 days. Clinical and technical advances may allow more care to be done on a day case or outpatient basis in future, requiring fewer hospital beds.
- Patients have to travel to hospital for some services or tests which could be provided more locally. This is a particular challenge for some inequalities groups including disabled people.
- Patients need to be in the right setting within hospital. We need to have quick access to appropriate specialist care when required. Too many patients are ‘outliers’ i.e. not in the appropriate ward, and this influences outcomes and length of stay.
- Patients value local access and to be supported at home or in their local community

Examples from the clinical groups

Planned Care. Ambulatory Care Hospital (ACH) Model provides great opportunity to build on, but requires

- Philosophical change to fully establish day surgery as the norm
- Standardisation of criteria for treatment as day case or outpatient;
- Extended recovery times;
- Management of peri-operative risk and medical cover.

Older People’s Services

Some admissions to an acute hospital bed could be avoided if alternatives were available. Extended stays in hospital when there is no clinical intervention required can impact on long term ability to live independently at home. Acute hospital settings can be particularly challenging for patients with dementia

Child and Maternal Health

Care is heavily focused on the acute setting with increasing admissions and outpatient attendances. Could the high and rising outpatient referrals rate and DNA rates be addressed with better access to advice?

Mental Health

The way services function can hinder timely access to care in the right setting.

There is scope to further develop care in community rather than inpatient settings - over reliance on care for older people with mental health problems in inpatient settings

There is still variability of services in responding to needs between areas within GG&C, between NHS teams and between NHS and social care.

where possible.

- We need to ensure that people who are dying receive good care and are supported in the most appropriate setting which takes account of their and their families' wishes.
- We don't always plan well in advance to make sure that patients don't end up in inappropriate settings in a crisis.

Access to addictions services is dominated by unplanned access following a hospital episode rather than planned access to support

Cancer

Specialist follow up is currently hospital focused – the challenge is that this could be done differently.

Changes to chemotherapy treatment may increase options for community administration including more oral administration.

4.5 There is growing pressure on primary care and community services

Demand on primary care and community services is increasing: a simple shift of workload between professions or settings won't work.

Moving to a model where we support patients at the earliest opportunity in the care pathway would place significant additional demand on primary care and community services and we would need to invest in these areas to support change.

We need to address all these issues together to avoid future over reliance on hospital care and ensure care can be provided in the most appropriate way.

- We don't currently have a comprehensive system of community care to be able to support all patients who could stay at home.
- The range and complexity of community services is not easily navigated for patients or professionals.
- The current system relies heavily on carers, many of whom face significant challenges and may also be ageing. We need to support carers better to continue to care.
- Rapid access to diagnostic tests, investigations and specialist advice could provide a better service to patients and avoid admission.
- Demand on primary care is driven largely by age and deprivation, which are also associated with complexity and multi morbidity. Current arrangements for primary care don't always enable enough time for a joined up approach for the most complex and vulnerable patients.
- We need to build on current successes such as the approach to chronic disease in primary care.
- Pre and post hospital care: more could be done in community, with appropriate resource, infrastructure and support.
- Infrastructure including premises and IT doesn't currently support a different approach.
- Primary care clinicians need rapid access to advice, and comprehensive information on treatment plans in secondary care to enable them to support patients effectively.

Examples from the clinical groups

Chronic Disease Management

Opportunity to build on enhanced services to provide support at earlier stages and significantly enhance self care.

Planned Care

More local access to tests and investigations could ensure that when patients attend appointments they have all the necessary information without having to travel to hospital several times.

Older People's Services

The barrier to patients returning home is often frailty or dementia rather than the acute condition. We need to have better support available for these patients. Anticipatory care is not currently systematic and we don't have services available quickly enough to respond to changing needs.

4.6 We need to provide the highest quality specialist care

Patients need to have access to high quality specialist care and trust that the health service will deliver care on this basis.

It is a challenge to provide highly specialist care across multiple sites and to get the right balance between local access and specialist input.

- There is a growing evidence base that in relation to emergency care services, early involvement of senior medical staff in the assessment and subsequent management of many acutely ill patients improves outcomes. Access to specialist care should be organised on a 24/7 basis to maximise patient health outcomes.
- Specialist units performing a large number of cases achieve better results, particularly in more complex work such as cancer surgery, major trauma management. Recent and planned changes in some specialties such as vascular and renal services achieve this but challenges remain in some areas.
- We need to provide specialist care to the patients who will most benefit. This requires clear agreement and criteria on who needs specialist or sub specialist care.
- We need to find the balance between enabling specialist input to a care plan, and transferring overall responsibility for care to a specialist.
- Local access to investigation, diagnosis and follow-up needs to underpin centralised specialist services, with the ability to provide local care and support post-acute treatment in more local facilities where appropriate.
- We need to ensure that everyone can access healthcare to ensure they can receive the appropriate specialist treatment: rates of outpatient attendance and DNAs vary significantly particularly in relation to deprivation.
- There is a need for further cultural change to ensure that the access and communication issues for equalities groups are addressed to enable everyone to be able to access the services they need.

Examples from the clinical groups

Emergency Care and Trauma

The majority of patients referred to hospital should have specialist review to ensure the most effective treatment plan is put in place as quickly as possible. This needs sufficient specialists to provide a specialty on-call rota and requires changes to the way services are organised.

Patients suffering from a stroke or severe trauma injuries should be taken directly to specialist centres. A comprehensive 24-hour interventional radiology provision with adequate access to the Out of Hours service should be in place to support this.

Child and Maternal Health

New standards for neonatal care emphasise importance of 24 hour access to senior medical and nursing staff¹¹.

RHSC provides a regional and national centre of expertise. There is a need to manage demands as a result of this and make sure patients return to their home hospital as soon as appropriate.

Older People's Services

Medicine for the Elderly Services provides specialist skills in the management of frail elderly patients with an evidence base indicating improvements in outcome.

Currently 25% of emergency admissions aged over 65 are admitted to specialist Medicine for the Elderly services; this rises to 50% for over 85 year olds¹².

Liaison arrangements are in place for medicine and orthopaedics; this is less well established for other specialties.

End of Life Care: need easy access to advice from Palliative Care Team in acute care.

Cancer care

Low volume, technically difficult treatments for cancers such as sarcoma, upper GI, pancreatic, rectal, gynaecological cancers should be

- Better information is required if patients need to travel; we don't currently make best use of alternatives to face to face visits and travel, including emerging telehealth and telemedicine, and even use of phone and email.

undertaken in specialist units to maximise patient outcomes.

Chronic Disease Management

Access to specialist care is critical, but could it be provided in different ways e.g. advice as part of a more joined up approach to multi-morbidity.

4.7 Increasing specialisation needs to be balanced with the need for co-ordinated care which takes an overview of the patient

It is not always clear to patients and professionals who is taking overall responsibility for all elements of patient care - in the community and in hospital.

Failure to balance specialist care with overall co-ordination means that there is a greater risk of fragmented care and poor outcomes.

- As well as access to specialist care, we need to be able to provide rapid access to emergency care and assessment for all conditions and to respond to the needs of those with multiple co-morbidities or complex problems.
- With increasing specialisation and sub-specialisation concern was raised about who are the 'generalists' in the system and how are they supported and developed – this was recognised as an issue across a range of disciplines in a range of different areas of care.
- With increasing specialisation patients, many of whom have multi-morbidity, can often be treated in specialty silos with limited account of the other conditions they may have. We also need to do more to enquire and understand the significance of patients' social and economic circumstances to enable effective packages of care and support to be provided.
- We need to find a balance between the knowledge and skills required across a range of professions, and the areas where specialist input is required.
- GPs currently take an overview of all a patient's conditions, but have to communicate with multiple different hospital specialists which can make it difficult to agree a comprehensive care plan.
- The current model of episodic, single specialty care leads to a risk of duplication of activity and multiple visits to hospital for patients.
- There is emerging evidence for integrated models of care¹³; we need to develop this more in a GGC context.

Examples from the clinical groups

Emergency Care and Trauma

Acute hospital care with patients managed in an area designated for their acuity of illness by a 'generalist' (Emergency Dept /Acute Medicine Physician, Medicine for the Elderly, Intensive Care Medicine or General Physician) with early input from a high volume specialist to ensure most effective treatment plans are put in place, or that decisions can be made rapidly to enable patients to go home

Mental Health

There is sometimes a lack of coordination and integration between physical and mental health care, and also between primary and secondary care

Service users & carers sometimes experience our services as complex, fragmented, and variable.

Older People's Services

There is a need for better liaison arrangements, skills and support services for people with dementia. There is also a need to get the right balance between geriatric liaison with other services, and transfer to the care of geriatric medicine to provide co-ordinated care for the frail elderly.

There is a need to ensure good links with community services and primary care to co-ordinate care.

Chronic Disease Management

There are clear examples of individual patients attending multiple hospital specialties and GP appointments and having complex care requirements but no joined up management plans in place to support care. This can result in duplication and inconsistent advice.

It is important in managing multi morbidity that addictions and mental health are also considered.

4.8 Healthcare is changing and we need to keep pace with best practice and standards to improve outcomes for all.

Consistent standards of care need to underpin the services provided across NHS GGC.

Advances in practice mean we have to continually change to meet a rapidly changing picture.

- Standards and guidelines for healthcare are numerous and challenging. While we perform well in many areas, we do not consistently meet all standards.
- There are increasing requirements to be able to access specialist services 24 hours a day which pose challenges to the way we organise our services.
- The evidence for effective models of care continues to grow and develop, and we need to keep up to date and respond accordingly.
- There is currently variation across sites in GGC in relation to the organisation of emergency care, planned care and the range and access arrangements for primary care and community services: We need to have a more consistent arrangement for core services, customised to local needs where required.
- We need to keep pace with advances in treatment to ensure patients are offered the best treatment; and make sure we support and build on our role as an academic centre of excellence and leader in clinical research.
- Our ability to prevent, diagnose and treat medical conditions is constantly improving. This offers new opportunities however this kind of advanced practice depends on better technology and equipment operated by more specialist clinicians. This means access to new treatments may not be possible at all sites.

Examples from the clinical groups

Emergency Care and Trauma

There are a range of challenging standards including:

- Emergency admissions should be seen by a consultant within 12 hours: acute medical and emergency surgery patients¹⁴.
- All emergency general surgical services should be able to offer laparoscopic surgery.
- A consultant anaesthetist's direct involvement in emergency operations is associated with better outcomes for patients.
- Emergency day case surgery provides a high quality service at lower cost, yet is not widely practised.
- GI Bleeding -national recommendations state that all acute hospitals should have 7 days a week access to out-of-hours endoscopy services which meet the emergency target times. The service should be sited within a hospital with appropriate clinical adjacencies such as ITU and interventional radiology.

Mental Health

- Stigma remains a concern for service users, especially where this may impair equal access to mainstream health support
- Recovery focused personalised care requires a culture and practice shift
- Quality improvement methodologies have not been applied systematically
- Specialist services are not all available GG&C wide
- Excessive wait times for psychological therapies
- Improving the inpatient environment of care,
- Access to early diagnosis and post diagnostic support for people with dementia
- Under use of addictions services compared to prevalence

Older People's Services

- Strong evidence base for comprehensive geriatric assessment– where is this best done and by whom?
- Evidence base for specialist rehabilitation: Orthopaedics;
- Emerging evidence base for integrated care;
- Systematic anticipatory care planning – care packages which can respond quickly to changing circumstances;
- Rapid and easy access to community services;
- Strong evidence base for specialist stroke units including acute care, rehabilitation and early supported

- Our health outcomes are worst for the most deprived populations (for example, maternity and cancer outcomes). It is important to ensure all patients are able to benefit from treatments.
- National policy will require changes to what we do and the service needs to be responsive to this.

discharge for patients of all ages.

In GGC, we don't systematically deliver these for all patients who would benefit most

Cancer

Need to keep pace with advances in treatment e.g. robotic surgery for prostate cancer, rapidly changing development in cancer drugs.

Child and Maternal Health

- Implementation of Key standards including Safer Childbirth¹⁵, Neonatology standards¹⁶ and Facing the Future standards for paediatric emergencies¹⁷.
- Late presentation to antenatal services for some vulnerable women.
- Concerns about transition to adult services for children with complex needs and chronic disease.
- Rights of the Child: Delivery of age appropriate care – not yet consistent across GGC.
Maintaining family and home life. Minimising time in institutional settings.

Chronic Disease Management

We don't consistently and systematically deliver evidence based pathways in all areas.

4.9 We need to support our workforce to meet future changes

All our services depend on having the right number of appropriately trained staff in place. Failure to plan for this could lead to services being unsustainable or facing crises.

All professions are under pressure so we cannot just think about substitution of roles, but need to look at how services can be delivered better by teams working across professions and agencies.

- There are challenging standards for timely access to skilled staff with increased senior decision making supporting the service in the out of hours period.
- For the medical workforce, the reduction in junior staffing and move to a service led by senior clinicians 24 hours a day will be challenging to current service models – affecting a number of specialties including A&E, Anaesthetics, Medicine and General Surgery.
- Growing specialisation and sub specialisation impacts on our ability to provide sustainable emergency rotas for all specialities, and on the expertise in general acute care.
- Some professions are currently hard to recruit and retain.
- We don't always fully take account of the impact on support services when we propose changes and developments.
- There is an ageing workforce across a range of professions in hospitals and in the community.
- We are planning changes in the context of significant current pressures for staff and will need to support people appropriately.

Examples from the clinical groups

Older People's Services

- Need to define the specialist input required - geriatric medicine, old age psychiatry and who /how / where that is best delivered.
- Balancing community input with specialist support in hospital.
- Recognising that there is an unpaid workforce supporting patient care, carers, who are also ageing.

Child and Maternal Health

- Have changes to training and services reduced maternity and paediatric experience, expertise and confidence within primary care?
- Sub specialisation in paediatrics challenges ability to provide 'general paediatric' services.
- Intensive nature of working with vulnerable families can lead to 'burn out' within primary and community settings.
- Specific high risk professions e.g. ultrasonographers.

Mental Health

Delivering required models of out of hours medical cover and ensuring sufficient specialist and non specialist services to deal with multiple morbidity is challenging with the current workforce.

Emergency & Trauma

Particular challenges in sustaining emergency rotas across a range of specialties.

5. Next Steps

The case for change is an important milestone in the Clinical Services Fit for the Future programme. It forms the basis of the next two stages of the programme which are:

- The development of service models. Each of the clinical groups is currently working on the patient pathways and service models we will require in future to meet best practice, clinical standards and improve patient outcomes.
- Developing options to deliver the new service models. Once the service models are developed, we will model the implications of these and how they can best be delivered with the resources, infrastructure and workforce we expect to have available.

Further updates will be brought to the Board on each of these stages as they progress.

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