Greater Glasgow & Clyde Health Board

Board Meeting   **Paper No. 13/57**

Medical Director Paper

CLINICAL SERVICES FIT FOR THE FUTURE: Clinical Services Review Update Paper

Recommendation:

The NHS Board is asked to consider the Clinical Services Update Paper and approve the Development Programme Proposal.

1. Background

Following agreement of the Board of the direction of travel set out in the Service Models paper presented to the Board in August 2013 the Clinical Services Programme has continued to progress the work to determine the strategy for NHS Greater Glasgow and Clyde to 2020.

At the Board Meeting 2 key tasks were identified for the next phase of the programme.

1) Work through the implications of service models likely to affect configuration to bring proposals back to the Board to consider the way forward. This will include a clear process for engagement, options appraisal and consultation for anything identified which may lead to major service change, in line with Scottish Health Council guidance.

2) Progress the development programme to test out the whole system approach and effectiveness of the interface service models. This will assess the approach and support more detailed planning to both develop confidence that the model can deliver the future position described and to allow costing of the approach to ensure that this approach is affordable and deliverable.

This paper provides a short update on the work being progressed and sets out the proposal for the development programme for the Boards consideration.

2. Update on the Implications of the Service Models

All of the groups are continuing work to determine the implications of the service models paper. This work is focused on considering the short to medium term where there is strong clinical evidence / consensus about service change to improve quality of care and patient outcomes, such as consolidation of low volume / high complexity care. The work of the emergency care group includes considering the implications for acute care of the receiving model, the 24/7 cover and the requirements for extended availability of senior decision makers.

Further work is ongoing to determine the detail of the models around cancer, frail elderly and chronic disease in particular the ongoing care models and to consider the interface requirements.

As part of the planned care model work is continuing to look at the ambulatory care models and the requirements to support this across the Board area.

Further information on these areas will be brought back to the Board in early 2014 for the Board's consideration.

3. Development Programme

3.1 Testing the CSR

Evidence from the emerging service models suggests that getting the basics right – integrated, multifaceted and coordinated primary, secondary and social care - are much more important than any single tool or approach. It is important to:

- Have core services consistently in place in primary, community and hospital care
- Develop strong working relationships that enable effective communication between the different parts of the system
- Establish networks (both actual and virtual) to share information and planning of care.

The proposed development programme aims to bring together a range of components of the emerging services models to further develop and assess their cumulative impact.   To test the models, it is important that there is:

- Strong local ownership and input to develop the range of services within an overall framework
- A need to have sufficient range of developments to allow best chance of overall impact across the system, and avoid small scale pilots.

3.2 Core Elements of the Model

The initial focus for the programme will be adult services however it is also proposed to undertake a programme in relation to children's services. The programme will focus on developing the interface services further, particularly focused on areas with greatest impact on demand and capacity:

- Timely access to **high quality primary care**
- Comprehensive range of **community services,** accessible 24/7 from acute and community settings
- Coordinated care at **crisis / transition** points, and for those **most at risk**
- **Hospital admission** which focuses on early comprehensive assessment driving care in the right setting: inpatient stay for acute period of care only.

The local development programme will test out both the service developments and the underpinning ways of working which are set out in the service models paper.

The development programme should build upon any relevant service developments being progressed through other initiatives, including On the Move, the Unscheduled Care Programme and the Change Fund initiatives. This programme will not seek to replicate activity underway or planned but rather to take stock of the position and level of implementation to understand the baseline and components of the model already established or being established.   Details of the components are attached in appendix 1.

The development programme approach should also consider the underpinning requirements and ways of working which will important to support the effective delivery of the programme.

These include:

- Supported **leadership** and strong clinical engagement
- Jointly agreed **protocols and care pathways**
- Effective systems to enable patients to **access** services
- Working with **social care and the third sector** to support people at home
- **Involvement of patients** and carers in care planning and self management
- Shared **learning and education** across primary, community and acute services
- **Governance and performance systems** which support new ways of working
- **Integrated planning** of services and resources.

The CSR Steering Group agreed that the programme arrangements should ensure the following:

- Ability and authority to drive service changes and developments quickly across the system, supporting closer working between health and local authorities
- Ability to influence other existing work programmes which can deliver on aspects of the service models rather than replicating them (e.g. information sharing)
- Strong clinical engagement (from all professions)
- Dedicated programme capacity through the appointment of clinical leads, programme manager, information manager and sessional time for additional
- Input from the existing CSR clinical leads to shape the work and ensure consistency with the service models developed so far
- Staff side involvement.

3.3 Location of the Development Programme

A high level process was undertaken to review the areas across NHS GGC to determine the location for the programme. This was discussed with the steering group, following which further discussions have taken place across the service to determine the area to test the programme.

The Paisley locality within NHS GGC has been identified as the proposed site for the programme. The area has the following profile, predominantly linking to the RAH, which would give a large enough group of patients to be able to test out the models and assess impact.

No. of Practices	Total List Size	No. Aged 75+	No. with 3 or more LTCs	% SIMD1	A&E Attends 2012/13 RAH	A&E Attends 2012/13 Other	Non- Elect Admissio ns 12/13 RAH	Non- Elect Admissions 12/13 other
13	82,949	6,200	205	39%	26,769	2,612	8,757	910

Preliminary discussions with the Clinical Directors within Primary and Secondary Care have indicated support and willingness to take this programme forward. Discussions with the clinical teams across both primary and secondary care have indicated strong interest to progress this. An initial meeting was held with Renfrewshire Council, who have expressed strong interest in working with NHS GGC to undertake the development programme. The discussion with the Council emphasised the work that has been ongoing between health and social care to implement some of the core components of the programme as well as a willingness to develop this further and have a more collaborative approach to addressing problems for patients with multi-morbidity and frailty across health and social care.

3.4 Programme Arrangements

Following approval of the Board, the programme structure will be established as follows:

- Identification of clinical leads in primary care and acute care and dedicated programme management to support the work. Identified funding will be required to support these roles.

- Establishment of a Programme Board to develop the work programme. The Programme Board will include the Programme Team; the existing Clinical Leads for the Chronic Disease, Older People and Emergency CSR groups; CSR Programme Leads; and key representatives from the Acute Division, the CHP and Social Work.

- Establishment of a Programme Team to develop the work programme. The Programme Team will include the identified Programme Clinical leads; the Programme Manager, Information Services Manager; Clinicians and Service Managers in primary care, community services and in hospital. Funding will be required for clinical sessions to support this involvement.

- The Programme Team will work with the existing services teams to:

  - Establish an overarching professional reference group comprising clinicians and service managers in primary care, community services and hospital. Determine the funding required for clinical sessions to support this engagement
  - Determine the connection to other ongoing programmes of work and redesign, which also involve considerable time commitment from clinicians, service managers and supporting team, such as the Flows programme at the RAH, LUCAP and the change fund
  - Establish evaluation arrangements with support from public health
  - Identify additional supporting requirements for the programme, including finance, information and IT.

- The Development Programme will report through the Programme Board to the NHS Board. Details of the programme structure are currently being concluded.

The plan is to start the work programme in the Spring of 2014 and we will seek to identify the two clinical leads to take this work forward.

3.5 Costs

An initial assessment of costs for the programme infrastructure is:

Roles required	WTE/ Sessions	Cost
Clinical lead acute	5 sessions	c.£50k
Clinical lead primary care	5 sessions	c.£50k
Programme Management and admin		c.£80K
Information Manager		c.£45K
Supporting clinical sessions		c.£75K
Total estimated set up costs		**c. £300K**

Further details on the costs of the programme will be developed following the baseline assessment of services and consideration of what is core to underpin the programme to optimise the outcomes from the programme. This may require a small amount of funding to support evaluation. Part of this process will look at the programmes currently being undertaken across the system to ensure these are effectively used to support the development programme.

There will also be an initial infrastructure cost to establish a programme in relation to Children's Services. This has yet to be determined but is expected to be in the region of £200k.

3.6 Evaluation

It is recognised that we need to ensure a robust evaluation plan for the work is in place to allow the impact to be assessed fully and that progress is monitored effectively to allow adoption of the learning across the system. A high level description of the evaluation methodology is set out in appendix 2.

4. Next Steps

The next stage of this programme is to:

1) Conclude the work to determine the implications of service models likely to affect configuration to bring proposals back to the Board to consider the way forward early in 2014. This will include a clear process for engagement, options appraisal and consultation for anything identified which may lead to major service change, in line with Scottish Health Council guidance.

2) Establish the development programme to test out the whole system approach and effectiveness of the interface service models.

This will assess the approach and support more detailed planning to both develop confidence that the model can deliver the future position described and to allow costing of the approach to ensure that this approach is affordable and deliverable.

3) Identify the key change management and planning processes which will enable the further work and implementation of the wider set of models and approaches, recognising the significant cultural change and approach required to deliver the service models.

5. Recommendation to the Board

The NHS Board is asked to consider the Clinical Services Update Paper and approve the Development Programme Proposal to undertake the programme based in Paisley (Renfrewshire CHP with the Royal Alexandra Hospital).

Components of the Service Models for the Development Programme

Theme	Specific components to be tested	Expected impact
Build on changes to front door assessment	• Senior decision makers at the front door: A&E, Acute Care Physicians, Geriatricians • Comprehensive geriatric assessment at the front door • 7 day working for key specialties • Diagnostics to support assessment • Early involvement of the primary/community care team in assessment / decision making for discharge	• Senior decision makers increasing the % of patients discharged without admission • Specialist input to care within 12 hours of admission to hospital • Capacity available to support urgent investigation without admission / reduction in patient numbers admitted for diagnostic tests or to wait for decision to discharge • Improved discharge planning with increase in number of patients accessing alternative care within 12-24 hours of hospital attendance? • Reduced length of stay in hospital / bed days used

Assessment drives management in inpatient or alternative setting - direct to appropriate place of care:	• Test 'acute' definition for inpatients
	
	• Set objectives for inpatient stay including appropriate ward environment, management plan and expected date of discharge
	
	• Range of alternatives to inpatient admission:
	  - Care instigated in the ED/CDU and continued in the community where clinically appropriate.
	  - Fast track discharge services
	  - Urgent planned outpatient clinic
	  - Rapid access to follow up outpatients and diagnostic services
	  - Define the range and scope to be increased of care at home (e.g. IV therapy)
	  - Quick access to community teams / non acute bed (see below)
		Improved clarity of what /who requires hospital admission Reduction in admissions /length of stay / beds days used Clear care plans for patient management including discharge planning in place and demonstrated
		
		Range of alternative care provision clearly in place with supporting evidence demonstrating number of patients cared for in alternative provision / impact on admissions / length of stay and inpatient bed days.

Non acute beds for step up / step down	• Determine the patients requirements where non acute beds offer a suitable alternative to inpatient or community care and test the impact of these alternatives such as
	  – Step up or step down?
	  – opportunities to access other beds for care such as nursing home beds
		Clearly define position in relation to non-acute beds role and requirements / capacity to support future model

Community services available 24/7 through a single point of access	• Access arrangements for community services – health and social care (CRTs, DNs, home care, aids and adaptations) • Extended working – weekdays and weekends • Urgent response out of hours	Extension to core services Most effective alternatives to admission clearly identified including capacity required Number of patients admitted reduced
Timely access to high quality primary care	• Review of capacity within primary care including same day and urgent access and capacity to respond to those with multiple and complex needs	Clear understanding of capacity required and likely impact of investment in relation to existing patient usage of services

Risk stratifying the population	• Agree methodology (potentially using SPARRA as the basis with additional clinical intelligence) and profile local population
	• Agree triggers for different levels of intervention, e.g.
	  – Self management
	  – Prevention and early intervention
	  – Protocol based care management
	  – Managing multi morbidity
		Improved understanding of the patient population
		
		Clearer link between patient requirements and service provision
		
		Likely service changes to better align services to support different patient group needs

Anticipatory care planning and delivery of support required	• Anticipatory Care and advanced care planning
	  – Planning for change – in clinical condition, function or social circumstances
	  – Multi disciplinary and multi agency
	- process for sharing plans with relevant parties
	- joint GP, community and specialist review where there is most potential benefit
	- review support services available to respond to ACP, including different approach to multi-morbidity: 'generic' or joint specialist clinics and / or primary care based extended consultation times
		Anticipatory care plans / advanced care plans in place for patient groups identified as priorities from above
		Multi-agency working developed
		Clearer actions identified to support patients in crisis / transition
		Clarity of the effectiveness of the alternative approaches to managing multi-morbidity
		
		Reduction in admissions/ Length of time in hospital post admission

Shared information system.	• Access to primary / community records on admission • Linked risk stratification information to support continuity of care for high risk patients • Notification of community teams on admission • Hospital care information available at discharge including notification of discharge • Support shared management plans, access to specialist advice.	Improved information sharing to allow more joined up care / more responsive in 'real time' More shared care to support more responsive systems for advice and ongoing care for patients

Modernisation of outpatient services to support interface working	• Alternatives to clinic consultation: emergency and planned setting
	   – telephone consultation
	   – telephone advice services for GPs to manage patient without referral to hospital
	   – direct to test approach where appropriate.
	   – Jointly agreed management plans
		New approaches for advice and consultation identified and trialled to allow impact and effectiveness to be ascertained. Support and infrastructure required to implement widely identified.

Evaluation Methodology
Establish a clear baseline of services current in place and activity / demand
Understand any underlying trends which are expected to influence activity and demand even if nothing changes
Consider identification of a control site or group in another part of the city (recognising there may be issues about comparability)
Clearly define the workforce and other changes required to be put in place to create the new arrangements, including the associated costs
Define where benefits are most likely to accrue, and monitor impact and potential / actual savings accordingly e.g. inpatient beds / bed day improvements
Define areas where there is a risk of increasing demand and monitor this robustly, including in-programme funding where required e.g. primary care, social work

Monitor cumulative effect of the programme of work, including:
 	
- **qualitative evaluation** including views of staff and patients involved
- **quantitative evaluation**:
  - length of stay
  - number of admissions
  - number of admission in particular target groups
  - activity in community services – referrals and / or care packages
  - % discharged from A&E / Assessment Unit
  - activity in new services, e.g. urgent outpatient clinics.
  - impact on GP services – demand
  - impact on partner agencies – demand or requirement for services (whether met or unmet)
  - any clinical outcomes which can be measured
  - response times for community services

Identify risk and issues and the actions to ameliorate the risk(s) / planned mitigation; confounders could include underlying changes in activity and / or changes in flows from other parts of the city in response to pressures.   Size insufficient to support some elements of the programme, e.g. urgent outpatient / diagnostic appointments.