Greater Glasgow and Clyde NHS Board

Board Meeting

Tuesday 20th January 2015 **Board Paper No. 2015/02**

Medical Director

CLINICAL SERVICES FIT FOR THE FUTURE: APPROVING THE CLINICAL STRATEGY

Recommendation:

The Board is asked to:

- **approve the clinical strategy developed from the clinical services review process**

1. INTRODUCTION AND PURPOSE

1.1 In February 2012 NHS Greater Glasgow and Clyde agreed to establish the Clinical Services Fit for the Future Programme to review services to prepare a single clinical strategy for NHS GGC for 2015 onwards. The purpose of this paper is to bring the output of the clinical service review process to the Board to enable it to be approved as a clinical strategy which will provide the basis for future service planning.

1.2 The key aims of the strategy are to ensure:

- care is patient focused 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.

1.3 This strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- safe and sustainable;
- patient centred;
- integrated between primary and secondary care;
- efficient, making best use of resources;
- affordable, provided within the funding available;

- accessible, provided as locally as possible;
- adaptable, achieving change over time.

1.4 Board approval of this paper will enable:-

- the publication of the strategy providing a further opportunity to engage all stakeholders;
- engagement with the new Integration Joint Boards to adopt this as a shared clinical strategy and to work together on planning service changes;
- a platform for the development of implementation plans, including delivering changes to reflect the output of the Paisley development programme across the Board area;
- engagement with GPs, wider primary care contractors and with the new Health and Social Care Partnerships to refresh the Board's Primary Care Strategy and plan the further development of primary and community services.

2. SETTING THE SCENE: NHS SCOTLAND POLICY CONTEXT

2.1 In 2012 the Cabinet Secretary for Health, Wellbeing and Cities set out her strategic narrative and vision for achieving sustainable quality in the delivery of healthcare services across Scotland.

2.2 This vision for NHS Scotland is:

> **"By 2020 everyone is able to live longer healthier lives at home or in a homely setting with a healthcare system.**
>
> **There will be integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the patient at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as possible, with minimum risk of re-admission."**
>
> ***Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision***

2.3 This vision provides the context for taking forward the implementation of the Healthcare Quality Strategy for Scotland and the required actions to improve efficiency and achieve financial sustainability and for the development of our approach to planning clinical services fit for the future.

2.4 The actions outlined for NHS Scotland which drive the requirement to reshape our services are:

- We need a shared understanding with everyone involved in delivering healthcare services which set out what they should expect in terms of support, involvement and reward alongside their commitment to strong visible and effective engagement and leadership which ensures a real shared ownership of the challenges and solutions.

- We need to develop a shared understanding with the people of Scotland which sets out what they should expect in terms of high quality healthcare services alongside their shared responsibility for prevention, anticipation, self management and appropriate use of both planned and unscheduled/ emergency healthcare services, ensuring that they are able to stay healthy, at home, or in a community setting as long as possible and appropriate.

- We need to secure integrated working between health and social care, and more effective working with other agencies and with the Third and Independent Sectors.

- We need to prioritise anticipatory care and preventative spends, e.g. support for parenting and early years.

- We need to prioritise support for people to stay at home/in a homely setting as long as this is appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible.

- We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community - and where someone does have to go to hospital, it should be as a day case where possible.

- Caring for more people in the community and doing more procedures as day cases where appropriate will result in a shift from acute to community-based care. This shift will be recognised as a positive improvement in the quality of our healthcare services, progress towards our vision and therefore the kind of service change we expect to see.

2.5 The direction underpinning this vision sees further focus on improving the quality of services, with expanded primary and community care, a focus on multi-morbidity and improving unscheduled and emergency care out with hospital where clinically appropriate. National work is currently underway between Boards and the Scottish Government to set out the steps which will need to be taken to deliver the 2020 Vision. This strategy provides our local basis to develop those changes.

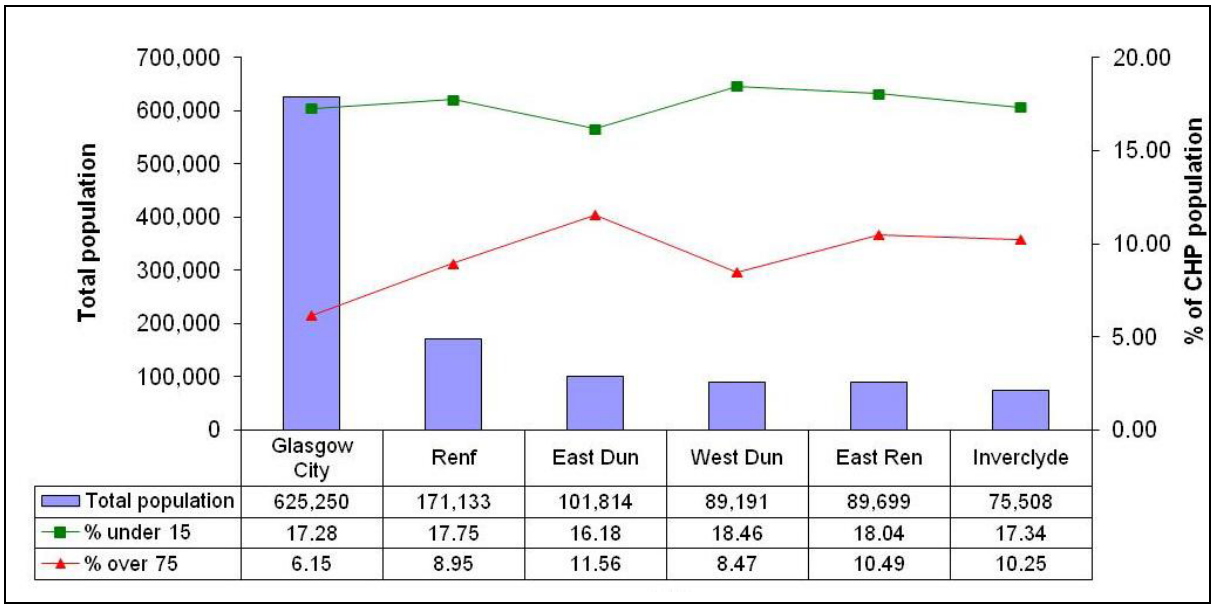
2.6 In addition to this context, a further important point of context for this clinical strategy is the establishment from April 201 of Integrated Health and Social Care Partnerships. Successful development of the new integrated partnerships will be key to the achievement of all of the strategic priorities and service models set out in this strategy which will frame our joint working with the Partnerships with shared responsibility for the strategic planning of acute services.

3. THE NHS GREATER GLASGOW AND CLYDE POPULATION HEALTH

3.1 In bringing forward this outcome of the CSR it is also important to restate the local context in which the CSR has been developed.

3.2 The Population of NHSGGC: Demographics

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



	Glasgow City	Renf	East Dun	West Dun	East Ren	Inverclyde
Total population	625,250	171,133	101,814	89,191	89,699	75,508
% under 15	17.28	17.75	16.18	18.46	18.04	17.34
% over 75	6.15	8.95	11.56	8.47	10.49	10.25

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

Age Group	Population 2010	Population 2015	% change by 2015	Population 2020	% change by 2020	Population 2025	% change by 2025
0-14	194,562	197,268	1.4	202,876	4.3	199,911	2.7
15-24	166,320	150,265	-9.7	137,743	-17.2	139,286	-16.3
25-34	176,434	193,672	9.8	184,614	4.6	166,623	-5.6
35-44	167,002	156,647	-6.2	172,422	3.2	187,458	12.2
45-54	177,130	177,566	0.2	159,827	-9.8	149,426	-15.6
55-64	136,201	147,198	8.1	164,852	21.0	165,878	21.8
65 & over	186,221	197,206	5.9	210,174	12.9	233,297	25.3
All Ages	1,203,870	1,219,822	1.3	1,232,508	2.4	1,241,879	3.2

3.2.3 During this time, the age profile of the population will continue to change. In common with much of Scotland, in most areas there will be a steep rise in the numbers and proportion of older people. The over 65 population will increase by 12.9% by 2020. This will impact differently across Greater Glasgow and Clyde with areas like East Dunbartonshire and East Renfrewshire already experiencing significant rises in numbers of older people, whilst Glasgow City is projected to see a short term decline in the numbers of older people, before following the same longer term trends. A small increase in the number of children together with a larger decrease in the number of people aged 15-29 will result in an overall reduction in the 0-19 age group.

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

3.2.5 Summary of key trends:

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

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

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

- There are **wide variations within NHSGGC**. East Dumbarton experienced a 47% increase in people aged 65+ and Glasgow city a 25% decline between 1982-2007.

- **Forecasts predict the under 50's will shrink** from 70% in 2008 to 62% in 2033; whereas the over 50's will expand from 30% to 38%. The biggest increase is expected in the over 65's age group.

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

- **Older single person households are expected to increase**. It is anticipated these will account for 54% of households by 2031.

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

- Aging is associated with an increased burden on long term conditions and chronic disease.

- There will be a significant growth in the numbers of people with dementia as the population ages. There will be an estimated 18% increase in dementia in GGC by 2020. One in three people aged over 65 will die with a form of dementia and one in four hospital inpatients will have dementia (Alzheimer's Research Trust 2010)

3.2.6 In recent years across NHSGGC, there have been some significant improvements in health. Overall life expectancy has risen; rates of premature mortality have fallen, with particular improvements for Coronary Heart Disease. Cancer survival has improved significantly across a range of cancers. However, there remain many significant health challenges and marked inequality across NHS Greater Glasgow and Clyde. Overall,

average life expectancy in NHS Greater Glasgow and Clyde is well below the Scottish average (see below). Again, there is considerable variation between different parts of NHS Greater Glasgow and Clyde.

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

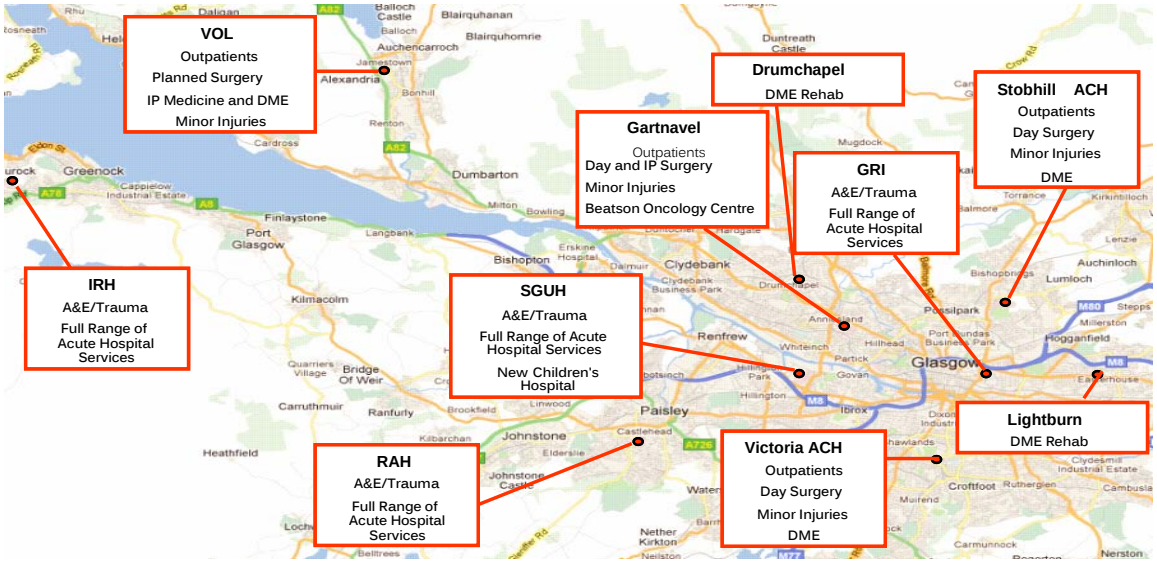
Life Expectancy at Birth by Gender 2007 - 2009 Source: NRS (formerly GRO(S))

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

4. THE CONTEXT OF ACUTE SERVICES PROVISION IN NHSGGC

4.1 Prior to the CSR NHSGGC had two separate approved acute strategies - one for Greater Glasgow, the Acute Services Review (ASR) agreed in 2002 and the other for Clyde (South Clyde in 2006/7 and North Clyde in 2009). The Clyde strategy has already been fully implemented and the Greater Glasgow ASR will be delivered during 2015. At that point the Acute Services Provision across NHS GGC will be as follows:

2015 GGC
Delivery of the Acute Services Review



4.2 In establishing the CSR the Board recognised the need to:

- integrate acute services across the whole Board area and ensure that there is equity of access to this level of care across NHSGGC;
- see acute services are part of a wider system of care including primary and community care that also requires to be considered to meet the challenges of the 2020 Vision and to deliver the integrated health and social care changes from 2015 onwards;
- recognise the changing landscape of health care with the developments in technology and treatments and the requirement to ensure care is provided in a patient centred way.

4.3 The following sections describe the approach we took to review the organisation of clinical services and to consider what would be required to achieve the best health outcomes for patients. The critical characteristics of the review work were clinical leadership, whole system clinical engagement and intensive patient and public engagement

5. THE CASE FOR CHANGE AND CHALLENGES THIS STRATEGY NEEDS TO ADDRESS

5.1 The first stage in the CSR was to establish the case for change. This part of the process was also based on the views of a wide range of clinicians on what is currently affecting the clinical services and what is likely to impact on services in the future, as well as the opinions of patients of what they value in the current service and what they would want of future services.

5.2 Following extensive engagement with stakeholders the Case for Change was published in December 2012. This identified 9 key themes:

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 patients[i].
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 care[ii].
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.

5.3 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. As outlined in the earlier sections the years ahead will see significant changes to the population and health needs of NHS Greater Glasgow and Clyde. 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.

5.4 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 full case for change is at http://www.nhsggc.org.uk/content/

5.5 The core of this clinical strategy is based on the case for change and the detailed work done in eight workstreams to consider how we can address these challenges. These workstreams, to determine the service strategy for 2015-2020 and identify the future clinical service provision, cover:

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

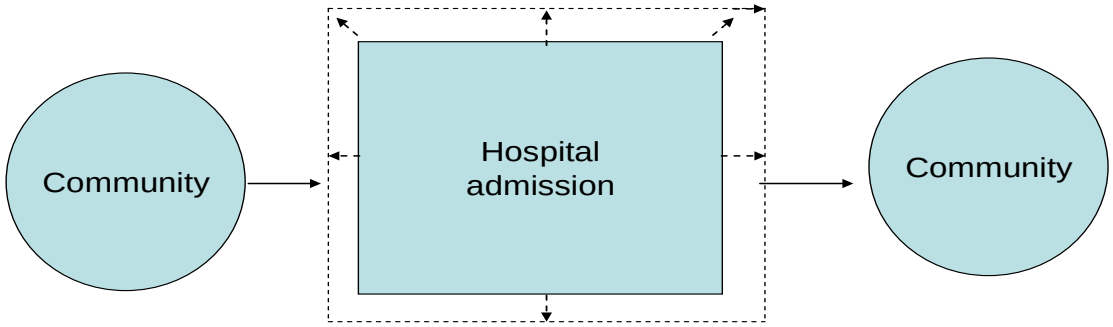
5.6 The detailed conclusions of this service models work are set out later in this paper

5.7 Meeting the challenge across the whole system

The diagrams below show the challenge we face across NHSGGC and the system we need to move towards in the future.

The current position is one where we face challenging demand pressures across a system in which 'hospital' and 'community' services are largely seen as separate, with often poor communication and joint planning across the system. While there are some good examples of joint working, these are not systematic and often on a small scale. The future demand pressures we face as a result of demographic and health changes mean that if we continue with the system as it is now, we would need an additional 500 acute beds by 2020. In an environment of constrained resources, the investment required for this would result in a vicious circle, with growing expenditure in acute hospital admissions and less money for investment in community services, which in turn reduces our ability to support people at home.

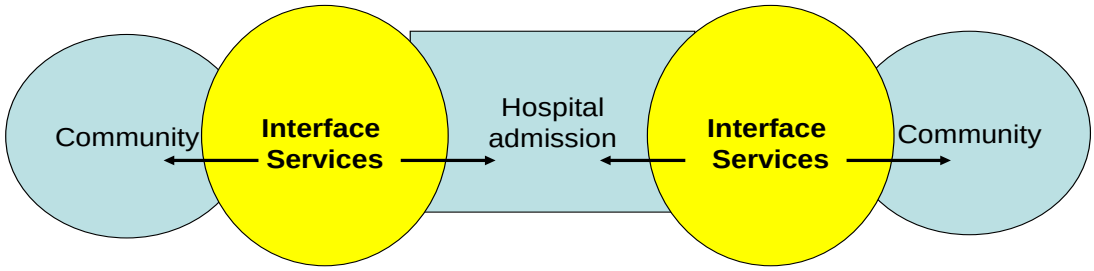
Figure 2



The system of care we want to move to sees a significant change focusing on providing care where it is most appropriate for the patient. This is based on strengthened 24/7 community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits.

Working differently at the interface (represented by the yellow circles below) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Figure 3



It is recognised that to change the system will require strong clinical leadership and commitment as well as a significant cultural shift across the organization to undertake this size of system change. To achieve this we require to:

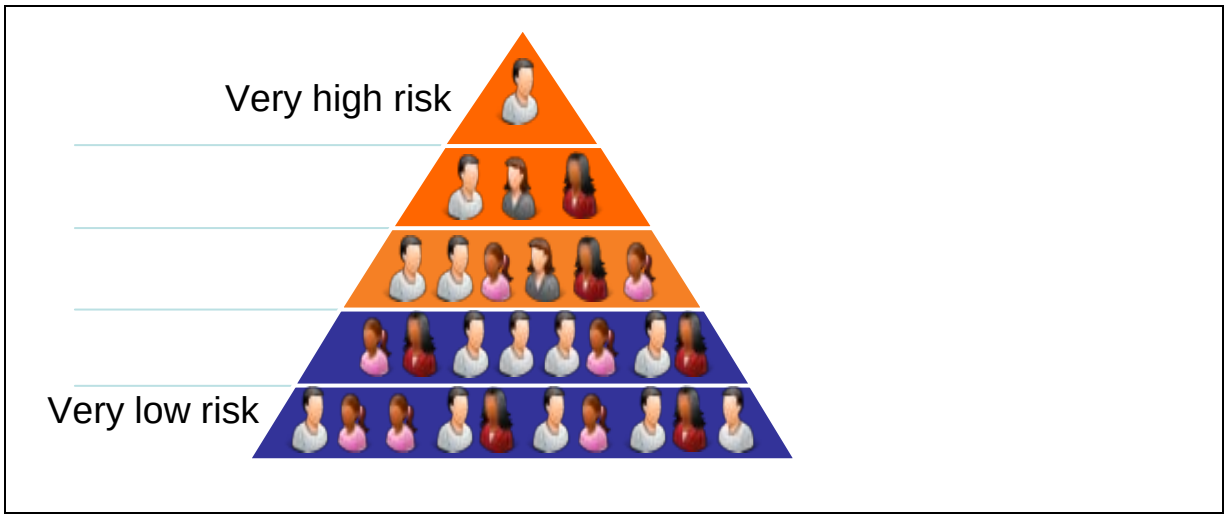
- think beyond artificial boundaries of 'hospital' and 'community';
- focus on patient pathway and needs at each stage;
- change the delivery of acute care: assess and direct to appropriate place of care;
- change the provision and accessibility of community services;
- create different ways of working at the interface.

5.8 This needs to build on the work of bringing clinical teams together to consider the problems and challenges facing the services, to jointly problem solve and plan services across the organisation for the future with shared responsibility for delivery of the new service models to maximise success.

5.9 Core components of the future health system

The overarching aim of this clinical strategy, based on the service models work, is to provide **a balanced system of care where people get care in the right place** from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

At the heart of this approach is the requirement to understand our population and provide care at the most appropriate level. Getting this right will enable more intensive support for those most in need, and supported self management with rapid access into services when required for the majority of the population.



This approach relies on a strong emphasis on prevention. It is therefore important that as part of the strategy we continue to emphasise the importance of health improvement and disease prevention. We need to encourage the population to improve their health and prevent disease, recognising that lifestyle choices in modifiable behaviours are responsible for around 80% of our current LTC disease burden. This requires all health care professionals to promote healthier lifestyles and to support the population to take responsibility for improving their own health by adopting healthier lifestyles.

The key characteristics of the clinical services required to support this approach are:

1. A system underpinned by timely access to **high quality primary care** providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:

   - Building on universal access to primary care.
   - Focal point for prevention, anticipatory care and early intervention.
   - Management where possible within a primary care setting.
   - Focus for continuity of care, and co-ordination of care for multiple conditions.

2. A comprehensive range of **community services,** integrated across health and social care and working with the third sector to provide increased support at home:

- Single point of access, accessible 24/7 from acute and community settings.
- Focused on preventing deterioration and supporting independence.
- Multi-disciplinary care plans in place to respond in a timely way to crisis.
- Working as part of a team with primary care providers for a defined patient population.

3. Co-Coordinated care at **crisis / transition** points, and for those **most at risk**:

   - Access to specialist advice by phone, in community settings or through rapid access to outpatients.
   - Jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation.
   - Rapid escalation of support, on a 24 / 7 basis.

4. **Hospital assessment** which focuses on early comprehensive assessment driving care in the right setting:

   - Senior clinical decision makers at the front door.
   - Specialist care available 24/7 where required.
   - Rapid transfer to appropriate place of care, following assessment.
   - In-patient stay for the acute period of care only (see Fig 4).
   - Early supported discharge to home or step down care.
   - Early involvement of primary and community care team in planning for discharge.

5. **Planned care** which is locally accessible on an outpatient / ambulatory care basis where possible:

   - Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
   - Appropriate follow-up.
   - Diagnostic services organised around patient needs.
   - Interventions provided as day case where possible.
   - Rapid access as an alternative to emergency admission or to facilitate discharge.

6. **Low volume and high complexity care** provided in defined units equipped to meet the care needs:

   - Driven by clear evidence of the relationship between volume and outcome.

The service models which follow at section 6 onwards consider what needs to be in place to deliver these core components of care for specific groups of patients.

5.10 Enablers

Changing the system on this scale will require a significant cultural shift and clinical commitment across the organisation. In order to achieve this, services will have to be underpinned by a series of enablers and improvements to supporting systems, including:

- Supported leadership and strong clinical engagement across the system to develop and implement the new models.
- Building on the clinical portal to enable shared IT systems and records which are accessible to different professionals across the care system.
- Jointly agreed protocols and care pathways, supported by IT tools.
- Stratification of the patient population to ensure that care is targeted at the appropriate level with supporting anticipatory care plans in place.
- Ensuring that access arrangements enable all patients to access and benefit from services
- Increasing the education and information shared with patients and the public to support people to take more responsibility for their own care.
- 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.
- Information systems which enable us to gather the information we need to monitor whether the changes are working, including disaggregated data on activity and outcomes for equality groups.
- Integrated planning of services and resources.
- Ensuring that contractual arrangements with independent contractors support the changes required.

5.11 Benefits

It is anticipated that a successful move towards this system of care would result in:

- Patients being in control of their care and empowered to share decisions about it;
- A system of care which is easier to navigate for patients and professionals.
- Clinicians and other staff at all stages having the necessary information about the patient, with care better tailored to the patient's needs.
- Better patient experience and patient safety, and improved health outcomes with a particular improvement for patients with multi-morbidity.
- A reduction in health inequalities as the most vulnerable patients receive better access to holistic person centred care.
- Care which is provided in the most appropriate setting, relative to the patients needs.
- More cost effective use of resources with care focused on early intervention, better management of complex multi morbidity and a reduction in duplication of care.

Figure 4

What is Acute Care? Who needs to be admitted for inpatient care?

The definition of Acute Inpatient Care we propose is:

"Acute care is where people receive specialised support in an emergency or following referral for surgery, complex tests or other things that cannot be done in the community. Acute care usually provides treatment for a short period, until the person is well enough to be supported in the community again."

The European Appropriateness Evaluation Protocol Approach has been developed and used in a number of countries to support this definition. This considers admission criteria in relation to both severity of illness and intensity of service required:

Admission criteria – intensity of service

- Surgery or other procedure in 24 hours requiring general/ regional anaesthesia or equipment or other facilities only for inpatients.
- Vital signs monitoring at least every 2 hours.
- Intravenous medications and or/ fluid replacement
- Continuous or intermittent (at least every 8 hours) respiratory assistance.

Admission criteria – severity of illness

- Severe electrolyte or blood gas abnormality.
- Acute loss of sight or hearing (within 48 hours of admission).
- Acute loss of ability to move any body part (within 48 hours of admission).
- Persistent fever >38 for more than 5 days.
- Active bleeding.
- Pulse rate <50 or >140 per minute.
- Blood pressure systolic <90 or >200, diastolic <60 or >120.
- Sudden onset of unconsciousness (except transient unconsciousness).
- ECG evidence of acute ischaemia, suspicion of new myocardial infarction.

Experience of applying this tool indicates:

- The most influential factor determining the appropriateness of bed utilisation is how the care system in place manages the patient, rather than the characteristics of the patient.
- Therefore it is important to consider the service configuration and care delivery to effect change.

Significant additional and different capacity is required if patients are to be treated more appropriately:

- A shift away from acute inpatient setting to provide a wide spectrum of home and community based care.
- Improved assessment and diagnosis.
- Non acute beds with therapy support.

Going forward we need to determine where the threshold for acute inpatient care is set

- ***Too high: difficult to implement, risk of readmission, significant impact.***
- ***Too low: won't be radical enough to address the problems we face.***

We need to develop a more comprehensive range of services in community settings based on the services we currently have. This will require us to determine what capacity is needed to ensure that core primary care and community services are accessible when required. It will require us to test the alternatives to ensure they are safe and cost effective.

5.12 The next section of this document sets out the high level service models to support the delivery of care in a more balanced system as we go towards 2020, indicating the areas where services should be further developed and the core components to underpin the health care provision.

6. SERVICE MODELS

6.1 The groups which developed the service models were clinically led and were formed with representatives of the hospital, primary care and academic clinicians. The clinical working groups included patient representatives and were supported by wider patient reference groups, involving patients, carers and voluntary organisations. The process was also supported by a series of cross-cutting events to consider specific issues across the groups, including primary care and the third sector. In addition work has been undertaken in relation to tertiary services which has been fed into the work of the different clinical groups where indicated.

6.2 The groups 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.

6.3 Underpinning each work stream was a core set of activities to consider current pathways, delivery models, workforce requirements and the relationship between primary and secondary care to ensure efficient and effective patient pathways.

6.4 The outputs from each of the groups were brought together into a discussion paper and summary document in June 2013, which set out how the models developed by all of the groups come together into a series of changes to the overall system of care in NHSGGC, as well as highlighting specific service models from individual groups.

6.5 The discussion paper was shared widely across NHSGGC, with partner organisations and with patients and third sector organisations. This included:

- Presentations and discussions with groups of clinicians, including Medical Staff Associations, Senior Nurses and AHPs
- Through each of our Directorates in the Acute Division, and all six of our Community Health (and Care) Partnerships
- Discussions with GPs through locality groups
- A session with all Patient Reference Groups
- A dedicated session for third sector organisations
- Discussions with West of Scotland Regional Boards and other partner organisations.
- 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

6.6 The general feedback was very supportive of the direction of travel set out in the service models paper and welcomed the approach being taken to involve the whole system. The approach described in the service models paper was considered an appropriate response to the issues raised in the case for change. Issues raised in the feedback included:

- Interface services require to be further defined: there was some concern about what it might mean for specific services and seeking details about how it will be taken forward
- The need for more emphasis on the role and implications for primary care.

- The need for explicit mention of health and social care integration, and effective working with social care.
- Request for inclusion of some patient stories to illustrate the proposed changes more clearly.
- Lots of examples of good practice, where services are already moving towards the sorts of models set out in the paper.
- Strong support for the emphasis on assessment and senior decision makers.
- Strong support for the focus on multi-morbidity
- The need to make sure that the service models recognise the different needs and approaches required for frail elderly patients, and younger patients with multiple chronic diseases.
- Respondents were keen to see the approach tried out before it is fully implemented, particularly to test out the affordability of the model.
- An appreciation of the level of engagement so far, and a request for reassurance that all parties will be involved in working through the details to understand the implications and the detailed models.
- An emphasis on the need for increased engagement and involvement of social care going forward, particularly to consider the interrelationship with the integrated health and social care agenda.
- Patients were keen to stay involved with and informed about the process

6.7 The comments received were incorporated into the final version of the Service Models paper which forms the basis of this clinical strategy. The detail of the outputs of the service models work is set out later in this paper but it is particular important to highlight a number of key consistent themes.

6.7.1 Equalities

- In addition to this, future service models will have to support NHSGGC to comply with its duties under the Equality Act 2010 to remove discrimination, close the health gap as a consequence of poverty and social class, and address the needs of marginalised groups.

6.7.2 Overarching principles

- Focus on what care the patient needs
  - care provided based on need and individual circumstance
  - care delivered in the best way
- Focus on improving clinical outcomes and delivering a good patient and carer experience.
- Locally accessible on an outpatient / ambulatory care basis where possible
- In-patient care only where necessary.
- Low volume and high complexity care provided in defined units equipped to meet specialist care needs.
- Consistently meeting core standards of care: patients should be able to access the same standard of care wherever they are in Greater Glasgow and Clyde.
- Continually evolving to ensure the most appropriate treatment / intervention is offered.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged
- Services should be provided in a non-discriminatory manner
- Supporting patients to have the best health possible.
- Research should be strongly supported and fostered.
- Services should be sustainable, both clinically and financially.

6.7.3 Issues for patients

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

6.7.4 The following comments reflect a view of what success would look like from a patient perspective:

"I know who the main person in charge of my care is. I have one first point of contact. They understand both me and my condition."

"The professionals involved with me talk to each other. I can see that they work as a team."

"There are no big gaps between seeing the doctor, going for tests and getting the results."

"I am as involved in decision making as I wish to be."

"I understand my condition and am supported to manage my care."

"Having someone identified to help coordinate my care is important."

"Understanding who can help and support me, not just with my clinical care, is important."

"Receiving care in a specialist unit is fine as long as I can access local services for follow up and advice."

7. FRAIL ELDERLY AND CHRONIC DISEASE

7.1 Core Elements of Service Models

7.1.1 There is significant overlap in the models emerging for frail elderly patients, and for those with chronic diseases. However, there are also areas where a dedicated focus on frailty, distinct from single or multiple long term conditions, is essential. And there is a clear group of younger patients, particularly in deprived areas, who experience multiple long term conditions long before they would be defined as 'older'. The common approaches and specific requirements are set out below, followed by the areas where separate emphasis or approach is required.

7.1.2 The evidence suggests that getting the basics right – integrated, multifaceted and coordinated primary, secondary and social care are much more important than any single tool approach. The following interventions are supported by consistent evidence

(http://library.nhsgg.org.uk) and should be linked into a coherent whole as part of a future strategic approach to change in NHSGGC:

- Shared, high-quality protocols across care settings
- Collaborative relationships between specialists and generalists
- Planned systems of collaborative care involving case management, systematic follow-up
- Improved integration of primary and secondary care
- High quality primary care
- Effective coordination of care and use of IT to support communication
- Effective self management/supported self care
- Multi-professional teams
- Explicit care planning
- information sharing with patients and among care providers
- Reliable methodology and application of risk stratification
- Ensuring that all health professionals ask about diet, smoking and physical activity in their consultations with patients
- Ensuring that all health professionals can direct people towards appropriate computerised decision support tools to ensure coherent protocols available and used by clinical staff
- Use of a range of professional specialists nurses (e.g. Specialist nursing has demonstrable benefits for asthma, COPD and heart failure and may be replicable for analogous long term conditions).

7.1.3 The core elements of the service model to deliver this include:

- **Anticipatory care planning** enables patients and professionals to plan for a change in health or social status, particularly for those at high risk of crisis.

  Plans need to be developed by multi-disciplinary teams including primary care, community services and hospital specialists.

  Successful implementation of plans require the ability to mobilise a wide range of support in community, including home care, aids and adaptations, housing, befriending and carer support in a timely manner, based on a 7 day model that can also support care in the evening and overnight.

- **High Quality Primary Care** Age and chronic diseases represent a significant proportion of patient contacts in primary care, and the majority of care is managed in a primary care setting. General practice and the services it connects to are critical to a focus on prevention, management of risk factors and continuity of care for those with long term conditions.

- **Front door assessment model** will require early comprehensive assessment with senior decision makers at the front door, identifying specialist input and appropriate management plans guiding treatment and care packages in all settings, to support chronic disease management and / or frailty.

- **Non-acute beds may have a place as alternative to admission or to enable step down care** – this model requires a smaller ‘acute’ element of care with more non-acute and community infrastructure. The non acute beds would need to have rigorous standards for patient throughput and clear outcomes. Further work is required to define this approach.

- **Managing multi-morbidity** -better integration of services across specialties within hospital, between hospital and the community, and between health and social services are crucial to the management of multi morbidity.

- **Inpatient Care focused on acute episode of care, with planning for rehabilitation and return home** – ensuring rehabilitation is available dependent on need not age, focused on ensuring return home at the earliest opportunity by supporting rehab care in the community.

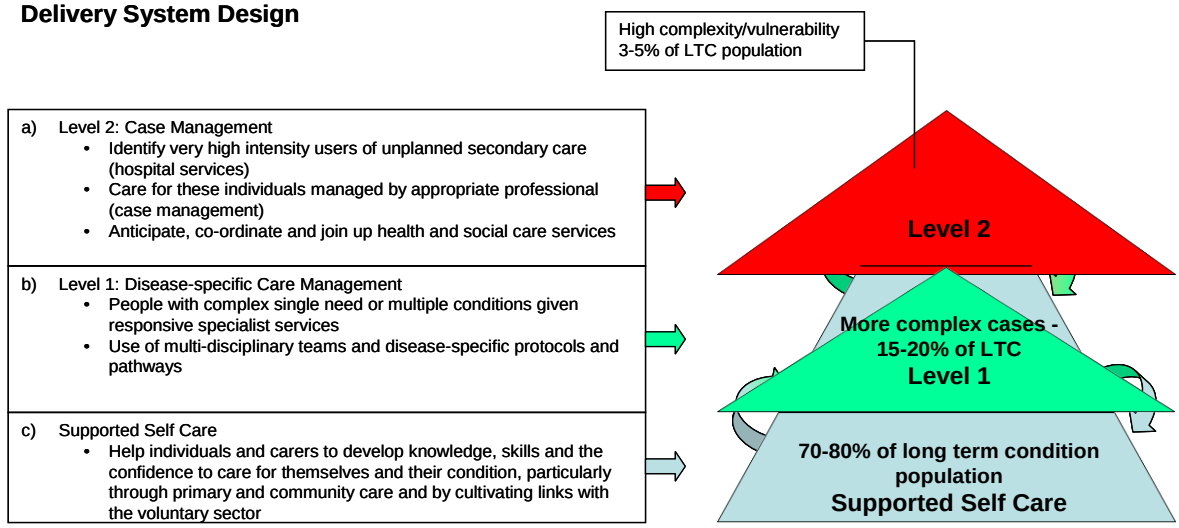
7.1.4 These are considered in more detail below in relation to both Chronic Disease and Frail Elderly pathways.

7.2 Chronic Disease

7.2.1 Overall approach

The proposed approach is based on risk stratifying the population by complexity and vulnerability, and providing care accordingly:

Figure 5



The key building blocks to support these models are listed below. A number of these are already in place, however the challenge is to ensure that they are consistently in place across the system, based on a 24/7 model, addressing the timing and volume issues currently facing many of these services.

Tailored Care - Care assistant - Physiotherapist/ OT - District Nurse - Community Pharmacy - Advanced Nurse Practitioner (generic) - Specialty Liaison Nurse - GP - Hospital Physician - Clinical Psychologist	**Advice** - Expert patient - GP - Nurse Specialist - Hospital Specialist - Acute Physician - Specialty Physician
	Access to Hospital facilities and outpatients
	Intermediate care
	Out of hours advice and assessment - Nurse provided - Expert Patient - 'Buddy system
Communication: Portal; e referral / direct referral	

These services need to work together effectively to provide both routine care, and to escalate support in response to a crisis or significant change in condition. These pathways are shown below at figures 6 and 7.

Fig 6: Chronic Disease Routine Care

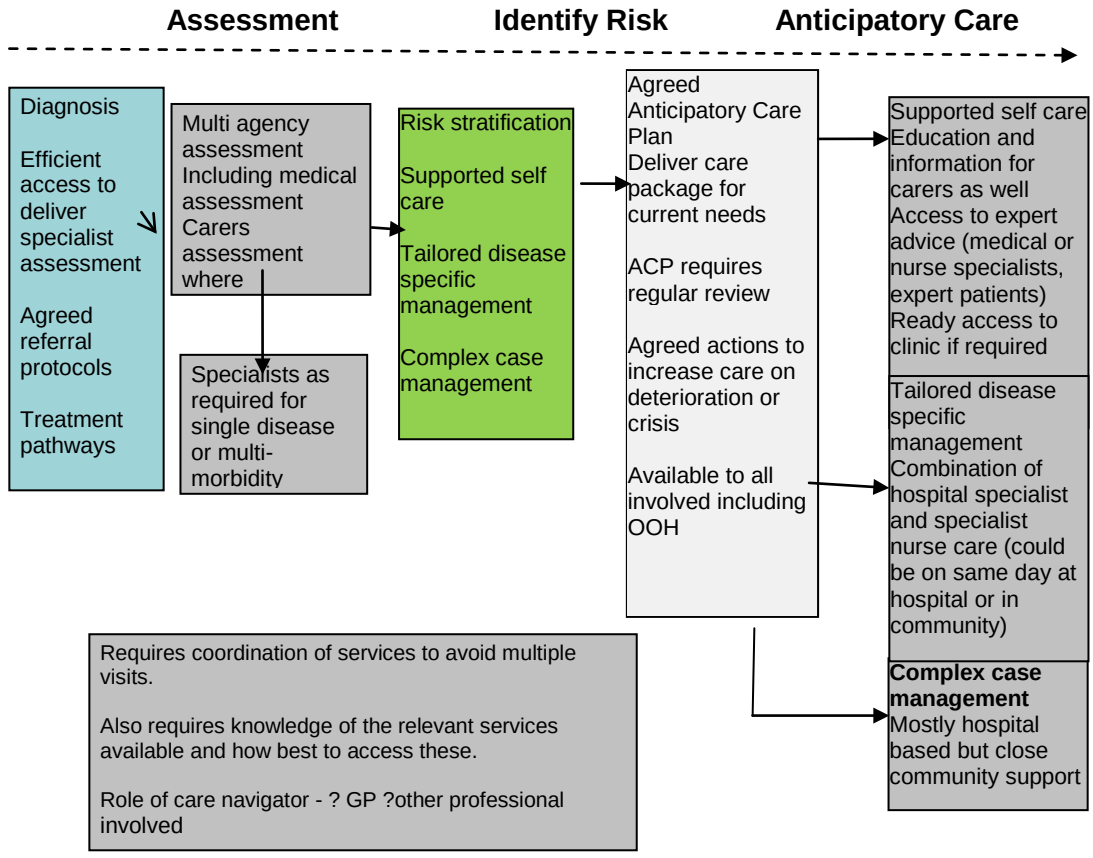
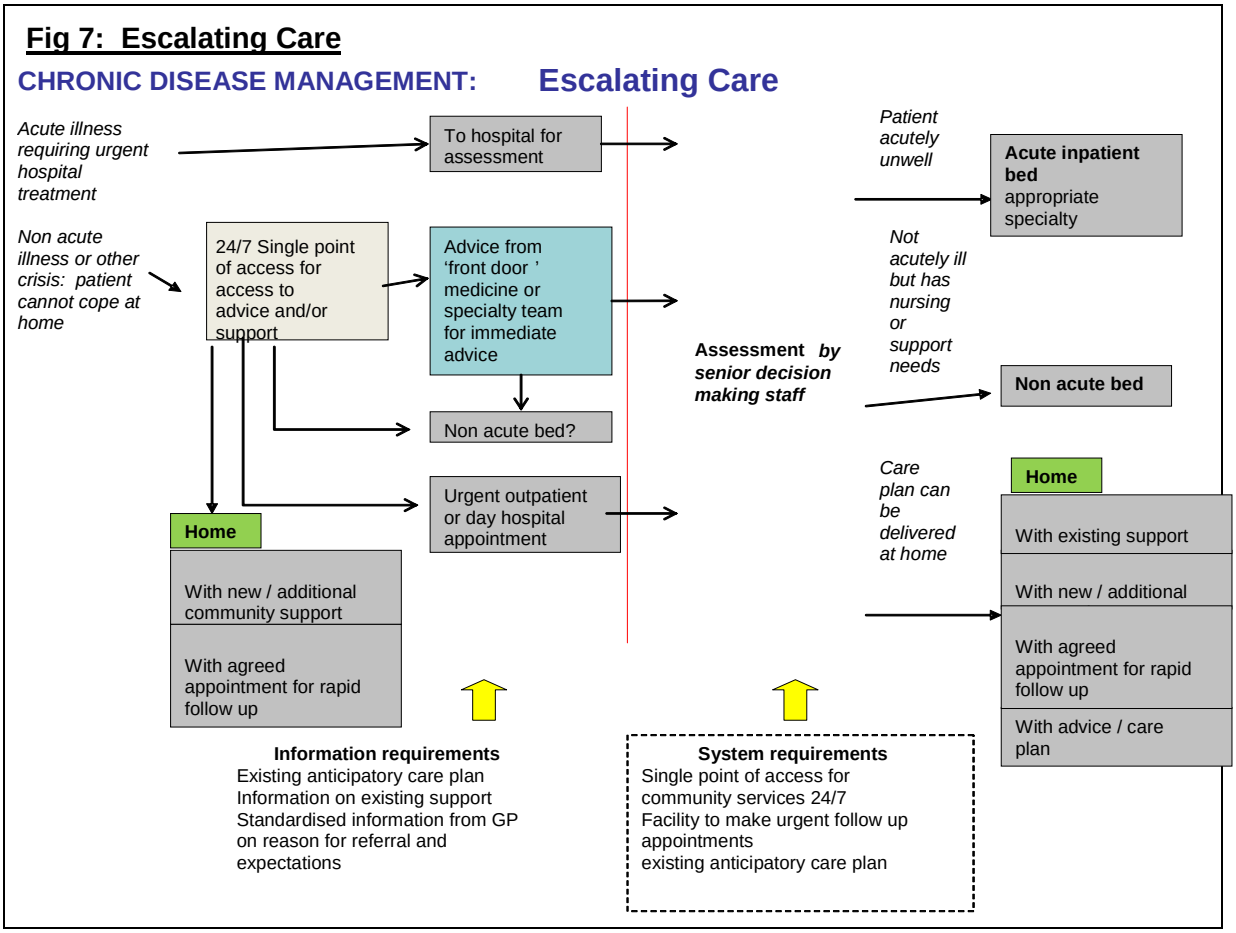


Fig 7: Escalating Care



7.2.2 Anticipatory care

A clear and responsive anticipatory care plan, which follows the patient and informs care in all settings, is a core part of this approach. While anticipatory care planning has been in development in NHSGGC in recent years, it is not yet a systematic multi-disciplinary approach focusing on those who would most benefit.

The agreed definition of anticipatory care in MHSGGC is "An integrated programme of defined preventive interventions delivered to individuals, operating across the continuum of primary, secondary and tertiary prevention. Its overall aim is to shift focus of service provision from reactive to preventive care, by adopting a whole population perspective across all aspects of service planning and delivery"

Anticipatory care planning is, by definition, planning of the above. It can be considered at an individual or population level. In both cases, it involves planning appropriate interventions that are i) evidence based; ii) connected to other interventions and services; and iii) applied across the entire continuum of disease, not just the latest stages.

Anticipatory care planning should be undertaken as early as possible – needs to start with diagnosis. Effective interventions relevant to that patient's needs should be delivered across the anticipatory care continuum, from primary prevention to end of life care. At each point along the continuum of primary, secondary and tertiary prevention, the objective is to control the underlying condition and prevent or delay progression of disease. Each stage of intervention in this process has a preventive component, a clinical management component and a self care component.

Health related behaviours, life circumstances and psychosocial factors all play an equally important role at each stage, not solely in primary prevention.

There are some good existing examples within NHSGGC of effective anticipatory care planning, including:

The Heart Failure Liaison Nurse Service cares for a well defined population of patients with chronic heart failure. These are referred from hospital and risk stratified to community or clinic care by the HFLNS. The HFL nurse will communicate with both the GP and the cardiologist about aspects of the care.

We would seek to roll out models such as this across GGC.

7.2.3 Multi morbidity

Developing better approaches to multi-morbidity has been a key theme of this Clinical Services Review. Within the pathways described above, the following elements will need to be developed further to establish a better approach to multi-morbidity:

- Continuing the work on QOF and Enhanced Services within primary care to bring together the management of different chronic diseases into a combined approach focusing on individual patient needs.

- Developing a better 'combined approach' to providing specialist input where patients are currently attending multiple outpatient clinics. This would focus on co-ordinating investigations, treatment and management so that any specialist input is managed in the context of the whole person and their environment not just narrow disease specific guidelines. This could be done through:

    - Shared clinics where there are common co-morbidities
    - Access to additional specialist input at chronic disease clinics (for example, specialist nurse input)
    - Improved access for GPs to specialist advice and opinion.

- Development of care navigator or case management roles to co-ordinate care and minimise visits and duplication, as well as improving co-ordination In some cases, this could be the GP, district nurse or specialist nurse as long as some form of designation occurs. There may be a need for another individual or care navigator in complicated cases. As with anticipatory care planning case management has been in development in NHSGGC in recent years, but is not as yet systematically in place focusing on those who would most benefit.

- Improving the identification and management of co-morbidities in emergency and inpatient settings. Co-morbidities are often a major reason for prolonged stays in hospital. Early generalist assessment to establish a comprehensive treatment and care plan for an individual will support better management of co-morbidities. Where a patient's care is transferred to a specific single condition specialist, we need to find better ways to enable input from generalist and / or other specialist, including the patient's general practitioner.

- Polypharmacy is often associated with multi-morbidity and carries with it a number of risks to patients. Medication reviews should be available on a regular basis to all

patients experiencing polypharmacy, and should be triggered by any acute or emergency episode of care.

- We know that multi-morbidity occurs is strongly linked to deprivation, occurring 10-15 years earlier in areas of high deprivation and encompassing both physical and mental health. Approaches to multi-morbidity therefore need to take account of a range of wider complex and challenging life circumstances which may act as barriers to patients' participation in new service models. Approaches to multi morbidity also need to focus on the changes in practice and behaviour required to take account of this.
- Multi-morbidity is a particular feature of patient contact in primary care, and we need to ensure that there is both sufficient capacity and support for effective approaches to managing multi-morbidity in a primary care setting, learning from current research activity in this area.

Illustration: for a patient, moving to the new model of care described might look like this:
Patient story

58 year old woman with diabetes, hypertension, chronic kidney disease and rheumatoid arthritis, is overweight and smokes and is unable to work.

Now: Has frequent appointments at hospital diabetic clinic, GP chronic disease reviews, podiatrist, renal clinic, hypertension clinic, rheumatology clinic. Frequent DNA because forgets appointments, doesn't see the point or doesn't have the bus fare to get there. This results in several acute admissions per year.

Future: Risk stratification flags up patient as high risk due to multi-morbidity; case review highlights multiple teams involved in care – case manager identified to develop a co-ordinated care plan involving the GP and appropriate specialists. Routine outpatient review minimized and clear triggers in place for return. Targeted support put in place and advice on diet and weight loss, smoking and benefits maximisation.

7.3 Frail Elderly

7.3.1 Overview

The older people group focused on 'frailty' as distinct from older people with other single conditions or multiple chronic diseases, with no additional functional problems. This reflects the fact that older people are cared for across all services, that amongst older people there is wide variety in terms of health and function, and that treatment should be needs based and not age based.

The main premise of the group is that specialist geriatric input should be focused on the frail elderly or those with 'frailty syndromes'. Stroke pathways are described in section 7.

What is frailty?

Frailty can be defined as a syndrome of multi-system reduction in physical capacity as t result of which an older person's function may be severely compromised by min environmental challenges, giving rise to the condition of 'unstable disability'.

Older people tend to present to clinicians with non-specific presentations or frailty syndrome

in contrast to the classical presentations seen in younger people. The reasons behind the nc specific presentations include the presence of multiple co-morbidities, disability a communication barriers. The ability to recognise and interpret non-specific syndromes is ke as they are markers of poor outcomes:

- ***Falls***
- ***Immobility***
- ***Delirium and dementia***
- ***Polypharmacy***
- ***Incontinence***
- ***End of life care***

These indicators should be the basis of simple assessment tools adapted to all settings – community, hospital 'front door' and inpatient.

The core pathways and components of care for frail elderly are set out in the diagrams below (figures 8-10):

Figure 8: Community support

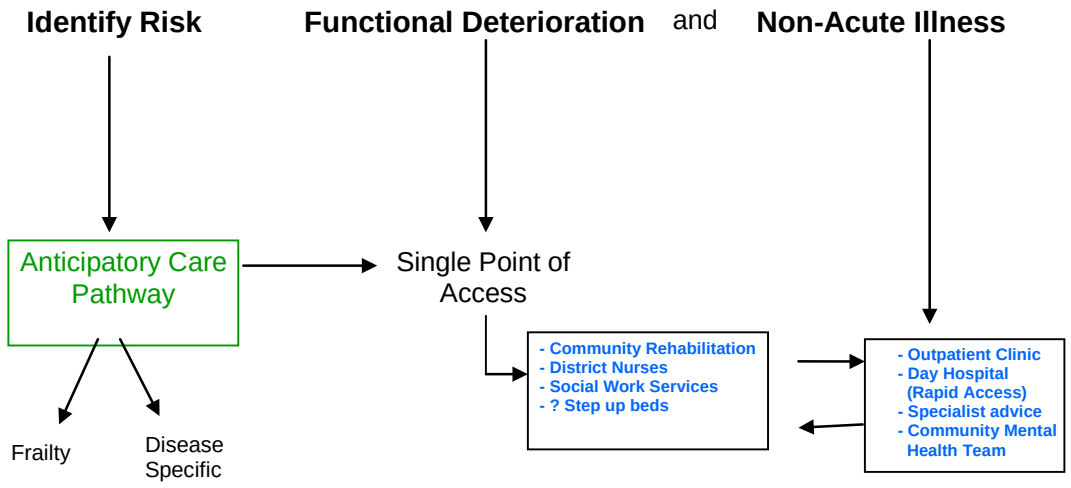


Illustration: For a patient, moving to the new model of care described might look like this:

Patient story

80 year old man with mild dementia and mobility problems, lives alone, has daily home care visits. Daughter lives 10 miles away, works full time and has small children but tries to visit several evenings a week.

Arrives one evening to find her father has an upset stomach and has been unable to get to the toilet quickly enough, and has fallen.

Now: Daughter unsure of where to get help, so phones NHS24. GP arrives, suggests admission to hospital. Patient admitted, investigated and treated for stomach bug. Confusion increases in strange environment, and mobility decreases as he stays in bed until his stomach is better. Stays in hospital for several weeks and now doubt about return home.

Future: Patient has been identified at risk due to mobility issues, dementia and living alone and has anticipatory care plan, informed by Comprehensive Geriatric Assessment, which sets out steps to take if he is ill or needs additional support. Daughter is able to see on the plan who to contact. Crisis team responds quickly, assesses father and helps to clean up and get him to bed. Arrangements made for GP to visit in the morning. Additional support put in place for a few days to ensure he is drinking enough and to support mobility until he is better. Care needs are reassessed and patient is given an alarm and increased support, with planned ongoing review.

Figure 9: Front door/hospital pathway

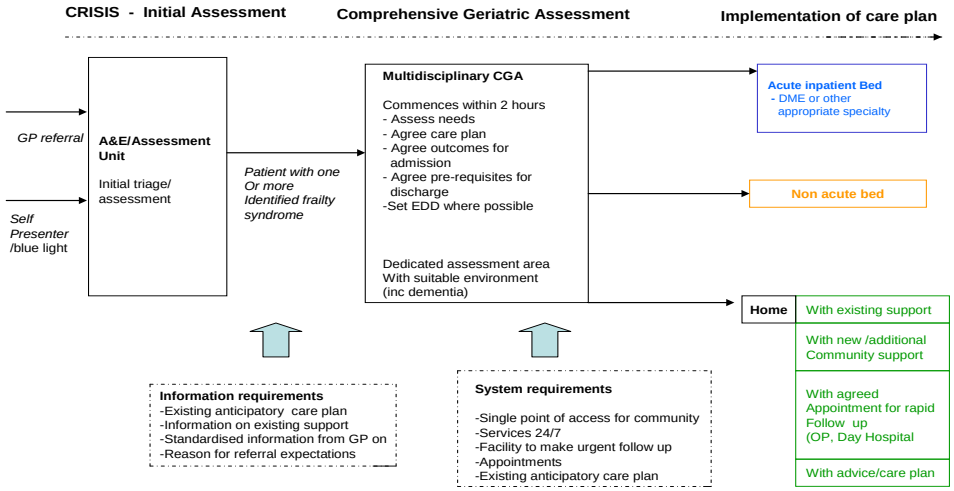
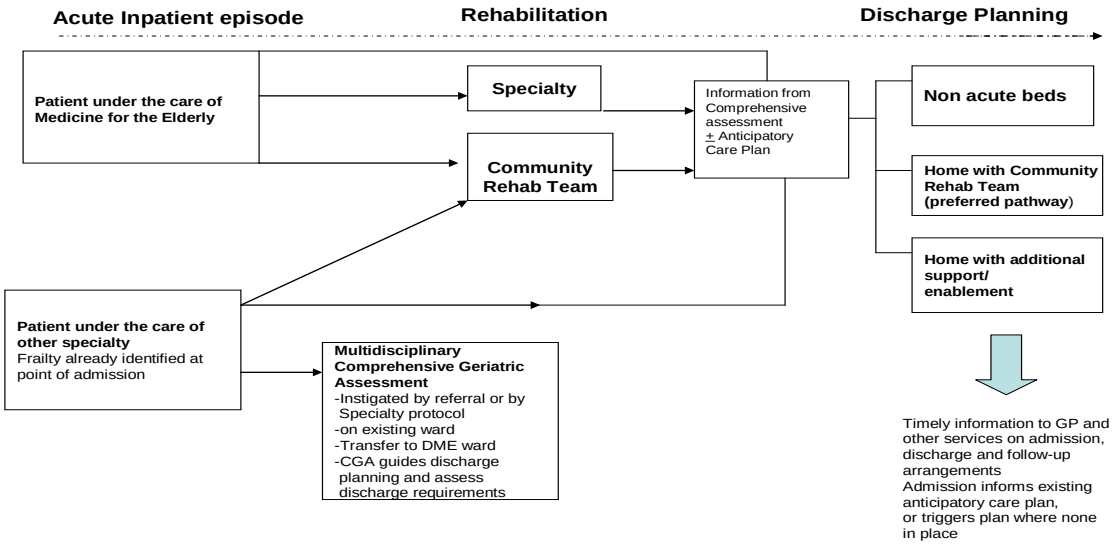


Figure 10: Inpatient Pathway (Frailty)



7.3.2 Anticipatory care

Anticipatory care plans must include frailty as well as chronic disease management. This includes consideration of social care needs, carer support, isolation, function and ability to manage the activities of daily living, supported by the multi agency single shared assessment process. It should explicitly include consideration of options for when carers are unwell or unable to provide support for any reason. The plans must enable rapid escalation of support from health, social care and third sector agencies supported by a 24/7 single point of access.

7.3.3 Comprehensive Geriatric Assessment (CGA)

CGA is strongly evidence based and drives the model for frail elderly. The pathways set out above enable CGA to be carried out in a community setting with specialist input through geriatric outpatients and day hospital services, and in acute settings with the presence of senior geriatric specialists at the front door.

Figure 11: The evidence base for comprehensive geriatric assessment

There is robust evidence to support multidimensional assessment and multi-agency management of older people leading to better outcomes, including reduced readmissions, reduced long term care, greater satisfaction and lower costs.

Comprehensive Geriatric Assessment (CGA) is defined as 'a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up'.

While integrating standard medical diagnostic evaluation, CGA emphasises a quality of life and functional status, prognosis, and outcome that entails a workup of more depth and breadth. The hallmarks of CGA are the employment of interdisciplinary teams and the use of standardised instruments to evaluate function, impairment, and social support.

Comprehensive Geriatric Assessment should be available to patients with one or more identified frailty syndrome within 2 hours of A&E attendance (14 hours overnight) and should drive the treatment and care plan both within hospital and in the community. CGA needs to be available within the community, at the hospital front door and in inpatient settings. It is a key requirement that information which may inform CGA, and the outcome of the assessment, is passed through the system consistently and is easily accessible and useable in a fast paced environment.

Delivering CGA in an emergency environment is challenging, and will require access to a separate quieter area (such as a medical assessment unit) with an appropriate environment.

Patients who have been admitted as inpatients (either emergency or elective) to any specialty, may subsequently exhibit frailty syndromes and require access to Comprehensive Geriatric Assessment. This should be available in all settings and specialties, as an assessment which drives a care or discharge plan, or to consider the appropriateness of transfer to specialist Geriatrics.

Figure 12: Falls

Falls are a common trigger of an emergency episode, and a key indicator of frailty. Falls must be a core part of broader approaches to risk assessment and care planning. This approach should include the following components, with timescales in line with the National Falls Bundles:

- Primary prevention based on falls assessment as part of general frailty assessment and anticipatory care planning, including self assessment
- Secondary prevention based on rapid notification of falls in both community and inpatient settings, leading to:
  - Falls assessment as part of more comprehensive frailty assessment
  - Individualised plan agreed with patient and actioned within 6 weeks. The plan should cover a range of interventions to prevent future falls taking account of related clinical needs, mobility issues, home and social environment and medication.
- Inpatient treatment where required (e.g. fracture) with access to Comprehensive Geriatric Assessment 7 days a week for Orthopaedic patients.
- Rehabilitation. Transfer to Geriatric Orthopaedic Rehabilitation Unit where appropriate. Multi-disciplinary discharge planning and discharge to community rehab teams for ongoing falls assessment and intervention.

Review and follow up. Review of plan within 6 months of commencement to update or close the plan

7.4 Dementia

Dementia is a syndrome caused by a number of illnesses in which there is a progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. It is increasingly present in patients presenting for a range of other health needs. Alongside this decline, individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These cause problems in themselves, complicate care, and can occur at any stage of the illness. Dementia was reviewed jointly by the Older People and Mental Health groups and is considered further in section 8, but assessment and response to dementia and associated symptoms must be a core part of assessment throughout the older people's pathways described above, in all settings of ca

7.5 Implementation challenges for this model

- Defining the alternative models to admission such as advice service to support patients in the community non-acute beds to enable step down care considering the how this might impact to create a smaller 'acute' element of care with more non-acute and community infrastructure. This will require further definition of categories of 'non-acute' patients and support required including the risk of change and deterioration in patients, level of nursing care required and any ongoing diagnostic requirements.

- Front door model – general assessment with quick access to specialist care for treatment where required and the staffing model to support.

- Sizing the different groups and input required, for example likely numbers with frailty syndromes will drive front door geriatric staffing model. This will be based on assessment of known demographic changes, assumptions re potential for avoiding admissions, and an assessment of the current proportion of admissions with frailty syndromes.

- Work to assess further potential for home based rehabilitation / re-ablement.

- Particular consideration needs to be given to end of life care and supporting alternatives to acute hospital admission, particularly where patients wish to die at home or supported in a community setting (see figure 13).

Figure.13: End of Life Care

A key group where acute admission may not be desirable is for end of life care. The approach to palliative and end of life care should be based on:

- Palliative care needs being identified as soon as possible with more effective use of the **Gold Standards Framework** (GSF) in primary care, the use of the **Support and Palliative Care Indicators Tool** (SPICT) in in/outpatient settings and the use of the **Support and Palliative Action Register** (SPAR) in care home/continuing care settings. This would allow appropriate, timely engagement in the process of **Anticipatory Care Planning** (ACP).
- Ongoing holistic assessment being undertaken by professionals with good communications skills and a knowledge and understanding of the disease process, likely symptomatic issues and an appreciation of where these needs could be met, in order that the ACP process can be engaged with in a realistic way by the patient and family. This may be the GP, District Nurse, Consultant, disease specific specialist nurse, ward staff, care home staff or any of this combination in partnership.
- Effective communication of priorities of care. Conversations could be initiated using the My Thinking Ahead and Making Plans (MTA&MP) communication tool and further details placed on **Key Information Summary** (KIS) or the **electronic Palliative Care Summary** (ePCS) which can be accessed by unscheduled care areas, the Out of Hours Services and the Scottish Ambulance Service.

The preferred place of care is influenced by many factors. Options should include:

- **Care at home**, with the facility for patients to be assessed at any time in a 24hour period with rapid access rehabilitation teams, increased home care provision or equipment. The need for an appropriately skilled, well coordinated multi agency service in the community with effective communication systems is essential to this.

- Patients, who need less acute interventions sometimes simply observed care, may be suitable for rapid admission to **non acute bed**.

- There will be an ongoing need for Acute Admission for patients with symptom issues that cannot be managed at home. There is also a need for a “wider team” (or “virtual team”) assessment of patients on admission

so that their palliative care needs are assessed promptly, their co-morbidities are taken into account and prioritised and a plan is made for that individual based on the above assessment. This could include referring patient immediately for Hospice admission or being able to get the patient home with enhanced community care.

- Rapid access to **hospice beds** for assessment, complex symptom control and end of life care may be appropriate for those with more complex care needs, not needing or wishing admission to an acute bed.

7.6 Mental Health

7.6.1 Introduction

The mental health clinical groups focused on the models of care required for:

- Adult Mental Health
- Dementia
- Drug and Alcohol Services

The overall approach which applies across these services is set out below, with condition specific examples given where appropriate.

7.6.2 Overview of the approach

The purpose of prevention, treatment and care activity in mental health is to deliver health outcomes, a positive user and carer experience from contact with services, and to contribute to user's progress towards recovery/living well with their illness.

Achievement of that purpose requires:

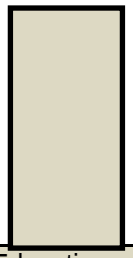
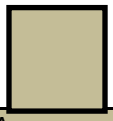
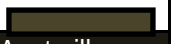
- A needs led structure of service delivery based on condition and frailty
- Interventions which are organised and delivered by condition
- Levels of intervention determined by the intensity and severity of the condition
- Interventions which are systematically delivered based on agreed condition specific care pathways consistent with evidence based/ best practice standards
- Users to be able to see their place on the care pathway
- Operational and team processes, practice, culture and pathways within and between teams which are organised and delivered to ensure:
    - Clinical interventions are systematically delivered based on the condition specific care pathways
    - Positive user experience in which carers and users are partners in care and feel well supported
    - Services are "easy in and easy out"
    - Interventions provide "everything you need and nothing more"
    - Patients with multiple morbidities receive coordinated rather than fragmented care
    - Care planning supports personal outcome based progress towards recovery/living well with the condition

7.6.3 Clinical framework for prevention, treatment and care

As with the approach described for physical chronic conditions, the overall approach is based on a stratified system of care, identifying need and responding at the most appropriate level of intensity.

The diagram (figure 17) below describes the overarching framework for mental health services. The Framework will be populated for each major clinical condition to set out the condition specific interventions and care pathway for that condition.

Figure 17

Numbers					
Need for help	Education and promotion of well being Targeted prevention for groups at risk	Anyone concerned about their own health or other peoples health	A prompt response for people who develop symptoms associated with a condition	Progress towards recovery whilst living with ongoing mental health problems	Acute illness
Type of Intervention	Information, screening, self-help	Education, self-help, peer support, group classes	"Low intensity" work: brief interventions, psychological therapies, guided self-help	Longer-term psychological therapies; community rehabilitation;	Risk management, physical health care
Access	Everyone	Open, self-referral	Self-referral and GP referral	GP or secondary care referral	GP or secondary care referral
Care level	Public	Open access /supported self care	ERBI: early response, brief intervention	Ongoing care and support	Intensive treatment

7.6.4 Personal outcomes for service users and carers

In their contact with services Service Users can expect:

- To define recovery goals together with the service
- Services support progress towards recovery /living well with their condition

People with mental health problems should be able to say that they have a positive experience of their contact with services and through this contact:

- I get the treatment and support I need when I need it
- Accessing services is straightforward
- I was diagnosed early
- I & those around me and looking after me feel well supported
- I am actively involved in decisions about my care
- I am treated with dignity and respect
- My care plan focuses on my recovery as I have defined it
- I have meaningful occupational interests and social involvement

7.6.5 Changes required to deliver the model

Moving towards this model will require the following changes:

1. Cease age based exclusions from access to service supports such as psychological interventions/crisis services and liaison psychiatry.

2. Shift from age based service configuration of adult and older people mental health services to needs based configuration of:

    - Mental Health 18+ (no upper age cut off, needs led transition based on physical frailty).
    - Dementia and Functional mental health combined with physical frailty service.

3. Consideration of service models for people with dementia given apparent commonality of health needs of people in acute wards and Older People Mental Health acute wards.

4. Address service gaps within the dementia care pathway:

    - Memory assessment service for early diagnosis of 2300 new patients per year in community setting.
    - Post diagnostic support services.

5. Review the functionality of services and teams to ensure their detailed operational processes are aligned to deliver the principles set out in sections 3, 4 & 5 above & in particular:

    - Systematic interventions of agreed condition specific care pathways.
    - Health outcomes.
    - Positive user and carer experience.
    - Recovery/living well with your condition.
    - “Easy in easy out”.
    - Coordinated management of multiple morbidities.

7.6.6 Implementation challenges for this model

Mental Health 18+

- Components of comprehensive service system are in place and no major service gaps per se
- Modest incremental further acute bed closures/balance of care shifts.

- Need to scope & size operational implications of shift to 18+ service for inpatient and community services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Dementia services

Resolve service model and relationships between mainstream acute and specialist dementia services to determine:

- Configuration of dementia services as integrated mainstream acute service or specialist dementia service.
- Size the dementia cohort and the challenging behaviour cohort to model workload implications of the configuration options for both acute and community services.
- Rework the bed model and site alignments between acute and MH sites to reflect the eventual agreed model and configuration of dementia services.
- Develop detailed service model and configuration of community based memory assessment services & post diagnostic support services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Drug and alcohol services

- Improve management of co morbidity between addictions and MH.
- Improve alignment between day services and community services.
- Improve access and support to substitute prescribing.
- Improve alignment of operational processes and recovery outcomes for service users.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

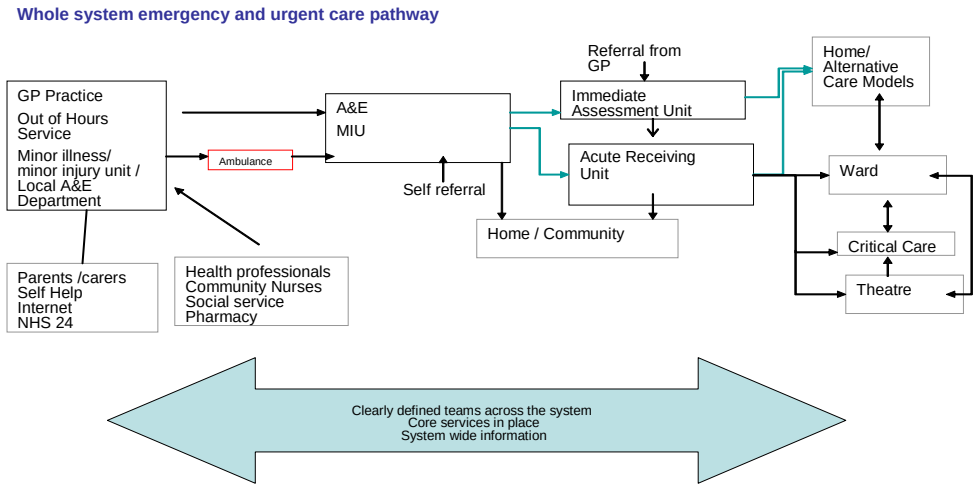
8. EMERGENCY CARE AND TRAUMA

8.1 Overview

Emergency services have to be able to respond appropriately to all patients who present. This section describes the proposed overall model for emergency services to meet standards and requirements for all patients and the changes to emergency services required to respond to the chronic disease and frailty pathways set out above (which form the majority of emergency admissions).

The overall pathway is summarised in the following diagram

Figure 14: Whole system emergency and urgent care pathway



8.2 Accessing emergency care

The key routes in to emergency care are set out below.

In-hours patients may:

- Call GP for an emergency appointment
- Call NHS 24 for advice and onward referral as appropriate
- Call other community service for an emergency appointment (e.g. Dental, Ophthalmology; Mental Health)
- Go to their pharmacy
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Go directly to the Emergency Department/Minor Injury Units

Out of Hours patient may:

- Call NHS24 for advice with onward referral as appropriate and may be offered either GP OOH telephone advice, GP Out of Hours appointment; Minor Injury Unit or Emergency Department.
- Patients may choose to go directly to Minor Injury Unit, Emergency Department or walk-in to the GP Out of Hours service.
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Call the Out of Hours District Nursing Service or other Community Services

8.3 Response to emergency assessment in all settings

When a patient is assessed in an emergency at any of the entry points above, a more flexible range of responses is required. A number of studies support the position that a much greater proportion of work could be undertaken as an outpatient or in an ambulatory setting including many acute medical emergencies. This requires our services to develop a

more “planned” urgent clinic approach to manage medical emergencies. Some examples are set out below:

Figure 15

Respiratory	Cardiology	Gastroenterology
- Community acquired pneumonia with a low CURB-65 score - Small pneumothorax - Asthma following British Thoracic Society guidance - Chronic obstructive pulmonary disease with supported home care - Asymptomatic pleural effusion	- Cardiac failure - Atrial fibrillation	- Upper gastro intestinal bleed with Rockall score of 0 - Lower gastro intestinal bleed with no haemodynamic compromise - Painless obstructive jaundice - Non-acute abdominal pain - Diarrhoea and vomiting
Endocrinology	**Infectious Diseases**	**General Medicine**
- Hyperglycaemia without ketosis - Hypoglycaemia with full recovery - Type 1 diabetes without ketosis - Electrolyte imbalances	- Cellulitis - Osteomyelitis	- DVT - Pulmonary embolism - Anaemia with no haemodynamic compromise - Syncope with low cardiac risk - Urinary tract infection

Based on the above position a number of services to support ambulatory emergency care are identified. These could be services that sit as part of the interface service model.

- Chronic obstructive pulmonary disease outreach
- Pleural disease clinics
- Rapid access chest pain clinics
- Transient ischaemic attack /stroke clinics
- Epilepsy clinic
- Pain management service
- Functional assessment teams and support teams
- Falls clinic
- Nurse specialists - diabetes, cancer, palliative care etc.
- Outpatient parenteral antibiotic teams
- Endoscopy services
- Heart failure team

A pre-requisite to changing how urgent and emergency care is provided is to ensure that there is quick and reliable access to GP appointments. This will allow patients to connect into the relevant services through their GP thus supporting patients accessing care in the right place at the earliest appropriate opportunity.

For most patients, the GP practice will be the first port of call for help or advice. Moving forward, we need to ensure that we have the right capacity in primary care to provide timely access to appointments for those who need to see a GP, and to build on the work of the access toolkit and productive general practice to provide a range of options for patients, including telephone advice where appropriate. This includes supporting GPs to free up

appointments by understanding and addressing the growing demand on primary care from multiple sources.

In addition to the disease specific approaches set out above, additional support to manage patients appropriately in the community could be provided through:

- Urgent access to specialist advice, for GPs to be able to discuss patients in an emergency situation.
- Urgent access to outpatient clinics (e.g. within 24 hours), directly bookable, where an immediate admission is not required.
- Single point of access to health and social care community services to provide immediate support at home where required.
- Access to step up beds where a patient requires additional support which cannot be provided at home, but does not require an acute admission.

It is also important that all services where people present as emergencies, work to the same common protocols with access to a consistent range of support services across GGC to ensure there is equity of access to care and that care is not escalated beyond the lowest level required.

To support this it will be important that all parts of the system can access the information about the patient, their ongoing care, e.g. their anticipatory care plan where applicable, to ensure the right intervention can occur.

8.4 Hospital Assessment and Admission

Once at hospital it is important to have clear patient pathways through each of the services. The major components of hospital emergency services are described below:

- Minor Injury Service
- Emergency Department
- Immediate Assessment Unit
- Acute Receiving Unit

8.4.1 Minor Injury Service

Nurse led Minor Injury Service led by Emergency Nurse Practitioners (ENPs) to provide treatment for a wide range of conditions including:

- Fractures of nose, shoulder, upper arm, elbow, forearm, wrist, hand (inc. fingers), knee, lower leg, ankle, foot and toes.
- Soft tissue injury including strains and sprains.
- Dislocations.
- Wounds.
- Burns.
- Minor head and neck injuries.
- Eye injuries and conditions.

This may be provided as part of a standalone Minor Injury Unit, or as an integral part of the Emergency Department, where the ENPs will work with medical staff as part of the wider emergency team.

8.4.2 Emergency Department

The Emergency Department provides care to patients with:

- Acute injury or illness associated with physiological derangement or threats to life or limb
- Acute undiagnosed illness or injury that requires time critical intervention to prevent long term impairment, disability or death
- Acute illness or injury resulting in acute severe pain until once made comfortable, they can have appropriate investigations or additional treatment before being directed to definitive care.

The Emergency Department does not provide services for:

- Minor non-urgent illnesses that can be better managed in a non time critical manner by other community or primary care services both in and out of hours
- Non acute exacerbations of chronic conditions that are under the management of specialist inpatient or outpatient services
- Non acute complications, enquiries or requests for advice following elective surgical procedures (including urology, orthopaedics, ENT, maxillofacial surgery, obstetrics and gynaecology etc).

The key role of the Emergency Department is to assess and treat quickly, and ensure that patients receive care in the most appropriate setting. Destinations from the Emergency Department will include home, home with community support which can be arranged directly from the Emergency Department, move to the Immediate Assessment Unit for a further assessment period, or admission to the Acute Receiving Unit.

8.4.3 Immediate Assessment Unit

GP referred patients will go directly to the Immediate Assessment Unit (IAU). The purpose of the unit is to provide rapid assessment of patients by senior decision makers.

The focus of the IAU will be to pursue appropriate alternatives to admission including: urgent out patient clinic appointments, rapid access to diagnostics, access to Comprehensive Geriatric Assessment by specialist multi disciplinary teams, initiating specialist care and opinion by the relevant specialty team and prioritising the timely admission of acute patients into the Acute Receiving Unit. Specific pathways will support patient management through this unit. Inter hospital transfers should not pass through Immediate Assessment Unit but should go directly to a specialty bed by agreement with the relevant specialty senior decision maker.

Care will be provided on a 24/7/365 basis. It is envisaged that the consultant input within the IAU for medicine will be predominantly from acute care physicians and the geriatric specialist team and will be supported by junior medical trainees and medical nurse practitioners.

The surgical model of care sees general surgery GP referrals, undiagnosed urology and undiagnosed vascular patients directed into the IAU.

The surgical receiving team under the control of the senior decision maker will provide opinion and admission or diagnostic decision making to the IAU 24 hours a day every day.

Orthopaedic, ENT and diagnosed vascular and urology patients should be directed from the Emergency Department for the relevant surgical specialist team to take the decision to discharge or admit to downstream wards or treatment facilities as appropriate.

It is proposed that all necessary imaging and diagnostic work is commenced in the IAU this should be available 24 hours a day 365 days a year; recognizing that these patients have the same diagnostic and imaging requirements as those within the ED.

8.4.4 Acute Receiving Unit

The Acute Receiving Unit (ARU) provides the initial period of acute management for patients assessed in the Emergency Department or Immediate Assessment Unit as requiring admission.

The ARU will enable senior decision makers to manage the patient's assessment with fast access to diagnostic tests and the ability to discharge home or for suitable patients for return to the emergency department outpatient department. The ability to care for patients in the ARU for periods over 24 hours will allow complex diagnostic investigations to be completed without the need to admit to a downstream ward. The aim is for all imaging of patients within the ARU to be completed whilst the patient is in ARU.

8.5 Principles and standards

8.5.1 For patients requiring attendance and or admission to hospital for emergency care the following principles and standards are proposed:

8.5.2 Principles

- Patients are managed in an area designated for their acuity of illness by a 'generalist' (this includes Emergency Department or Acute Care Physician, Care of the Elderly Physician, Intensive Care Medicine Physician or General Physician) with early input from a specialist where required to ensure the most effective treatment plans are put in place as quickly as possible
- Consistent standards of care are in place across the systems which maximise patient outcomes.
- Prompt commencement of time critical treatment.
- Prompt access to appropriate imaging (CT, U/S, plain radiography) to allow immediate diagnosis of life threatening conditions.
- Availability of appropriate critical care expertise and skills across the system.
- Early informed decision making regarding patient disposition.
- An extended presence of senior clinicians providing expert direct patient care, leadership and supervision.
- Timely, planned discharge to an appropriate setting and with appropriate support.

8.5.3 Process standards

- Emergency admissions should be seen promptly by someone who is appropriately trained to make an assessment of their care needs, and with prompt consultant input where required. The different needs of medical and surgical patients should be managed appropriately.
- The Assessment Unit approach is a core component of emergency care, providing protocolised periods of investigation, observation, and review for patients who would otherwise be admitted to scarce and expensive hospital beds or discharged potentially unsafely.

- Ambulatory care- care should be instigated in the Emergency Department / Immediate Assessment Unit / Acute Receiving Unit and continued in the community where clinically appropriate.
- A comprehensive 24-hour interventional radiology service should be available.
- To maximise patient outcomes, where specialist care is required, it should be provided by senior clinicians undertaking high volumes of cases/ operations in line with national guidelines.
- Emergency day case surgery should be available where clinically appropriate.
- Patients should be provided with any necessary care, treatment and support in the most appropriate setting and environment, compatible with the delivery of safe and effective care, including the community where appropriate.

8.5.4 Disease/condition specific standards

- Frail elderly patients should have early access to comprehensive geriatric assessment to support effective management.
- Appropriate and timeous access to mental health services should be in place for people with mental health needs.
- Patients suffering major trauma injuries should be taken directly to a major trauma centre.
- Patients suffering from chest pain should have timeous access to angiography services.
- Patients suffering from a stroke should be taken directly to a specialist centre (see figure 16)
- Acute hospitals providing care for patients with GI bleeding should meet the national recommendations and provide 7 days a week access to out-of-hours endoscopy services; within 1-2 hours of admission for severe bleeding and within 12 hours for moderate bleeding. Appropriate assessment systems should be in place in all sites, with appropriate care pathways in place to treat patients or to transfer patients to the appropriate site for definitive treatment.
- National guidelines should be met where available; for example in the care of patients with myocardial infarction, head injury, bleeding in early pregnancy, suicide prevention and child protection.

8.5.5 Diagnostics

- Underpinning the new models will be a heavy focus on access to diagnostics to support the assessment of patients. This will require changes to how the services are currently organised to support early investigation to support decision making without the need to admit patients to organise tests.

Illustration: for a patient, moving to the new model of care described might look like this:

Now: Present to A&E and is admitted to hospital

Future: assessed by a consultant, not acutely unwell requiring admission, sent home with an appointment for a diagnostic test the following day with an outpatient appointment. GP informed, community team informed where indicated. Patient has information on what to do if condition changes / warning signs to look for.

Figure 16: Example of future models: Stroke

- **Prevention:** Primary prevention and management of risk factors [Rapid assessment of high risk TIA patients within 1 day of referral. All GPs using rapid assessment service; cardiac and vascular services resourced to meet demand from stroke.

- **Hyper acute stroke service (HASS):** Scottish Ambulance Service take patients with FAST +ve suspected stroke directly to hospital with HASS beds; early specialist stroke team assessment; immediate imaging and investigations; treatment commenced (including thrombolysis where indicated); rehab commenced in HASS; 35% patients discharged home from HASS bed.

- **Integrated acute/rehab stroke unit:** transfer from HASS at average of 2.5 days post admission; 7 day stroke specialist Multi Disciplinary Team assessment and rehab (AHPs, nursing, medical); planning for discharge and support for carers; average length of stay in unit 21 days.

- **Early Supported Discharge within Community Stroke Team:** 6/7 day stroke specialist rehab; multiple visits per day to support early discharge from hospital; close links with re-ablement care services; time limited intervention with review/follow up.

- **Support in the Long Term:** local community and voluntary sector services with awareness of stroke; GP Enhanced Service for stroke.

8.6 Implementation challenges for this model

- How we can consistently support a model of the 'generalist' as first line approach supported by specialist rotas allowing timely intervention. It will also consider the implications of this model across Glasgow and Clyde in terms of:

    - Activity and patient flows
    - The staffing model of generalist and specialists required to support the model
    - Accommodation requirements to allow for the effective components of the models to manage patient flows as described.
    - Assessment / Decision Unit approach and availability of urgent outpatient service across GGC.
    - Contact system for GPs to discuss patients prior to referral to hospital.
    - Develop a more detailed position on key areas identified for a change in specialist approach:
        - Stroke
        - Angiography / angioplasty
        - GI bleeding
        - Vascular
    - Develop the major trauma centre in line with regional and national planning, considering the critical clinical adjacencies to support this.

9. PLANNED CARE

9.1 Key Components of the approach

9.1.1 Local provision of outpatient and ambulatory care facilities

It is proposed that wherever possible outpatients, investigations, day surgery and short stay surgery should be provided as locally as possible across NHS GGC. This would provide a full range of core clinical services locally to meet the majority of patient needs with patients travelling only where clinically required to other sites.

9.1.2 Outpatient model modernisation

Outpatient model of referral and attendance at outpatient clinic needs to be modernised to provide alternatives to clinic consultation. This should include telephone consultation, telephone advice services for GPs to manage patients without referral to hospital; direct to test approach where appropriate.

Return appointment models should be reviewed with the aim to reduce the return appointments where appropriate and to facilitate alternative follow-up arrangements where possible. This should include telephone follow up; discharge with patient driven return initiation. The recent cancer services group and the work on Quality Performance Indicators suggest that the follow up arrangements could be reduced. For chronic disease management, different approaches to ongoing management and follow-up are also being considered with both groups considering how community based follow –up and patient initiated follow up could be part of the future models.

9.1.3 Community based service provision

Care should be provided within the community wherever possible. This could include:

- Further development of local phlebotomy services and monitoring of patients in community.
- Nurse/AHP led clinical services in the community or in hospital where applicable. This would build on the currently available services such as the diabetes and respiratory services. Some of the areas currently proposed to be developed could include:
  - Lower urinary tract and incontinence service;
  - Raised PSA clinic – Nurse led triage clinic where TRUS biopsy is provided;
  - Chronic pain service.
- Specialist clinics in community settings, working with GPs and community teams to develop joint care plans for patients.

9.1.4 Consolidation of low volume/ high complexity care

The evidence suggests that there is a case for improving outcomes by providing complex investigations and treatments in only a few specialist centres. This applies in particular to cancer care, which is covered in the next section.

9.1.5 Maximisation of ambulatory care including day surgery and the development of short stay surgical models within Ambulatory Care Hospital type facilities

There is scope to improve the use of Greater Glasgow and Clyde's inpatient beds for planned care. This is in part by maximising day case surgery / day treatment but also by

managing the time patients spend in hospital after elective care, which can be quite variable across sites.
This variation is caused by a number of factors, including availability and the quality of home and community support as well as the surgical techniques used.

Programmes such as the Enhanced Recovery after Surgery (ERAS) should be in place to ensure that patients spend no longer than they need in hospital. These programmes also encourage active participation of patients in the care plan and recovery process. This type of approach should be encouraged across surgery. Similarly, less invasive techniques should be used where clinically appropriate to improve the patient experience and the speed of recovery.

Reducing length of stay, where clinically appropriate, will be important to improve the patient experience and to bring financial benefit to allow investment in other parts of the service.

9.1.6 Planned 'urgent' care clinics

Through the work of the Emergency Care work stream there are a number of areas being identified to develop a more planned approach to care to avoid emergency admissions. This was detailed in the earlier part of this report and requires the service to consider different approaches.

9.1.7 New service models

New service models to better support the management of patients are being considered such as the digestive diseases service combining gastroenterology and upper and lower GI surgery to provide a single coordinated service for GGC.

Illustration: for a patient, moving to the new model of care described might look like this:

Patient Story
70 year old woman lives in Argyll and Bute, 4 hour travel time to services in Glasgow, main carer for husband. She attends outpatient clinic once a year for specialist follow up.

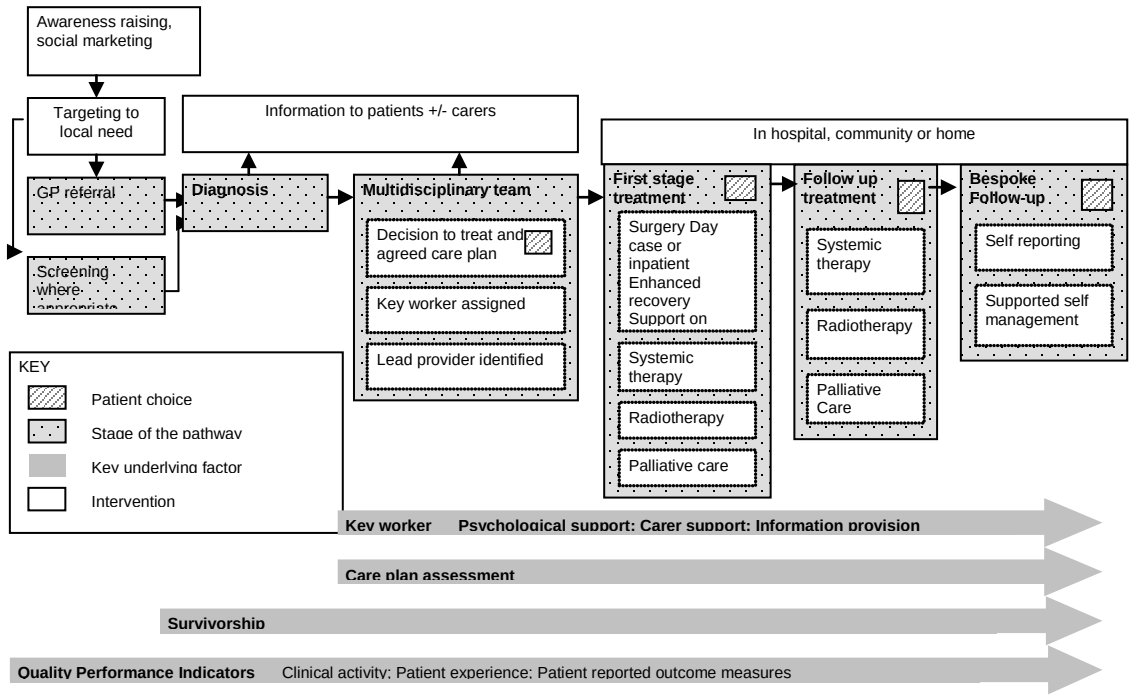
Now:
Sent an appointment for 9am, has to change to a time she can travel for
Makes arrangement for husband to be cared for
Travels all morning for rearranged early afternoon appointment
Has bloods taken and sees consultant for 5 minutes to be told everything is fine
Travels 4 hours home again – arriving late evening

Future:
Blood tests done locally, OP only arranged if indicated from results. Phone consultation or via telemedicine link for follow up where clinically appropriate.

10. CANCER

10.1 Key Components of Approach

Figure 18: Cancer Pathway



The key aspects of the care pathway identified to enhance survival and quality of life are shown on figure 18 above. In general the cancer pathways are considered to be well established and working well. Some areas were identified as areas where further consideration and development is required which are discussed below. Clinical evidence suggests that common cancer care such as systemic anti cancer therapy and patient follow-up should be provided as locally as possible and where possible outside the hospital setting. The evidence also makes the case for improving outcomes by providing complex investigations and treatments in only a few specialist centres.

10.2 Cancer surgery

The number of site(s) providing cancer surgery should be based on numbers of patients and outcomes achieved. The proposed model of care recommends some further consolidation of surgical services for both common and rarer cancers. This will ensure that clinical teams and environments are in place to provide high quality care and improved outcomes for patients across Greater Glasgow and Clyde.

10.2.1 Impact for Common Cancer Surgery

- **Breast cancer surgery**

  Breast cancer surgery can be delivered as a day case, with surgeons using less invasive techniques so that patients do not have to stay in hospital unnecessarily. Guidelines suggest that 60-70% of breast surgery should be day case.

To improve outcomes and experience, day case breast services should be available locally to all patients who require less complex surgery.

Patients undergoing more complex surgery should have the opportunity to discuss their breast reconstruction options and have immediate breast reconstruction if appropriate.

- **Colorectal surgery**

  The number of patients being seen and patient outcomes from cancer audit results should determine the number of sites. Where clinically appropriate this should be delivered locally. Complex colorectal surgery with plastic surgical involvement should be delivered in a specialist unit.

10.2.2 Impact for rarer cancers

Over recent years NHS Greater Glasgow and Clyde has consolidated services into single sites for some rarer cancers such as upper gastrointestinal cancer. For a number of cancers this has also resulted in supporting other boards within the region to provide a tertiary level service such as ovarian cancer. However there are still some areas where we are providing care on a number of sites for relatively small numbers of cases. Consolidating services into fewer hospitals would create and maintain complete clinical environments that can enable the delivery of best practice providing improvements and benefits for patients by focusing experience in limited areas within services.

There are a number of rarer cancers where volumes mean that the service can only be provided from a single site.

- **Rarer urological cancers**

  As with other small volume cancers urological cancers need to be provided from a specialist urology team. General urology services should be able to refer patients with complex needs to the specialist team. To ensure the best outcomes and experience, rarer urological services should have access to all of the requirements of a high quality service such as 24 hour access to interventional radiology, appropriate consultant cover and resident surgical juniors. NHS GGC needs to consider creating a centralised specialist team and unit to support the provision of complex urological cancer care. Currently there is ongoing work with other Boards within the region to realign small volume surgery into one service within NHS GGC.

10.3 Changes to Treatment

10.3.1 12.3.1 Systemic Anti-Cancer Therapy (SACT)

Guidelines recommend that to provide patient centred care the inpatient delivery of systemic anti-cancer therapy (SACT) should be minimised. Over recent year's local provision has developed in many areas linked to the central unit at the Beatson to provide more convenient treatment to patients where it is safe and clinically appropriate to do so. As therapies evolve with the development of oral preparations it will be important to develop the service to increase the care delivered locally and where possible and clinically appropriate out with the hospital setting.

10.3.2 Managing emergency care

For patients admitted as an emergency the guidelines indicate that arrangements should be in place to assess cancer patients immediately when they arrive at hospital to expedite care.

It is proposed to provide an acute oncology assessment unit (OAU) and 24 hour phone to provide a dedicated service for all adult oncology /haematology patients who are currently receiving /or have received treatment (chemotherapy /radiotherapy) in the past 6 weeks at the cancer centre, or are at risk from disease / treatment related immuno-suppression.

It will also support all patients attending the cancer centre who are identified to be at risk of developing malignant spinal cord compression (MSCC) as per the National Institute for Clinical Effectiveness (NICE) and the West of Scotland Cancer Network Guidelines.
It is expected that this will prevent unnecessary hospital admissions, and where hospital admission is required, ensure patients are seen /and or admitted to the right facility to support the care they require, improving patient outcomes and care.

10.3.3 Haematological cancers

The management of haematological (blood) cancers is increasingly dependent on the detection of particular genetic changes within the cancer cells. These require highly specialised molecular techniques and many new agents are being developed. These genetic changes are important for determining both prognosis and appropriateness of therapies, including the need for stem cell transplants. Molecular techniques can be used to monitor response to treatment.

Access to modern diagnostic techniques is critical to ensure appropriate use of therapies and to monitor effectiveness.

10.3.4 Follow up and Support

The follow-up of most cancer patients is done on a routine basis in hospital outpatient departments. Recent regional and national work through the Managed Clinical Networks (MCNs) indicates that there is a requirement to change the follow-up arrangements for many areas. This includes providing monitoring and follow–up within the community where possible including patient blood tests.

With changes to survivor rates it is recognised that the approach needs to be altered to offer more individualised aftercare services and more responsive to patient needs as some patients can become ill again between outpatient appointments and not feel able to see a specialist until their next scheduled visit. Changing the method of follow-up will improve outcomes and quality of life for patients and could free up specialists' time to continue to improve quality of care for all patients across GGC in other ways and could support a more person-centred interaction with the clinical team. To support this it will be important that patients are given the relevant information to make an informed choice on their preferred model of follow-up.

10.3.5 Supportive and palliative care

This is a key part of care, especially with the changes in survivor rates, and so needs to meet the needs of patients both living with cancer as well as to support advanced care planning for the end of life. Across NHS GGC the Gold Standard Framework has been

implemented as has the use of advanced care pathways. This has helped improve both palliative care and end of life care planning. See figure 13 on End of Life Care.

As future services are planned it is recognised that there is a need to ensure that holistic assessments are part of the patient pathway including assessment of psychological needs and the support requirements of carers with advanced care plans in place consistently across GGC to support patient care.

10.4 Implementation challenges for this model

- Modelling of the capacity required to meet the future predicted increase in cancer patient numbers.
- Consolidation of complex / low volume surgery / care – impact on patient activity changes / clinical team and infrastructure changes required.
- Front door model to support emergency care of patients with cancer.
- Provision of increased chemotherapy in the community – estimating the impact of chemotherapy changes and the community / local service capacity requirements or changes.
- Service requirements in primary care to support monitoring and follow up including links with the 3rd Sector to support patients and carers.
- Requirements to support palliative care and end of life care out with hospital with effective advanced care planning – this is linked to other work in relation to long term condition management and management of the frail elderly to consider alternatives to hospital care.

11. CHILDREN SERVICES

11.1 The emerging models from the Children's Services group in some respects mirror the developments in other work streams, such as emergency care and the management of patients with complex care needs, particularly in relation to the development of primary care, community services and better working at the interface. The specific drivers and proposed changes for children's services are set out in this section.

11.2 The Children's Group focused primarily on services provided to the NHSGGC population rather than on the wide range of regional and tertiary services provided by the Royal Hospital for Sick Children (RHSC). This acknowledges the national and regional planning fora which cover these more specialist areas, as well as the significant amount of work and redesign going into the planning for the new RHSC.

11.3 The work of the group focused on general paediatrics, long term conditions, links to the community and providing support in an emergency, as well as on effective transition between children's and adult services. These were the priority areas highlighted during the development of the Case for Change.

11.4 Core principles

- Care should be focused on the needs of children and families.
- Care should be provided in dedicated child friendly environments.
- The approach to care in settings should uphold the Rights of the Child
- There should be a focus on co-ordination of care and clear points of contact.
- There should be an appropriately trained, skilled and senior workforce: complying with relevant standards.
- Information should be shared and available across the system to inform care.

- There should be robust child protection systems in place.
- Emotional support has to be central.
- Clear transition arrangements should be in place when children move to adult services.
- Standards of care and access to range of children's services should apply equally across the whole of Greater Glasgow and Clyde.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged and supporting children to have the best start in life.

11.5 Key components of approach

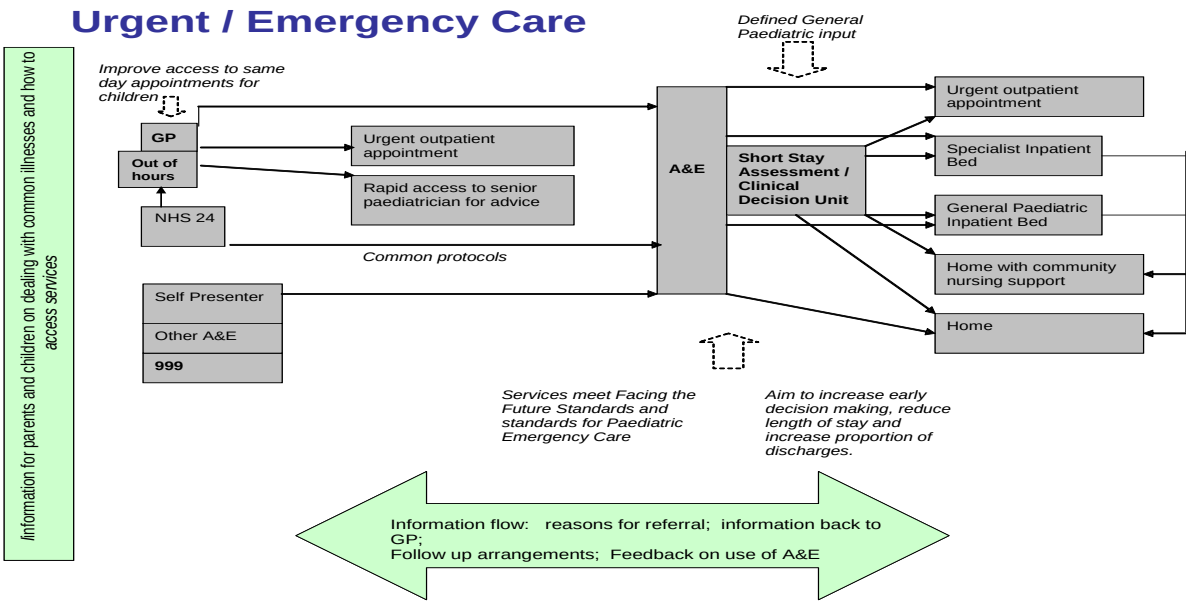
11.5.1 Emergency care

As with the model for adult emergency care there are a number of ideas being proposed to provide a range of alternatives to admission, which are accessible from the Emergency Department such as urgent outpatient appointment and community nursing support to enable earlier discharge.

This needs to be underpinned by the effective flow of information from the GP to the hospital and vice versa, supported by clear follow-up arrangements and feedback to practices on Emergency Department attendances and outcomes.

Where there are admissions for exacerbation of chronic disease this needs to prompt review of the care plan. The diagram below sets out the urgent / emergency care pathways.

Figure 19



This model requires a greater focus on the development of dedicated General Paediatric input as a focal point for the management of emergencies and alternatives to emergency admission. It also requires further development of nursing roles and closer working across acute and community services, facilitating earlier discharge and ensuring children can be supported at home were possible.

The 'Facing the Future' standard and Standards of Care for Paediatric Emergencies set out clear expectations for the skills, expertise and specialist opinion which should be available for children in all emergency settings. We need to ensure that we can provide this required range of specialist paediatric services to all children presenting as emergencies and those requiring inpatient care.

Key elements of this pathway will be implemented as part of the move to the new Royal Hospital for Sick Children on the South Glasgow Hospitals site. This move will enable all 'blue light' emergency cases for children in Glasgow to come to the dedicated paediatric unit which represents a gold standard in terms of access to the definitive place of care with specialist treatment, a dedicated child friendly environment and dedicated paediatric staff across a range of services and disciplines, including triple co-location between children's, adult and maternity services.

The changes described above will support that move and we need to consider further the pathways for 'blue light' emergencies and inpatient care, as well as minor injuries and self-presenters, across Greater Glasgow and Clyde to ensure that patients can access the right level of care as quickly as possible.

While this diagram focuses on access to urgent and emergency care from the community to hospital settings, we recognise that neonatal services also deal with a significant emergency workload with a pathway to urgent care from maternity units to neonatal units and that this is an additional route into emergency care. As such, it needs to be supported by clear criteria for identifying and transferring sick newborns both in maternity wards and in the early days following discharge home.

11.5.2 Planned care and long term conditions

The emerging service model seeks to establish local **Integrated Children's Centres.** This supports:

- Local provision of a range of services, enabling better joint management of patients across services and agencies, with locally accessible specialist care.
- Promote different way of working: not current hospital activity in a different place but rather a focus on effective joint care planning across primary care, community services and specialist paediatrics.
- Point of contact for families with long term conditions / complex disabilities, including being a focal point for transition.

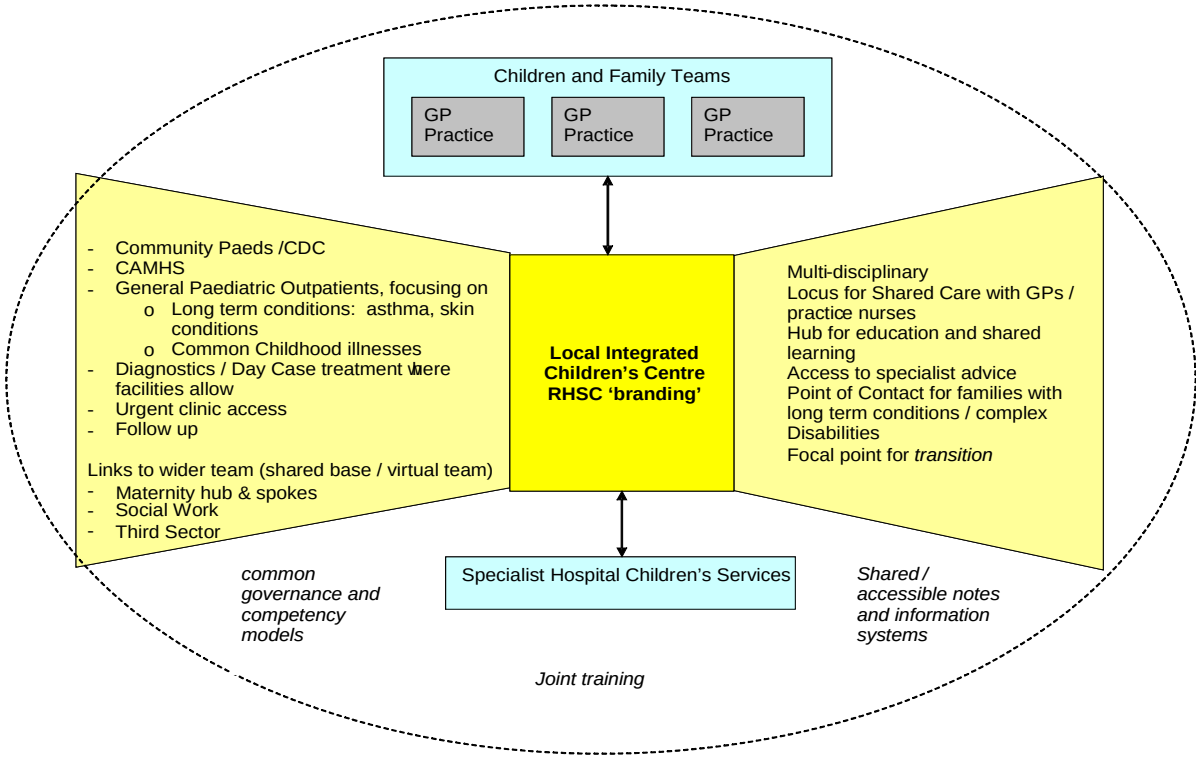
Core components of the **Integrated Children's Centres** would include:

- Community Paediatrics / Child Development Centres
- Child and Adolescent Mental Health Services
- General Paediatric Outpatients, focusing on
    - Long term conditions: asthma, skin conditions
    - Common childhood illnesses
- Diagnostics / Day case treatment where facilities allow
- Urgent clinic access
- Follow up
- Links to wider teams and services (shared base / virtual team)
    - Maternity hub and spokes
    - Social Work
    - Third Sector
- Link to localities / clusters of GP practices

- Locus for Shared Care with GPs / practice nurses
- Hub for education and shared learning
- Local point of access for specialist advice

This model will only work if it is seen as a very different way of doing things, rather than providing the same services in a different location. The real potential of integrated children's centres is to enable services and families to work together in a different way, across current service boundaries. The Royal College of Paediatrics and Child Health estimate that 50% of paediatric outpatients could be seen in a community setting, and that a greater community focus will lead to better long term conditions management and a more holistic social and behavioural approach. The centres also offer the opportunity to look at different ways of working to support children and families at home, and to set the foundations for effective chronic disease management for a lifetime. This includes using new technologies and making the most of opportunities for home monitoring and supported self care.

Figure 20: Integrated Children's Centres



11.5.3 Transition

Transition has been a recurring them of discussions with patients and professionals. The model described above will support effective transition through the integrated children's centres, enabling a clear point of contact and co-ordination for families, and by involving GPs at an earlier stage in the management of long term conditions and complex care packages for children which will give greater continuity into adulthood. In addition to this, good practice in the approach to transition has been identified as including the following components:

- Transition should be viewed as a process, not an event. Services need to view transition as a period of at least 2 years, which starts in early adolescence, and allows gradual, coordinated transfer of care to primary care and adult health services. The aim of the transition process is therefore to enable and empower young people and their families to confidently access adult services.

- A key worker should be identified to coordinate the transition from paediatric to adult health services.

- In order to develop workable transition care pathways, there should be good communication and cooperation between paediatric and adult services and GPs.

- Joint transition clinics for paediatric and adult health services would help support the transition of young people with more complex needs and/or those requiring ongoing active management. The future co-location of adult and paediatric hospital services at the South Glasgow Hospitals site might help to facilitate this joint working for some hospital-based teams.

- The collation and sharing of information between health professionals needs to be improved to ensure effective transfer of health information to adult services. This sharing of information may be facilitated by improved IT systems. The use of a patient-held health record should also be considered.

12. MATERNITY SERVICES

12.1 Principles

- Focus on providing safe, accessible and effective care which improves outcomes for women and babies and reduces inequalities.
- Care focused on the health and social needs of women and families.
- Promotion of normal childbirth and reduction of interventions.
- Appropriately trained, skilled and senior workforce: complying with national workforce recommendations.
- Strengthen communication and collaboration between services which include other key NHS services and local authorities.
- Women are able to make informed decisions about their care.
- Use women's experience of care to drive service improvements.

12.2 Key components of approach

The key components of the approach of the service model for maternity care are set out below:

- Pre-pregnancy advice and health promotion.
- Early booking.
- Comprehensive assessment as early as possible, informed by shared information.
- Early identification of red / green pathway: midwife led care where possible, with regular review and ability to move between pathways when required. Identification of risk and appropriate support is critical to successful outcomes, and to defining future service and workforce needs both for maternity and neonatal services.
- Early pregnancy assessment service available 7 days a week.

- Increased support for vulnerable women and families in pregnancy: identification of vulnerability based on broad assessment of individual family and social circumstances.
- Supporting access to wider services including financial inclusion, welfare advice, and family support.
- Health visitor involvement as early as required, especially for vulnerable families: co-ordination of care and handover between midwife and health visitor.
- Team based approach with a central role of midwives as autonomous practitioners of normal pregnancies, working as a team with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated pregnancies.
- Delivery suites meet required staffing standards: Midwife, Obstetrician and Anaesthetic cover. Move to 24 hour consultant obstetrician presence. Increasingly this will require to be covered by dedicated Obstetricians, with the increasing specialisation of gynaecology.
- 'Timely' discharge from hospital: reducing length of stay.
- Neonatal units which comply with Neonatal Quality Framework standards, with clearly defined pathways to ensure that babies are identified in post-natal settings and transferred in a safe and timely manner.

13. UNDERPINNING SYSTEM CHANGE

13.1 As we move to develop implementation plans for this strategy there are a number of areas of work which need to underpin system change. These include:

- Diagnostics and diagnostic Systems
- Information and Information Systems
- Communications
- New Ways of Working - appointment systems / technology
- Ways we deliver care – person centred care. Equalities sensitive practice

13.2 There are also implications for Other NHS Organisations including the SAS, NHS 24 and other territorial health Boards.

14. PUBLIC AND PATIENT ENGAGEMENT

14.1 There has been extensive engagement through the development of this clinical services review which has been referenced throughout this document. Formal approval of the Clinical Strategy is a further opportunity for that wide engagement. As we develop specific change proposals engagement will continue to be fundamental.

14.2 The Scottish Health Council (SHC) have been involved in this process from the start, attending the ongoing engagement events with the patient reference groups and the third sector as well as attending the event at Hampden in April when the emerging service models work was shared with the wider clinical group. In addition they have met with Board Officers to discuss the programme and to share thinking on the approach being taken, feedback on their observations and to support planning for the ongoing engagement. As the planning to develop service change proposals follow this strategy this close engagement will be continued to ensure the approach taken is in line with SHC guidance in relation to engagement, pre consultation and consultation, where this is indicated. The fill SHC commentary on the review is attachment one to this paper.

15. CONCLUSION

15.1 The clinical service review has enable us to develop this clinical strategy to provide a basis for the development of detailed service change proposals working with Integration Joint Boards and with the emerging national approach to clinical strategy and delivering the 2020 Vision. We need to work together to deliver:

- Improving health and prevention of ill health; empowering patients and carers through the development of supported self care.
- Developing primary care and community service models; simplification of community models; focus on anticipatory care and risk stratification to prevent crisis.
- Improving the interface between the community and hospital to ensure care is provided at the right time in the right place; Community and primary care services inward facing and hospital services outward facing; focused on patient and carers needs.
- Developing the ambulatory approach to hospital care, with inpatient hospital care focused on those with greatest need ensuring equitable access to specialist care.
- Redesign of specialist pathways to establish a consistent service model delivering the agreed clinical standards and good practice guidelines.
- Developing the rehabilitation model based on need not age; working across the service within primary and secondary care and with partner organisations to provide rehabilitation in the home setting where clinically appropriate.
- Changing how care is delivered - patient centred care; shifting the paradigm to deliver care differently for patients particularly for patients who have multiple conditions; helping patients and the public to develop and understand the new approaches to care

[i] London Health Programmes: A framework for action, 2011.

[ii] Better cancer care: an action plan (2008). Edinburgh: Scottish Government.

Attachment 1

Board consideration of clinical services review

Clinical Services Review

21 February 2012	Board Meeting	Clinical Services Fit for the Future paper to the Board for agreement for agreement to progress
02 October 2012	Board Seminar	Briefing on Clinical Services Review
18 December 2012	Board Meeting	Case for Change to Board for Approval
07 May 2013	Board Seminar	Emerging Service Models (presentation)
07 August 2013	Board Seminar	Service Models (presentation)
20 August 2013	Board Meeting	Service Models Paper to Board for approval
6 December 2013	Board Away Day	Clinical Services Review Update (presentation)
17 December 2013	Board Meeting	Clinical Services Review Update - Development of the Renfrewshire Development Programme for approval
14 February 2014	Board Away Day	Clinical Services Review Update (presentation)
21 October 2014	Board Meeting	Clinical Services Review Renfrewshire Development Programme update paper to Board
09 December 2014	Board Away Day	Clinical Services Review Update (presentation)

9th

Attachment 2

scottish health council

making sure your voice counts

Ms Catriona Renfrew
Director of Corporate Planning & Policy
NHS Greater Glasgow and Clyde
Gartnavel Royal Hospital
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Glasgow
G12 0XH

Date: August 2013

Our Ref: J B Russell House

Enquiries to: Louise Wheeler

Direct Line: 0141 429 7545
Email: louise.wheeler@scottishhealthcouncil.org

Dear Catriona

Clinical Services Review Fit for the Future

The Scottish Health Council has welcomed the exchange of information that's taken place between ourselves and board officers over the past 18 months. We consider that this has been helpful in enabling us to have a dialogue to ensure that the process, as it develops, observes the principles of openness and transparency, contained within national guidance.

As well as providing comment on the board's early process of engagement and information, we have also used these meetings to provide feedback on our observations from the meetings hosted by the board and share the findings of our recent survey on participants' experience of involvement.

Scottish Health Council staff attended most of the Patient Reference Group sessions held during the period March 2012 to April 2013; Third Sector events held in January and June 2013; the Combined Clinical Group workshop in April 2013; and the Combined Patient Reference Group meeting held in June 2013.

We also note that there was patient and public representation on each Clinical Steering Group and that an Overarching Patient Reference Group met several times throughout the process. In addition we are aware that NHS Greater Glasgow and Clyde officers took the opportunity to discuss this review process with Public Partnership Forums and some community groups across the Board area.

For each meeting between the Scottish Health Council and board officers we prepared a "feedback paper" to inform our discussions. Our most recent meeting was held on 25th July 2013. The feedback on the board's review process for June and an extract from the May feedback is provided as an appendix to this letter.

Some of the key themes from the engagement so far have included:

- Participants appear to support the general direction of travel (anticipatory care and early intervention) and some acknowledge that difficult decisions may be needed in order to deliver new models of care.
- Some people have expressed concerns around the interface between acute services and primary care (including access to and capacity of GPs), discharge planning and community support.
- Some participants at the Patient Reference Group sessions have whether there are sufficient links with local authorities, other public agencies and the Third Sector to support multi-agency pathways of care.
- Challenges have been identified around how some of the aspirations can be implemented eg staff training, finance and resources.
- Some participants at the Combined Patient Reference Group session in June 2013 noted that it was difficult, at this stage to see anything coherent within the draft service model discussion paper and referred to the challenge of articulating the emerging models of care, with the inclusion of the proposed 'interface services'.
- Consideration should be given to continued discussion and engagement with neighbouring Boards

and their patients/public involvement structures in any proposed service development and change. As part of the Scottish Health Council's survey to capture participants' experience of involvement to date, we issued130 questionnaires (70 by hand, 47 by post and 13 by email) and received 36 completed questionnaires giving a response rate of 28%. Responses included:

- 29 people (81% of respondents) felt they'd been able to contribute to the emerging models and 24 people (73%) felt that the models reflected previous group discussions.
- 25 people (69% of respondents) felt they'd been able to influence the process
- 32 people (89%) indicated that they intend to continue their involvement in the process

In response to some of the issues raised, the Scottish Health Council would encourage NHS Greater Glasgow and Clyde to:

- Consider how patients, carers, the public and voluntary sector may continue to be meaningfully involved in further engagement.
- Ensure that information is accessible for a wide range of people and that acronyms and technical language is kept to a minimum. Information and communications should be developed with patients, carers and public representatives to ensure that the language and content supports peoples' understanding of any proposals.
- Seek to address the issues and concerns that have been raised by patient and public representatives and staff during this early phase of engagement to inform the next steps.
- As the detail of the review emerges, demonstrate the 'contrasts' between existing and proposed new services. The paper makes reference to "support to maintain people at home, when clinically appropriate", "need to do more to stop people being admitted to hospital" and "help people leave hospital more quickly". However it may not be clear to people whether this drive is to maintain existing structures and services or may result in disinvestment or changes to service configurations. The use of case studies may also help people to appreciate the impact of change.
- Work in partnership with special and neighbouring NHS boards, public agencies, the Third Sector and others as more detail around service models emerges.
- Continue to develop the equality impact assessment, with additional elements from health inequalities.
- Evaluate its process and structure of engagement (March 2012 – June 2013) to identify any learning and areas for improvement.

At our meeting on 25th July, representatives from the board acknowledged that the service models developed do not currently contain the necessary detail required for public consultation. We agreed that the timescales in the draft discussion paper did not reflect the further work required to develop specific models/proposals in order for or a wider group of people to then be engaged. T This should include option development and appraisal which should assist in identifying any preferred options. Where the proposal, or elements of th his, may be considered 'major' the guidance "Informing, Engaging and Consulting People in D Developing Health and Community Care Service" (CEL 4 (2010)) indicates that the board should not move to consultation until they have confirmation from the Scottish Health Council on the public c involvement process to date. Finally, we would like to acknowledge t e the scope of involvement work conducted to d date and encourage this to be carried forward as the process develops. We would be happy too continue our dialogue with NHS Greater Glasgow and Clyde as planning is progressed and look f forward to hearing from you in due course.

Yours sincerely

Louise Wheeler
Service Change Adviser

Appendix

Extract from Feedback on process for Clinical Services 'Fit for the Future'
May 2013

Emerging themes from PRGs from discussions

- Numbers have remained consistent at each of the workshop sessions (suggesting that people have stayed involved in the process)
- Participants at the PRGs have questioned the 'links' with local authorities, public agencies and the Third Sector to support multi-agency pathways of care
- Participants have had the opportunity to respond to the issues/themes raised from earlier PRG sessions. Clarity was sought on shared understanding at the start of each session.
- At several of the workshops, participants have questioned buy-in to the review from GPs and the primary sector
- Concerns around how some of the aspirations can be implemented eg staff training, finance/resource (Unplanned care/Chronic Disease)

Information

- Note that information from the first two PRGs is available on the Board's website.
- Information and presentations do not appear to be shared consistently with participants in advance of meetings
- The presence of a clinician has enabled participants to ask, and get immediate response, to some probing and specific questions.
- To date, lay participants appear to be content with the review process and their involvement with some representatives speaking supportively of it at sessions.
- Some people noted that there were too many acronyms in some of the presentations (Planned care, Cancer). Where possible the use of these should be eliminated or reduced.
- In Mental Health, some participants found the papers difficult to understand. The content, detail and format of these should be considered for future participation.
- Participants raised an impression that there may be reluctance by NHS staff to refer to third sector services. This point was agreed upon as something requiring further investigation by the Board officer present.

Next steps

- Participants have suggested that it would be helpful to bring all the public representatives together for the next round of discussions, given the cross-over/ entire patient pathways
- With patient flows between services across neighbouring Boards – have discussions taken place to engage these Boards and their patients/public involvement structures?
- The Scottish Health Council welcomes the development of the EQIA for the review process – we would encourage the Board to consider how people with protected characteristics may be involved in considering service models and engagement and consultation processes.

- Gauge impact re specialist tertiary care – have other Boards and patients been involved in this work? Board officer stated that the Tertiary Care Clinical Group has been informed from discussions of other PRGs and the service models will be shared at event in June – will relevant Boards/ patients/ public representatives be invited to this session?
- Discussion around the Scottish Health Council's survey questionnaire (June 2013).

Feedback on process for Clinical Services 'Fit for the Future' July 2013

The comments below come from the Scottish Health Council's attendance at the Third Sector event on 24th June, the Combined Patient Reference Group session on 26th June, the Scottish Health Council's feedback survey and consideration of the Clinical Services Review discussion paper. It is also informed by reviewing footage of interviews conducted by NHS Greater Glasgow and Clyde with six members of the Overarching Patient Reference Group.

Information

- The Scottish Health Council welcomes the ongoing exchange of information and communication that's taken place with board staff and the Scottish Health Council and their response to feedback.
- Three people in NHS Greater Glasgow and Clyde's interviews advocated the use of plain language, without acronyms, to support understanding.
- From the Scottish Health Council's survey, 29 people (85% of respondents) said they'd received enough information and 32 (91% of respondents) said that information had been shared in a timely manner.
- The events in June were planned to share the emerging service models with patient and public representatives and the Third Sector. Although Board officers presented an overview there was little detailed discussion or interrogation of the discussion paper that was sent in advance of the meeting
- At the Combined PRG session, some people felt that there was too much information to take in and that it was difficult to see how this had evolved from PRG involvement.
- Some participants highlighted that they felt the presentations were comprehensive and provided a good overview.
- Some participants noted that it was difficult to see anything coherent within the discussion paper and that it was difficult to articulate the emerging models of care, with the inclusion of the proposed 'interface services'.
- One group at the Combined PRG session noted that there was not enough information for people to understand what the models mean. The Scottish Health Council notes that public representatives sit on the Clinical Groups as well as the Patient Reference Groups.
- Two respondents to the Scottish Health Council survey suggested that more detail would be needed to engage with the public.

Implementation and themes

- It was suggested that there may be challenges to collaboration within the Third Sector as each organisation seeks to:
- o Preserve their own identity and empowered budget
- o Successfully compete for the same pot of money
- Most participants at both events appeared to support the general direction of travel (anticipatory care and early intervention) and recognised that some difficult decisions would be needed around disinvestment in acute care.
- Some people are concerned around GP interface, discharge planning and community support.
- Three people (through the Overarching PRG interviews and Scottish Health Council survey) commented that work to date appears to have been mainly led by medical professionals – participants suggested that the Board extend involvement to other staff groups
- Participants suggested that further engagement is needed with social work, education etc.

Process

- Some participants at the Combined PRG session noted that they had welcomed the Board's openness and opportunities for discussion
- The Scottish Health Council notes that there were fewer people at the Third Sector event in June (around 35) compared with that held in January (around 100).
- • Responses to the Scottish Health Council survey indicated:
- o 32 people (89%) intend to continue their involvement in the process (note that Board advised that the PRG work has now drawn to a close).
- o 29 people (81% of respondents) felt they'd been able to contribute to the emerging model and 24 people (73%) felt that the models reflected previous group discussions.
- o 25 people (69% of respondents) felt they'd been able to influence the process
- • Some additional comments from the Scottish Health Council survey (not covered elsewhere):
- o Exciting and ambitious project
- o Continue to engage with service users and the public
- o Aim to recruit more young people/identify gaps in representation

Scottish Health Council's Survey Responses

The Scottish Health Council issued 130 questionnaires (70 by hand, 47 by post and 13 by email) and received 36 completed questionnaires giving a response rate of 28%.

Half of the respondents indicated which workstream they were involved in – but all workstreams had a response from at least one representative (highest was Older People with six responses).

Most people indicated that they were representing a group or structure eg Public Partnership Forum (12), community/voluntary group (12), Third Sector (11). Note that the Third Sector is also involved through a separate process.

Clinical Services Review Discussion Paper

- The Scottish Health Council is unaware of any discussions with lay representatives around the detail and content of the board's discussion paper though there has been lay representation in the development of service models through the Clinical Groups. We acknowledge that people have indicated general support for the direction of travel for the process to date. However, some people have commented on the lack of detail about what is being proposed.
- We acknowledge the scale of the Clinical Services Review project and the board's attempts to provide a comprehensive overview – and this is reflected in the length of the discussion paper. However, this may be to the detriment of making the paper accessible to lay participants. Consideration should be given to some of the terms used such as polypharmacy and co-morbidity and whether a glossary would assist with this.
- We welcome the Board's production and distribution of a more succinct four page summary. It may be helpful if this format is used as the process progresses and the details emerge.
- As the detail of this review work emerges it would be helpful to demonstrate the 'contrasts' between existing and proposed new services. The paper makes references to "support to maintain people at home, when clinically appropriate", "need to do more to stop people being admitted to hospital" and "help people leave hospital more quickly" however it may not be clear to people whether this drive is to maintain the existing structures or may result in disinvestment or changes to service configurations.

Next steps

- The Scottish Health Council notes that the service change models are still at a high level and give a general direction of travel. The paper and Board officers have acknowledged that more work involving stakeholders is needed to develop these further.
- The Scottish Health Council would suggest that in future information should aim to communicate the impact of change perhaps through the use of case studies or 'contrasts' (comparing existing service with the new service). Information and communication should be developed with patients, service users and carers to ensure that the language and content supports people's understanding.
- Consider how existing patient representatives may be further involved in the engagement process.
- It will be helpful to clarify what stage NHS Greater Glasgow and Clyde has reached in their review process in terms of the Informing, Engaging and Consulting guidance, CEL 4 (2010)and discuss expectations and next steps.

In particular we note the timescale outlined in section 13 of the board's discussion paper. The timescales do not appear to indicate further work may be required to develop more robust models/proposals that a wider group of people can then be engaged. This engagement should include option development and appraisal in order to identify any preferred options. This review process, or elements of this may be considered 'major' change. In such cases, the guidance indicates that the board should not move to consultation until they have confirmation from the Scottish Health Council on the public involvement process to date.