

NHS Greater Glasgow & Clyde	Paper No. 19/47
Meeting:	Board
Date of Meeting:	22nd October 2019
Purpose of Paper:	For Noting
Classification:	Official Sensitive
Sponsoring Director:	Dr Jennifer Armstrong, Medical Director

Moving Forward Together: From Blueprint to Action (October 2019)

Recommendation

The Board is asked to note the progress in implementing the MFT vision. The Board is also asked to approve the priorities detailed in the conclusion to this paper and the development of the next steps.

Purpose of Paper

- To note the clinical and service priorities to improve healthcare across the NHS and care system as we implement the MFT vision.
- To note the financial implications of these priorities.
- To note the future planning work required.

Key Issues to be considered

- Scale and complexity of change
- Financial consequences of change

Any Patient Safety /Patient Experience Issues

No issues in the immediate term; however, the outcome of the completed programme will contribute to GGC's delivery of the Scottish Government aim of Better Care.

Any Financial Implications from this Paper

The paper notes a number of approximate revenue and capital costs associated with the MFT and other planning priorities. These will require further testing and prioritisation.

Any Staffing Implications from this Paper

Many of the benefits from the Implementation of this programme require new roles and new ways of working. The MFT Workforce group are developing a workforce plan and oversight of workforce issues to support the programme.

Any Equality Implications from this Paper

No current issues.

Equality Impact Assessments (EQIAs) will be carried out on planned service changes.

Any Health Inequalities Implications from this Paper

No issues in the immediate term, however the outcome of the completed programme will contribute to GGC's delivery of improved health equality.

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

MFT has a risk register for the programme and individual workstreams are producing risk registers.

Highlight the Corporate Plan priorities to which your paper relates

Develop a new five-year Transformational Plan for the NHS Board working in partnership with other key stakeholders and taking cognisance of the key local and national strategies, including the Health and Social Care Delivery Plan

Author

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Date 15 October 2019

Moving Forward Together

From Blueprint to Action

1. Introduction

This paper brings together the vision described in Moving Forward Together: NHS Greater Glasgow and Clyde's vision for Health and Social Care with a review of the estate, capacity and service demands facing us. It translates the vision into the steps we require to take and the necessary workplan to achieve this vision.

The Moving Forward Together Blueprint was approved by the NHS Board in June 2018 and subsequently supported by the six Integration Joint Boards in the NHSGGC area. Six cross system workstreams have been established to develop cases for change in priority areas. In addition we are implementing a number of developments in GGC as part of Regional and National plans. These include the West of Scotland Trauma network; a new model for delivering chemotherapy, new models of care for ophthalmology and urology and the development of primary care improvement plans to support the new GP contract.

The cumulative effect of these changes will have implications on our estate and our workforce, and this paper describes what we need to do to prepare for this range of changes. The service changes are an important driver for change, but the condition of our existing estate, the need to vacate sites and the requirement to match capacity with demand whilst meeting national targets create a complicated set of dependencies and time-scales which need to be articulated and built into future plans. All of this planning needs to be done in partnership with other West of Scotland Health Boards and with Regional and National Planning. We need to be prepared to blur traditional geographical boundaries both within GGC and across the West of Scotland for the benefit of delivering excellent health and social care to our population.

2. What will health and Care Services look like in 2030?

Our vision is to have a tiered model of care, delivering the majority of care as near to local communities as possible but recognising that more specialist care is better delivered in a smaller number of sites. For example, trauma services, which are currently dispersed across the area will have major trauma brought to a single Major Trauma Centre at the QEUH, supported by Trauma Units in three sites and rehabilitation being provided in local communities. Chemotherapy services which are currently mostly delivered at The Beatson West of Scotland Cancer Centre on one site will in the future be provided more locally. Developing this tiered service model across specialties will have a significant cumulative effect on our hospital and community sites.

The key principles of MFT are threaded throughout our change programme, they include:

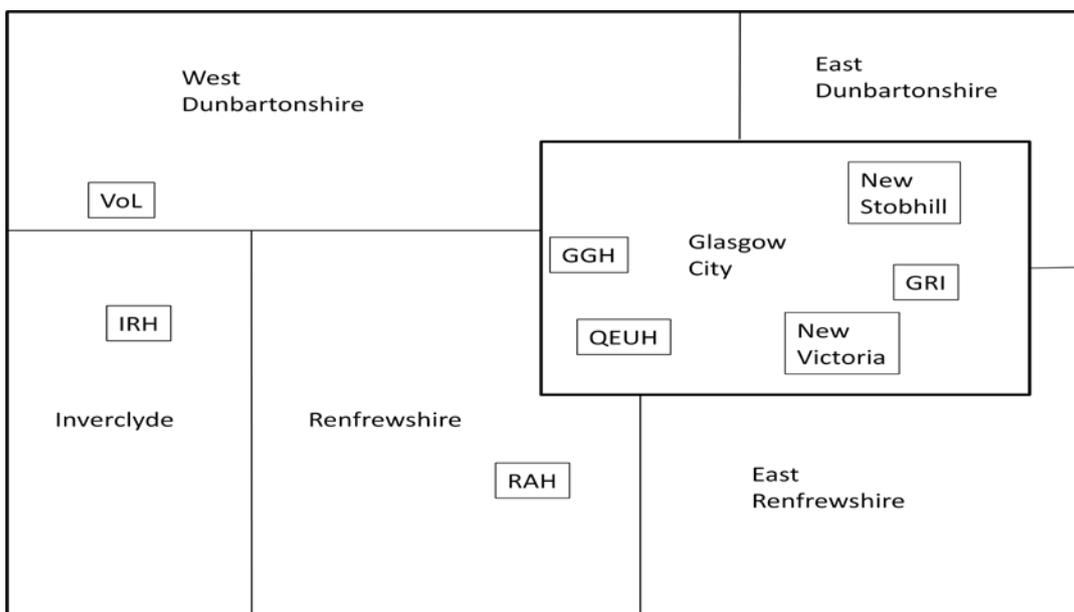
- Maximising the benefits of technology.
- Delivering care at home or in local communities.
- Supporting people to manage their own conditions.
- Involving people and carers in decisions about their care.
- Listening to staff who work in services.
- Reducing our dependency on inpatient beds.

As the MFT workstreams develop cases for change using these principles, health and care services will begin to take a different shape. We need to plan now for an infrastructure which supports this model.

Communication and engagement remains key to the MFT programme. Over the next 6 months the Project Management Office will lead engagement work in the following areas:

- Our staff: Engagement events will be organised at all sites (acute, mental health and HSCPs)
- MSPs/councillors: All IJBs will be offered support to hold MFT engagement events for elected members. A meeting for MSPs will be organised centrally.
- Public: Our Stakeholder Reference Group continues to meet, testing progress and advising us on wider engagement. Work continues with local HSCPs, using existing engagement structures and there is continued dialogue with the Scottish Health Council.

3. What do our services look like now in 2019?



There are currently nine acute hospital sites providing a range of specialist, general and ambulatory care services across our the 6 GGC local authority areas. Most provide both planned and unscheduled care and different levels of inpatient facilities, day cases and outpatient services. The current service configuration is a mixture of historic legacy and existing buildings along with other planned developments.

Mental health and learning disability inpatient services are provided at nine sites across the GGC area.

In addition, there are a number of health facilities, health and social work centres and community clinics providing health and care services across GGC. This is supported by a network of GP practices and clusters which form part of the network of community resources. There is an opportunity now to re-shape this configuration learning from experience and looking ahead to the vision articulated in Moving Forward Together.

4. Current challenges and demands

In moving from our current position to the desired configuration of services, we need to address a number of challenges which will determine how we can define sustainable, high quality health and social care.

These include:

- Delivering our elective programme.
- Managing increasing demand for unscheduled care.
- Some of our infrastructure is older and requires significant modernisation/upgrade, investment or replacement. This includes the Institute of Neurological Sciences (INS) on the QEUH campus.
- Building backlog maintenance and capacity issues at IRH, RAH and GRI.
- Review of The Beatson West of Scotland Cancer Centre on the Gartnavel Site.
- The need to vacate the West Glasgow ACH site.
- Making appropriate use of the Vale of Leven, Gartnavel General, Lightburn and Inverclyde to support the tiered model.
- The need for a robust community infrastructure and premises plan.

There are ongoing pressures to meet waiting time targets in our elective programme. Early work to assess the number of beds required to address these challenges shows that there is a shortfall across the main surgical specialities. Work is ongoing to quantify this. These pressures have prompted work to rationalise surgical services, maximise the use of Ambulatory Care Hospitals and optimise referral and triage processes.

Our current position is further challenged by the rising demand for unscheduled care with year on year increasing in Emergency Department attendances and hospital admissions.

There is continuing pressure on both general medical and medicine for the elderly beds across all of the major acute inpatient sites, with occupancy consistently above 90% and it is the norm for medical beds to be full at various points every day. An exercise using Staffnet Bed Occupancy reports was carried out to calculate additional beds required across the NHSGGC system to achieve 85% occupancy. Based on 2018/19 figures and assuming no changes to activity, an additional net 57 beds would be required to achieve 85% occupancy. To achieve this throughput, there would have to be significant redesignation of existing beds across the sites. This highlights the challenge to our system as we strive to shift the balance of care.

The level of delayed discharges in the system adds to pressure on beds. In the last 12 months, 140-150 beds at any one time are occupied by patients deemed fit for discharge. It is therefore essential to focus on preventing unnecessary hospital admission and facilitating timely discharge.

The increasing demand for services is mirrored in Health and Social Care Partnerships where addressing increasing demand for care at home services and care home places is made even more challenging by difficulties in recruiting and retaining appropriate care staff and by sourcing specialist care home places to meet the needs of local populations. In mental health, most inpatient sites run at high capacity, with occupancy figures averaging at 96% last year.

Transformation across the whole system requires a positive culture of enabling and supporting change at all levels. The MFT programme has embedded staff engagement from the early planning stages. This will continue as we move into implementation, and we have developed a 'Leading Change' toolkit to support staff who are facilitating change.

5. Future Challenges and demands

There are also a number of service developments on the horizon which will impact on service configuration and how we use our resources. These include:-

- Development of the Major Trauma Centre in QEUH and the requirement to create capacity to provide an additional 42 beds. (24 major trauma ward, 6 critical care, 12 hyper acute).
- Re-design of trauma services in Clyde and the requirement for capacity at the RAH to be established as a Trauma Unit. This requires an additional 12 beds.
- The need for improved hyperacute stroke pathways/and in the medium term capacity, to deliver a WoS thrombectomy service on the QEUH.
- Space for the Forth Valley vascular work currently located at an interim facility in QEUH.
- Implications of The West of Scotland urology and ophthalmology work which recommends the establishment of a tiered model of care.
- Implementing the Gynaecology service review rationalising the number of inpatient sites.
- Review of complex cancer surgery across the Board area and the region.
- Development of SACT/Chemotherapy services at the RAH and expansion in other areas.
- Implement the Best Start model of maternity care.

6. Opportunities to work differently

Focusing major and moderate trauma on three sites provides an opportunity to develop elective work on other sites where operating capacity will not be impacted by fluctuating demands for emergency care. Our aim is to develop centres of excellence, addressing waiting list challenges and delivering high quality and high value activity.

There are opportunities to work differently by maximising use of technology. eHealth is key to this, and through MFT, we are exploring how to use many systems and technologies which are already available. This includes Active Clinical Referral Triage (ACRT), virtual consultations, remote monitoring and sharing information.

There may be opportunities to work with other Health Boards, many of whom are undergoing their own transformational programmes and developing their estate and considering capital investment opportunities.

The planning landscape is complex, and needs cross system solutions. The priorities and demands impact on each other and we need to align the transformational with the operational. Importantly, we need to plan to achieve financial balance.

The original MFT Blueprint identified a number of areas where services currently provided in secondary care, could be provided in Primary Care or in local communities. The Board's MFT Workstreams are led by HSCP Chief Officers, Acute Directors and all have senior clinical leadership embedded. This Cross System working has facilitated the opportunity to consider and develop different solutions to long standing challenges by creating an opportunity for collaborative leadership and building relationships.

In the early planning stages of MFT, a core team was established to take the programme forward. As we move into implementation, we need to embed the change process in a much wider staff group. During the next month we will recruit a second Programme Manager to work with the dedicated admin, engagement and workforce teams. Resource will also be allocated to ensuring we have strong clinical leadership.

The wider planning team (corporate, HSCP and mental health) will take a more active role in leading the programme, and our Managed Clinical Networks will bring experienced clinical input. Capital planning experts are also being aligned to MFT work. This approach of wider ownership of the change programme is important to working across the health and care system.

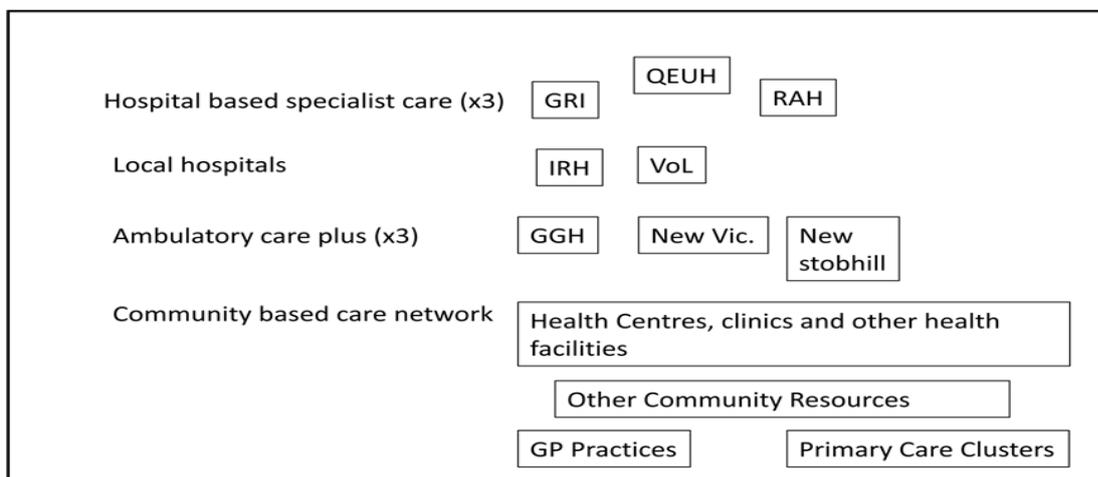
7. Moving Forward Together

The six MFT Workstreams have identified the following priority areas and are developing cases for change. These priorities have to be cognisant of our current demands and pressures to ensure that an immediate response to these demands fits with the vision we are aiming to achieve.

- | | |
|---------------------|---|
| 1. Planned Care | <ul style="list-style-type: none"> a) Outpatient transformation. b) Maximisation of Community Health Centres. c) Diagnostic one stop shop model. |
| 2. Unscheduled Care | <ul style="list-style-type: none"> a) ED redirection and alternatives to ED attendance. b) Support to and interface with care homes. c) Out of hours provision. d) Management of frequent ED attendees. |
| 3. Local Care | <ul style="list-style-type: none"> a) Long Term condition management. b) Palliative and end of life care. c) Health literacy and technology. d) Anticipatory Care Planning. |
| 4. Mental Health | <ul style="list-style-type: none"> a) Unscheduled Mental Health Care. b) Mental Health in Primary Care. |
| 5. Older People | <ul style="list-style-type: none"> a) Community intensive supports. b) Early identification and management of frailty. c) Dementia Framework. |
| 6. GGC Regional | <ul style="list-style-type: none"> a) Comprehensive West of Scotland Cancer Strategy. b) Neuroscience Services. c) Best Start. |

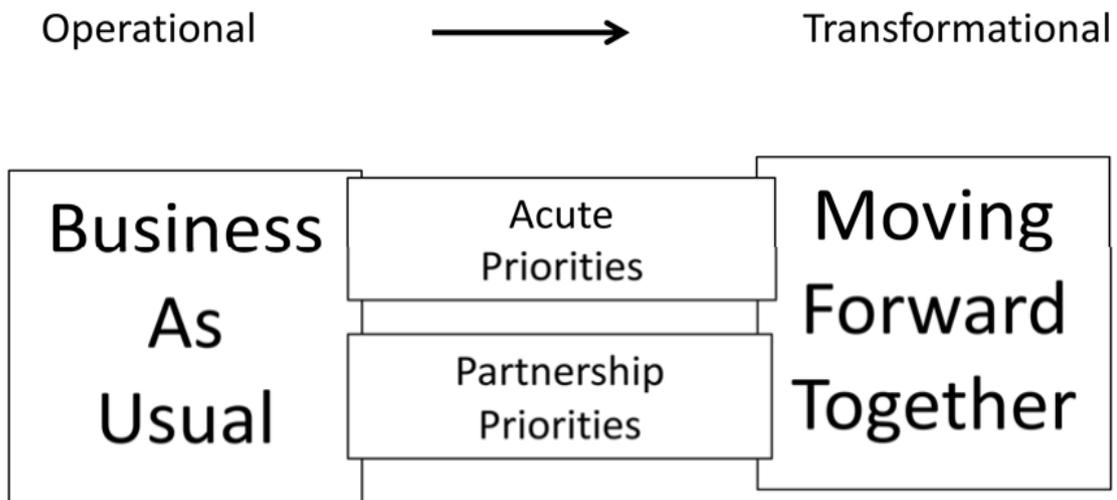
During 2018/19, an internal audit of strategic planning alignment was carried out. It concluded that through MFT, strong foundations have been put in place that were appropriate for the scale of change. The auditors identified some key areas for the MFT team to consider around communication, involvement and monitoring/repairing. The Project Management Office will review these areas and report progress to the Programme Board.

8. What will the tiered service look like in 2030?



9. Aligning the Transformational with the Operational

As we drive forward transformational change, whilst managing a large organisation with complex interdependencies we need to recognise that the planning landscape is complex.



Integration Joint Boards have produced three year strategic plans which describe the transformational work which is being led locally to support the MFT programme. These plans focus on preventing ill health and supporting people and communities to manage and improve their health. Local HSCPs have developed multi-disciplinary teams to improve access to advice, help and support. These teams work with local hospital teams to help people avoid unnecessary admission to and support effective discharge from hospital.

HSCPs support local service users to live in their own homes and communities wherever possible, promoting independence and social connections and activities – this approach is underpinned by the work of the community rehabilitation and re-ablement services, care at home services and the work of District Nurses.

HSCPs work to ensure services are available wherever a need arises, prioritising and supporting people who need or require to move back into the community from hospital – minimising delays in discharge and optimising support to get home first and to remain supported where required so readmission is avoided and independent living promoted.

Primary Care

The new Scottish General Medical Services contract was agreed in January 2018. It aims to improve access for patients, address health inequalities and improve population health including mental health, provide financial stability for GPs and reduce GP workload through the expansion of the multi-disciplinary team. This has established a substantial programme of change across the 6 HSCPs, 236 GP practices and 39 practice clusters in NHSGGC. IJBs have approved Primary Care Improvement Plans (PCIPs) which describe how contracted commitments will be delivered. Commitments include:

- Transfer of responsibility for vaccination and immunisation delivery to the HSCPs.
- Provision of a comprehensive range of pharmacotherapy services.
- Treatment rooms available to every practice.
- Development of urgent care roles.
- Recruitment of Link Workers.
- Other professional roles such as Musculoskeletal (MSK) physiotherapy services and mental health.

Funding of £10.2m was allocated to NHSGGC in 2018/19. This is expected to rise in line with national funding which has the following indicative figures:

National Funding	2018/19	£47.5m
	2019/20	£50.0m
	2020/21	£105m
	2021/22	£155m

PCIPs and MFT are progressing in parallel and are mutually reinforcing. MFT envisages the development of an enhanced community network of services and staff and PCIPs are an opportunity to build an infrastructure and base for this. In particular, the drive to extend community treatment and care services complements the work of the Planned Care MFT workstream around maximising the use of community health centres / hubs.

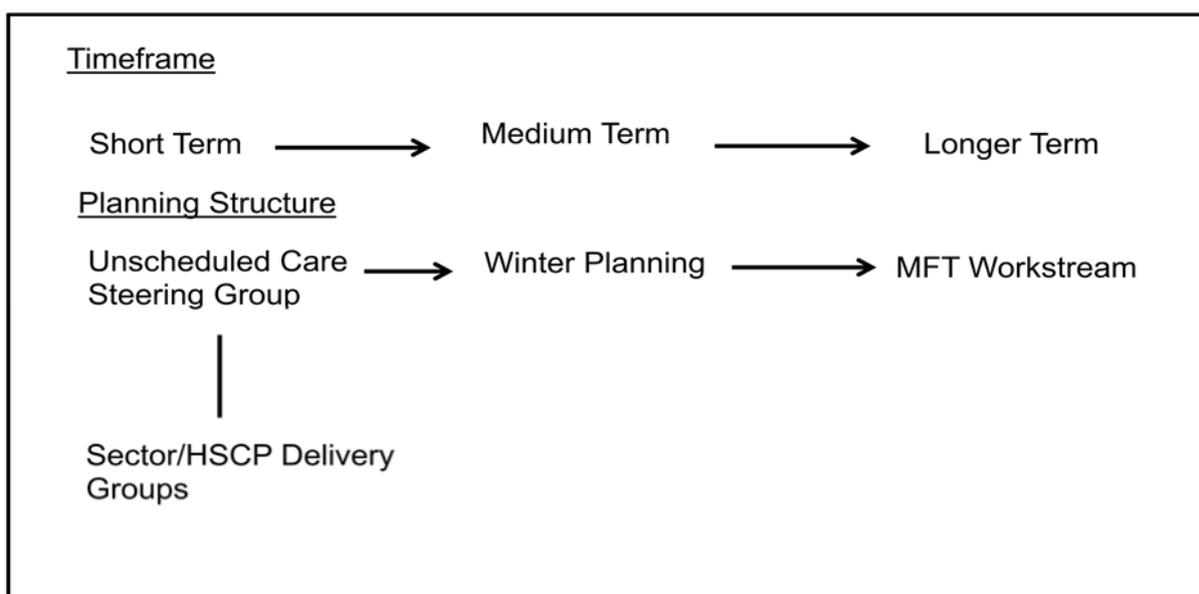
10. Unscheduled Care (MFT Workstream)

Unscheduled Care is complex, and issues are multi-factorial. As people live longer the demands on urgent care increase. Long term conditions, managing complex co morbidities alongside the underlying increased demand generated through deprivation across GG&C creates a significant challenge to resources. Alongside this we have a population culture where the A and E department is often the default first choice and therefore demand continues to outstrip capacity in our hospitals.

Annual ED attendances with NHSGGC over the last 10 years (the 2008/09 baseline planning year for the QEUH) have increased by 14.1% or 64,073. Demand at the QEUH and the GRI has already exceeded planning assumptions.

NHSGGC delivered 90.3% compliance for 4 hour Emergency Department waits for 2018/19 and has been on a downward trajectory with 2011/12 being the last year the Board achieved 95.4% compliance overall.

Planning structures have been established to focus on short, medium and longer term timeframes.



The HSCPs are developing a Strategic Commissioning Plan across GGC that reflects a consistent approach in the following three areas:

- Early intervention and prevention to better support people to receive the care and treatment they need at home or as close to home avoiding hospital admission where possible.
- Improve the interface between primary and secondary care services to better manage patient care in the most appropriate setting in line with IJBs' and the NHS Board's strategic direction as set out in Moving Forward Together.
- To improve hospital discharge and better support people to transfer from acute care to appropriate support in the community.

We will work collaboratively across the healthcare system to develop service improvements to target both the short term issues and longer term redesign. The following detail provides an overview of the specific priorities being progressed, many of which are incremental building blocks providing operational improvement whilst working towards the MFT tiered model of care.

The combined impact of the activity noted below will positively impact on the increasing demand for unscheduled care. The MFT workstream is currently assessing the individual and collective impact of each action.

Alternative Pathways to Admission

We continue to support the development and implementation of improved pathways and new models of care for high volume conditions. Focusing on condition specific pathway alternatives for long term conditions such as COPD and heart failure alongside targeting high volume conditions presenting to ambulatory emergency care that result in short stay admissions (e.g. cellulitis and abdominal pain) is a key priority for both short and longer term work. This enables us to identify current pathways through acute hospital services and to consider where suitable local service alternatives or planned urgent care could be more appropriately delivered.

Collectively the top 6 target ambulatory care areas account for 19% (25,463) of the total admissions for 2018/19.

Work also continues on the frailty pathway through the MFT Older People's workstream and we continue to drive improvements within acute services for the pathway towards comprehensive geriatric assessment.

This includes enhancements to the TrakCare system to ensure that Frailty Screening is recorded electronically so patients can be easily signposted to the appropriate resources. Further work is in progress to develop alternatives to admission and is described below:

1. Consultant Connect - we are extending initiatives employing 'Consultant Connect'. Last year, this was introduced in the South Sector to provide GPs with a more responsive contact number to obtain consultant advice across a number of specialities. This year, we intend to broaden the range of specialties involved and consider a test of change for one of the Sectors by delivering professional-to-professional advice for paramedics. Paramedics attending patients who have suffered a fall or have a chronic long term condition such as COPD may be able to refer those who are clinically appropriate to community based teams. This would therefore avoid emergency attendance and possible short admission to hospital.
2. Anticipatory Care Planning - actions are in progress to provide enhanced information or access to community services, where the aim is to prevent escalation and therefore maintain and manage the care of individuals at home or in a community setting.

OFFICIAL SENSITIVE

A clinical handover template has been developed to standardise the current information and to ensure that the key components of the patient's current medical status are consistently recorded.

This is being integrated within the IT systems to ensure that there is visibility and transference of this information as patients move from primary care into acute with the objective of avoiding unnecessary interventions when a patient moves across the services. Development of pathways offering alternatives to admission, ambulatory care and hospital processes that rapidly identify patients with existing care plans are all part of the developing strategy for managing these patient in a more clinically appropriate setting. This work is being led by the MFT Local Care workstream.

3. Care Homes – significant effort was made in 2018/19 to introduce the 'Red Bag' system that ensures all relevant clinical information and personal belongings are conveyed with a patient who needs urgent assessment or admission. Current focus has extended to understand the needs of Care Homes residents and the resources that they currently have available to respond to their needs. The aim in the short term is to develop a workplan in collaboration with Care Home providers to ensure that the most appropriate pathways and access to a range of community and primary care services are available. In the longer term through MFT the ability to ensure wherever possible Care Homes have access to clinical teams within the home or in the community will be pursued. This could result in alternatives such Treatment Rooms/Clinics for long term condition management, frailty and geriatric assessment in the home or community setting avoiding the need to attend a hospital or GP Practice.
4. Falls – work continues on the National pathway in collaboration with the Ambulance Service and the Falls Team to reduce conveyance rates and refer to the community falls teams across the Board.

Alternative Pathways to Emergency Department or Assessment Unit (AU) Attendance

There are a number of initiatives underway to respond to the increase in both ED and AU attendances. Whilst these may stem from immediate demand and capacity challenges, they form the basis for progressive service redesign through the MFT programme.

Having previously identified a number of target areas we continue to focus on pathway/service redesign alternatives. This includes reviewing the available existing services and ensuring appropriate public messaging, with the development of a more planned approach to urgent care, enabling access to clinical teams in primary care and the community to provide services closer to home. The priority areas are described below:

5. GP Referrals to Assessment Units - A significant cohort of patients who are referred by their GP to the Acute Assessment Units are discharged on the same day of attendance. Aligned to the ambulatory emergency care pathway work, the acute hospitals have significantly reduced the need for admission with GRI, QEUH and RAH discharging 45% (28,637) of the total attendances to AU for 2018/19 without the need for an overnight stay. This year Clinical Directors from HSCPs have been retrospectively analysing the reason for attendance with the aim of developing options that would remove the need to attend in an unplanned way. Early insight suggests that there are some common themes such as urgent access to diagnostics, IV antibiotics and falls/frailty related concerns. A test of change will be developed to offer a range of alternatives over the peak winter period to reduce attendance rates in particular for patients with lower complexity and National Early Warning Scores of zero or one.

To support this we are establishing an electronic method of referral using SCI Gateway that will enable standardised recording of reasons for attendance and include the core clinical information available to the GP including current medications.

In the medium term GPs will be given consistent rapid access to diagnostic or 'hot clinic' specialist advice.

6. Minor Injury Activity - All Emergency Departments (ED) across GGC deliver a Minor Injury Unit (MIU) service and in total this accounts for 49% of all 2018/19 ED activity. GGC's dedicated MIU's at Victoria, Stobhill and the Vale of Leven received 15% of the activity with the remaining 34% attending an MIU located within one of the main Emergency Departments. MIU compliance across GGC was 97% for 2018/19 however overall compliance remains challenged with limited availability of physical space in main ED's contributing to department overcrowding. Our understanding of demand also indicates that there may be further potential to utilise existing MIUs at Stobhill and the Victoria Hospitals and this will be considered alongside winter planning. In addition, options to expand the clinical space available at both the GRI and the QEUH to establish a dedicated area for minor injuries outwith the main ED is underway.
7. Effective Management of Frequent Attendance - the aim of the work is to better understand the needs of the individuals who have been attending hospital frequently (more than 5 times) over a 12 month period, and to respond more appropriately to their needs. Often this group includes individuals with complex health and social care needs and joint working through multi-disciplinary teams is key to developing alternatives to ED attendance. We have reviewed UK research literature and will continue to work in collaboration with primary, secondary, community and third sector organisations to develop more suitable alternatives for this patient group.
8. Direction and Redirection – all GGC hospitals participated in the delivery of the redirection policy introduced for winter 2019. This has had limited success thus far however we continue to promote the process and are looking at more robust ways of establishing this as close to the point of patient registration as possible. This will feature in the winter plan initiatives and further work to improve the process will be explored.

Management of Current Inpatient Capacity

Our ability to embed efficient inpatient management processes as embodied in the 'Exemplar Ward' concept across GGC has been a core area of focus for the acute sector. Significant progress has been made in this area with the QEUH identified as a National area of good practice and used to develop the guidance document on Daily Dynamic Discharge process.

Having introduced 'hospital flow hubs' and new senior management roles to provide seven day leadership and direction of demand and capacity, our aim is to optimise local escalation processes to drive further improvement in a number of areas.

9. Estimated Date of Discharge - the introduction of mandatory Estimated Date of Discharge processes in May 2019 will provide a new baseline to promote further process improvement within the hospitals to generate timely capacity and flow.
10. 'Day of Care' Survey – all major acute sites participate twice a year in the national survey to provide a snapshot of bed utilisation and inform the development of both in and out of hospital solutions to minimise in-patient delays. Follow up work includes a focus on AHP resource provision and the introduction of a new ward length of stay review process designed to reduce delay and ensure timely management plans are in place for every inpatient on the ward.
11. Delayed Discharge – use of the current in-patient dashboard is to be developed across all HSCPs to support an in-reach or targeted approach to avoid delays. The plan is to develop a more integrated and proactive process with social work professionals to ensure that patients are known to local teams in advance of referrals.

Public Messaging

Public education is key to managing the immediate increasing demands on our services and to achieving the longer term vision of Moving Forward Together. In the short term we need to support patients to make the right decisions when accessing services with unscheduled care needs. Longer term, education is required to support a change in public expectations about the role of the NHS and the responsibility of individuals for maintaining their own health. Building on evidence from across the country and local experience, the MFT Executive Group has proposed a segmented approach to developing a campaign aimed at specific groups. The proposed target groups (based on ED usage) are Musculoskeletal patients, and parents of children with low acuity conditions.

It is also proposed to target patients who attend ED, who could instead be directed to pharmacy. Finally, a specific campaign directed at supporting GP surgeries with high numbers of ED attendances will be developed. This will be progressed between now and March 2020.

Urgent Care Resource Hubs

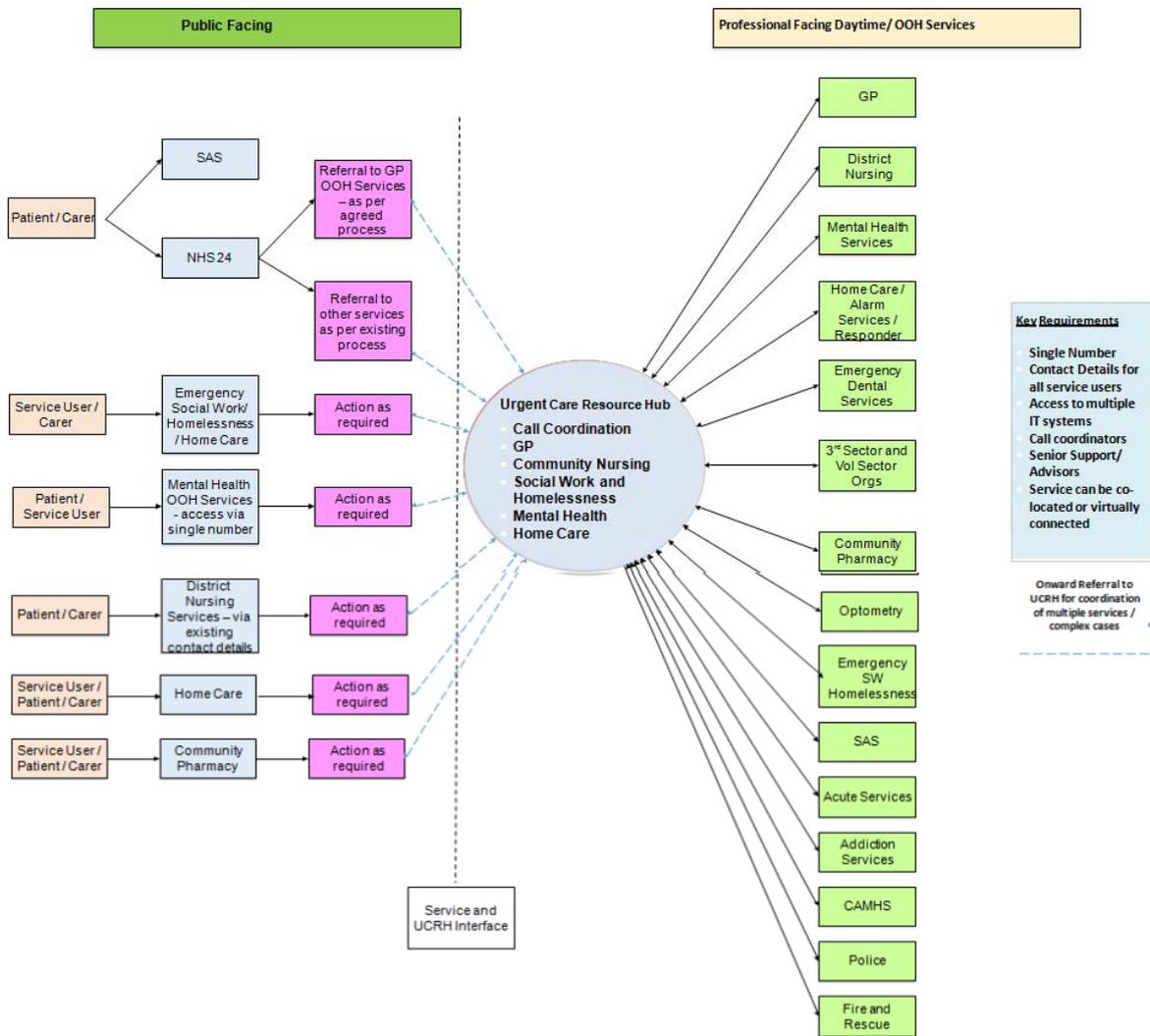
Following publication of Sir Lewis Ritchie's Review of Primary Care Out of Hours Services in January 2015, a local review of Health and Social Care Out of Hours provision was commissioned in GGC. The scope of the review included: GPs, District Nursing, Community Rehabilitation, Children's Social Work Residential Services, Emergency Social Work Services, Emergency Dental services, Homelessness, Home Care, Mental Health, Community Pharmacy, Optometry. The review identified a number of challenges around communication, sustainability and meeting the needs and expectations of increasingly complex patients at home. Following an options appraisal and extensive engagement, it has been agreed that a hub and satellite model, with a phased approach, should be implemented.

An Urgent Care Resource Hub (UCRH) will be established in Glasgow City to co-ordinate local and Board wide service provision during the OOH period with virtual connections to and from local HSCP existing hubs and services.

The professional facing hub will be able to mobilise and co-ordinate the most appropriate out of hours health and social care response during times of crisis or escalation. The hub will be aligned to and connected with NHS24, district nursing and mental health services.

The model is critically dependent on eHealth solutions to support sharing of information to support decision making across the system. Good connections and relationships with HSCP local services are essential. The key components are set out in the diagram below.

Health and Social Care Services and Urgent Care Resource Hub Interface



The GP Out of Hours review was carried out to address the challenges currently facing the service and to develop a sustainable service model. Early phases saw enhancements to the workforce with additional GPs, ANPs, nurses and pharmacists. Professional to professional support (district nurses and GPs) is being rolled out and frequent attenders to OOH services are being targeted to determine alternative pathways. Work is now underway to encourage patients to call NHS 24 in advance of attending, and a final phase of the work will review the impact of early phases with the development of the Urgent Care Resource Hub to determine the shape and location of future services.

11. Planned Care (MFT Workstream)

The Access Collaborative and other access planning structures focus on addressing the immediate concerns around waiting times and improving patient pathways.

Addressing those operational issues has to be aligned to our transformational work through MFT and should direct our prioritisation. For example, implementing Active Clinical Referral Triage (ACRT) is an operational issue, but agreeing the long term outcomes resulting from ACRT and setting trajectories and milestones is part of the transformation programme. The priorities currently being progressed are:

1. Active Clinical Referral Triage (ACRT)

Most commonly consultant referrals currently received from Primary Care are vetted electronically within a few days of receipt and patients are typically added to the waiting list for a face-to-face consultant appointment.

ACRT takes an alternative approach by establishing a variety of appropriate pathways to which a patient can be directed following referral, with the aim that patients are triaged to the optimal, evidence-based, locally agreed pathway. Face-to-face consultant attendance would only occur if there is a clear clinical need. The range of pathways will be many and varied depending on the individual circumstance but will include the provision of advice, opt-in' options to treatment, direct to investigations or treatment, or direct to other members of the multi-disciplinary team.

For patients this approach ensures patients have timely access to information without waiting for a face to face consultant appointment, and ensure people are informed promptly about the available options for investigation and initial management to facilitate shared decision-making.

A number of services across NHSGGC have implemented, or begun to implement, ACRT. However this is not yet systematic and will require time and resource for clinical teams to establish the redesigned pathways necessary for successful implementation.

Early indications from limited areas where this has been implemented show this can reduce patient appointments by up to 30% enabling the consultant sessions released from this redesign to be directed towards areas where waiting times are longest.

2. Effective and Quality Interventions and Pathways (EQUIP)

NHSGGC is one of two Health Boards working with the Scottish Government to test a systematic approach to identify appropriate alternative pathways to procedures that are less effective in the general population. Four conditions have been selected initially; benign skin lesions, varicose veins, haemorrhoids and inguinal hernia.

These are common conditions for which surgery is often not indicated or appropriate, and importantly where clinical consensus for change exists across Scotland.

By November 2019 NHSGGC will have implemented changes across all four of the referral pathways that will see treatment no longer offered routinely in NHSGGC. There will be a greater emphasis on providing patients with high quality advice. In appropriate, defined circumstances patients will still have the opportunity to 'opt-in' to treatment options.

The impact of this programme will be evaluated over the coming months but it is clear already this change is enabling the release of consultant outpatient sessions from minor surgery clinics into other specialty areas where there are significant waiting times pressures. In addition it is expected there will be a small decrease in the numbers of patients being added to inpatient waiting lists in these specialties.

3. Maximising Community Health Centres/Hubs.

Emerging work within the MFT programme is beginning to outline an integrated community network across NHSGGC.

It is proposed that each HSCP and/or locality would bring services together in a virtual network or in some places a single physical hub from which services would provide outreach. There is an opportunity to develop this model in the new North East Hub which is currently being planned.

The North East Hub will bring together a significant number services including for example : all the existing Parkhead Health Centre services and, in addition to this, Specialist Children's Services, Rehabilitation and Enablement services, District Nursing, Health visiting and school nursing, Social Work, children and family teams, Sandyford East sexual health services, Primary care mental health services and psychotherapy services, Health and social work addiction services, Criminal justice social work services, Acute hospital services, such as chronic pain clinics, older people services, speech and language therapy, physiotherapy and many more.

The preferred site for the North East Hub is the former Parkhead Hospital. The design of the new hub is in development with stakeholder input and it is anticipated that the Outline Business Case will be submitted to the Board in January 2020. The Full Business Case is anticipated to be completed in March 2021 with a start on site in summer 2021. Capital costs are expected to be circa £47m.

There has been significant investment in community health resources in recent years:

Project	Date Opened	Capex	HSCP
		£'000	
West Centre - Drumchapel Family & Child centre	Aug-10	4,170	Glasgow City
Renfrew Health & Care Centre	Mar-10	18,000	Renfrewshire
Vale Health Centre	Aug-13	21,000	West Dunbartonshire
Barrhead Health & Care Centre	Apr-11	18,000	East Renfrewshire
Possilpark Health & Care Centre	Feb-14	10,000	Glasgow City
Shields Centre - East Pollokshields	Jan-15	2,700	Glasgow City
Eastwood Health & Care Centre	Jun-16	14,850	East Renfrewshire
Maryhill Health & Care Centre	Sep-16	12,395	Glasgow City
Orchard View Mental Health Wards	Aug-17	8,385	Inverclyde
Gorbals Health & Care Centre	Jan-19	17,198	Glasgow City
Woodside Health & Care Centre	Jul-19	20,234	Glasgow City
Stobhill Mental Health Wards	Jun-20	10,600	Glasgow City
Greenock Health & Care Centre	Sept 20	20,815	Inverclyde
Clydebank Health & Care Centre	July 21	19,625	West Dunbartonshire
		197,972	

Community hubs could include a range of services provided at home, in Primary Care, in the wider community and, where necessary, in or by specialist or hospital teams and facilities. This would provide opportunity to include services previously provided in hospitals. An example of this would be routine bloods and monitoring, which is currently provided by individual acute specialties within hospitals but could potentially be delivered by a generic service in a community setting. This would complement the current work to redesign patient pathways and ensure the most efficient service for patients; for example following the local test/monitoring a follow up 'hospital' appointment is provided via telephone rather than a face to face appointment. This work is still at a very early stage of discussion and will require detailed discussion to scope and quantify the optimum service delivery model and any resource for staffing and facilities.

Within the planned care workstream, further work has to be done to match demand and capacity. This work will be directed by our drive to meet national waiting times targets. Options to be explored include:

- Focussing elective care in local hospitals, as well as the Trauma Centre and Units.
- Reviewing cancer surgery to support wider cancer services.
- Maximising the use of Ambulatory Care Hospitals, extending opening times and days.
- Implementing regional plans for ophthalmology and urology, which deliver on the tiered model of care.
- Maximising the opportunities for using day surgery rather than overnight stay in hospital.
- Identifying opportunities for 'one stop shop' approaches to create a more efficient patient pathway.

12. Older People (MFT Workstream)

The Older People's MFT workstream works closely with the MFT workstreams for unscheduled care and local care. It has identified priorities around frailty, dementia and intensive community support.

The frailty priority aims to identify people with frailty early in the community and use a risk stratification approach to prevent avoidable admissions to hospital and maximise independence for people. All 6 HSCPs are working with the iHub and have established a living and dying well with frailty collaborative. HSCPs are working with local GP practices (23 already signed up) to identify mildly frail patients and to signpost them to evidence based exercise programmes and other community activities. The collaborative outcomes are expected to be:-

- 1) People spend more time living in the community with fewer moments of crisis (measure: reduce hospital bed days for people aged 65+ by 10%, per 1000 population).
- 2) People experience fewer incidents of unplanned service use and GP practices reduce their unplanned workload (measure: reduce unscheduled GP visits for people aged 65+ by 10% per 1000 population).
- 3) People living with frailty are involved in decisions about their own care. (measure: Increase in percentage of Anticipatory Care Plans in the Key Information Summary for people living with frailty by 20% per 1000 population)

The dementia work aims to bring together a wide range of existing dementia good practice from across the health and care system. Inverclyde HSCP has been successful in a bid for iHub support over 2 years to redesign the dementia pathway in the community. This will complement the work of the acute dementia steering group.

In addition, this workstream will work with mental health colleagues to focus on Older People's mental health teams and inpatient provision. With investment in community services and redesign of dementia pathways, there is potential to significantly reduce reliance on beds in GGC.

Intensive community support for older people is still at the scoping stage. The group is reviewing the Hospital at Home model, and comparing this to different models across GGC. They are also exploring models of delivering rehabilitation at home rather than in hospital.

13. Local Care (MFT Workstream)

The Local Care workstream is taking forward three priorities:

- Long term condition management.
- End of life care.
- Anticipatory care planning.

For long term conditions, the group is testing the principles of self-care, supported self-care and remote self-management with diabetes. It will include a comprehensive cross system education and self management programme, using self monitoring technology. The model will be tested with diabetes, then rolled out to other long term conditions.

The end of life care work is now being scoped out, with a stakeholder workshop being set up in the next few months.

The final priority is to expand the use of anticipatory care planning access to health and care systems in primary and secondary care. eHealth is supporting this work to ensure the ACP can be electronically updated and shared.

14. Mental Health (MFT Workstream)

The two priorities identified by The Mental Health Moving Forward Together workstream are Unscheduled Care and Mental Health in Primary Care. These priorities form an integral part of the Adult Mental Health Strategy which centres around prevention/early intervention, providing effective services and recovery. This workstream has made significant progress and is underpinned by "Action 15" national funding.

By working across the health and care system and by blurring organisational boundaries this funding has been effectively used to support mental health and wellbeing and to address challenges in other areas of the system e.g. Emergency Departments.

Key activity has included:

- i) **Unscheduled Care** – The liaison psychiatry service is being strengthened to improve response times with the appointment of additional nursing and psychiatry posts. A consultant led crisis and home treatment model is being tested in one locality. A Safe Haven Cafe is being developed in Glasgow City. These initiatives aim to have a positive impact on ED patient attendance rates for mental health issues.
- ii) **Mental Health and Primary Care** – This work is being progressed in partnership with GPs, HSCPs and mental health services. Mental health training and support for partnership staff continues and family nurture strategies are being progressed in individual HSCP areas including exploring implementation of routine enquiry of Adverse Childhood Experience. A perinatal peer worker pilot has been tested in Glasgow city and is now being extended to all HSCPs.

- iii) Experienced Peer Workers – These workers will be located in Community Mental Health Teams to support recovery oriented model of care.
- iv) Efficient and effective Community Mental Health Teams (CMHTs) – Service managers for all 19 CMHTs across GGC have come together to identify high impact tests of change. Referral guidance for GPs has been developed. A rapid access pathway for individuals discharged from services is being tested in Autumn 2019 and the development of nursing and occupational therapy evidence based groups is being explored.
- v) Borderline Personality Disorder – A clinical lead for this function has been established to progress the service.

In 2019/20, Action 15 funding of £2.23m has been made available to support these changes to mental health services. This funds Board-wide initiatives and local HSCP developments across the areas of prevention, productivity and recovery. As these initiatives progress, it is hoped that there will be a lower reliance on hospital beds. Currently occupancy in GGC adult mental health beds is around 96%, but by reducing lengths of stay and variation, by improving throughput and processes and by avoiding delays and optimising standard practice, this should reduce. There may be scope for reviewing the older people's mental health bed model.

15. Regional (MFT Workstream)

The three priorities for the GGC Regional workstream are:

1. Development of a comprehensive West of Scotland Cancer Strategy.
2. Neuroscience services.
3. Specialist neonatal and maternity services.

In addition, the implementation of the Trauma Network in GGC is linked to MFT. Because of the existing governance structure, Trauma reports directly to the MFT Programme Board rather than through the regional workstream. The regional priorities are at varying stages of planning and implementation.

Development of Comprehensive Cancer Strategy

The future planning for Beatson services is covered in Section 18.

A short life working group has been established to take forward the planning for surgical oncology, and this is at the early scoping stage. The group is exploring the option of a single Tier A complex cancer surgery service, supported by increased ACH day case procedures at the New Stobhill and New Victoria Hospitals.

The draft Systemic Anti-Cancer Therapy (SACT) strategy is detailed in this document.



Systemic Anti-Cancer Therapy (SACT).docx

At a high level it sees the establishment of a single Tier 1 Cancer Centre at BWOSCC, three Tier 2 cancer units at the RAH, the New Victoria and BWOSCC and outreach units at the local hospitals.

The model has capital costs at the RAH of between £1m and £3m, depending on the location used, and revenue costs of £1.9m across all the sites to recruit treatment delivery staff, non-medical prescribers and pharmacy staff.

Neuroscience Services

In terms of neurosciences, the QEUH is the preferred site for delivering stroke thrombectomy services for the West of Scotland, and a small group is working to progress a high level implementation plan. Early scoping work in neurology services has also commenced. The national pathway, and care group are about to publish pathways of care in relation to neurosciences.

Best Start Maternity

Early Implementer work is progressing in Clyde. Further planning work is underway to determine the optimum network of midwifery hubs in the community to provide comprehensive local outpatient care that is often currently based within GP premises. Engagement of service users and stakeholders will play a key role in this. The Community Maternity Units at IRH and VoL will continue to provide maternity services to local mothers and their babies.

From the 19th August NHS Ayrshire and Arran (NHS A&A) and NHSGGC are implementing the Neonatal pathway recommendations in 'Best Start: The 5 Year Forward Plan for Maternity and Neonatal Care in Scotland'. One of the Best Start recommendations is to concentrate expertise in the care of the most premature and unwell infants in fewer specialist centres. Women at high risk of extreme premature delivery will be transferred antenatally to QEUH for initial management, delivery, postnatal care and neonatal intensive care for their new born baby. Where a safe antenatal transfer is not possible, extremely premature infants will be transferred to QEUH as soon as safely possible after initial stabilisation at Ayrshire Maternity Unit. Currently women and babies less than 26 weeks gestation are transferred from Ayrshire to the Royal Hospital for Children's Neonatal Unit and Maternity Unit on the Queen Elizabeth University Hospital site, these figures are expected to be very low (in the initial 4 week period there were no transfers). From the 7th October mothers and babies less than 27 weeks gestation are also being transferred. The neonatal work will be supported by the introduction of Transitional Care at the QEUH to enable babies who require some medical or midwifery support (but not intensive care) to be looked after beside their mother. This will improve quality of care whilst releasing capacity in Neonatal care.

16. Trauma

Background and Governance

In August 2019 a paper was presented to NHS Greater Glasgow & Clyde Board which outlined the plans for both the National and West of Scotland Major Trauma Network and described how services would be reconfigured within Greater Glasgow & Clyde to deliver the model. The model outlined described:

- Major Trauma Centre at Queen Elizabeth University Hospital for adult and paediatrics.
- 6 Trauma Units, 3 of these based within Greater Glasgow & Clyde at Glasgow Royal Infirmary, Royal Alexandra Hospital and QEUH.
- Local Emergency Hospitals, one of which would be at Inverclyde Royal Infirmary which would also become an elective centre of excellence.
- Specialist Rehabilitation Service, including a 12 bed Hyper Acute facility, to support both the major trauma centre and the West of Scotland network.

The paper also outlined the significant financial investment by Scottish Government in the West of Scotland to support creating the network i.e. £17m of which £10m is dedicated to the development of the major trauma centre and £7m to support Trauma Units and the specialist rehabilitation service. The finance section below will describe in more detail the financial release for NHS GGC over the next 5 years.

During 2019/20 there will continue to be a key focus on both the development of the MTC in QEUH, but also on the significant re-design required to deliver the single Trauma Unit within Clyde. This will include the development of a capital plan to support the re-design and upgrade work required.

Major Trauma Centre

For the Major Trauma Centre, the key focus in 19/20 will be:

- Developing the operational policy for the major trauma centre at Queen Elizabeth University Hospital which includes creating a 24 bed major trauma ward.
- Agreeing service reconfiguration within/outwith Queen Elizabeth University Hospital to create the theatre and bed capacity required for major trauma. This is linked to the capital planning work ongoing to upgrade wards in Gartnavel General Hospital which will deliver the required bed capacity in QEUH.
- Pathways/Protocols – work is progressing with key stakeholders to develop robust pathways both into and out of the major trauma centre.
- Workforce – a number of key clinical nursing, AHP and diagnostic roles will be appointed.
- Clinical Governance – a local Morbidity and Mortality Group has now been established within Queen Elizabeth University Hospital and Royal Hospital for Children.
- Performance – activity reporting templates have been developed to support the above, monitoring of activity and providing detailed analysis to support pathway redesign.
- Rehabilitation – options appraisal on location of Hyper Acute Unit will be completed.

Trauma Units

Glasgow Royal Infirmary and Clyde have both established local groups to develop their own operational policies and to manage the redesign of services. The GRI is currently a Trauma Unit for the North Glasgow population the changes will have only a minimal impact on the site. The GRI Trauma Group are therefore focusing on the operational aspects of the new model. The most significant areas of redesign associated with the trauma units will be in delivering a single trauma site for the Clyde population.

Clyde Trauma Model

In June 2019 the Board agreed the new model for Clyde which will see the RAH becoming the Trauma Unit for the sector. The Clyde orthopaedic trauma workload is significant accounting for 32% of all trauma admissions within the Board. The redesign of services will see the concentration of this activity in the RAH, which presents a number of capacity and implementation challenges.

Based on admissions in previous years, it is anticipated that the total trauma inpatient activity on the site will increase by more than a third, with early capacity planning indicating that an additional 12 beds and 7 theatre sessions will be required in the RAH to support the new pathways.

Inverclyde Royal will operate as a Local Emergency Hospital and will continue to receive medical and general surgery patients. Trauma activity accounts for 8% of all emergency admissions within IRH and 92% of all activity will be unaffected by these changes. Emergency inpatient episodes will reduce by 1.8% overall, and it is anticipated that this will be offset by the redirection of some of the Sector's elective orthopaedic workload. The site will therefore continue to be a vibrant and busy DGH with capacity released to further develop the elective orthopaedic programme in the hospital with an aim of establishing the site as an elective centre of excellence. Investment to expand consultant workforce numbers to support emergency flow in IRH has been secured and a recruitment processes is underway.

The key areas of focus throughout 2019/20 to facilitate a smooth transition in Clyde are noted as follows:

- Agree clinical pathways into and out of the Trauma Unit and LEH including Rehabilitation pathways.
- Develop the workforce and recruitment plan to deliver a sustainable workforce across the professions and specialties that supports the new model that meets the National Minimum Requirements for a Trauma Unit.
- Re-design of theatre templates and identify option/displacement of activity to deliver 2 full time trauma theatres.
- Create bed capacity – 12 additional orthopaedic trauma beds required.
- Develop plans to establish an elective Joint Replacement service - centre of excellence in IRH (5 Sessions of capacity will be released (M-F)).
- Review of capacity in Larkfield required to accommodate repatriated patients. This includes the establishment of a Geriatric Orthopaedic Rehabilitation Unit pathway.
- Development of a Capital plan. Project request documentation currently being populated. Initial areas of upgrade identified as follows:
 - Upgrade of existing theatres to deliver 2 Laminar Flow theatres – 1 in RAH, 1 in Inverclyde.
 - Upgrade of RAH Trauma Theatres to improve flow and efficiency.
 - Redesign of Level 4 ward to re-provide Elective Area to accommodate the additional trauma bed capacity.
 - Orthopaedic Assessment capacity in RAH to support flow associated with the additional ED workload.
- Diagnostic colleagues to develop capacity and reporting requirements associated with the new model.
- Delivery of an Engagement and communications strategy for both the local communities and staff working across the service.
 - Staff Engagement plan being developed and agreed with Staff Side.
 - Broad clinical representation from across specialties engaged as part of Clyde's Trauma Group.
 - Patient user engagement plan to be enacted.

Education, Training and Learning

Developing and delivering training plan for staff across all aspects of the major trauma network is an essential area of work underway. A number of staff have attended a range of training courses including: Damage Control Surgery; Nurse Practitioner courses; seminars and events across England and shadowing in hospitals where major trauma centres are currently operational. The learning from this is shared across the wider staff groups.

The first West of Scotland Stakeholder event was held on Friday 6th September 2019 which provided the opportunity for 170 staff from across the network to come along and hear from colleagues in England how they had established their networks; what was planned for West of Scotland both in terms of major trauma centre, trauma units and rehabilitation and through workshops to input to the further development of the network.

The aspiration is for trauma units and major trauma centre to be operational during 2021. For Greater Glasgow & Clyde this will require a significant amount of redesign and recruitment to all posts associated with both the major trauma centre and the trauma units.

- The full revenue funding will be available from April 2020 and a robust recruitment programme will begin from January 2020.
- Services will begin to move out of the Queen Elizabeth University Hospital to free up the theatre and bed capacity required.
- By middle 2020 it is planned the major trauma ward will be operational to allow the ward staff and new model of care to become established prior to all major trauma from across West of Scotland coming in.
- Enabling capital works to be carried out in RAH.
- Staff and public engagement programme.
- Pathways and protocols will be finalised.
- Paperwork will be standardised.
- Training and development of staff ongoing.
- Clinical Governance for major trauma will be embedded
- Information Technology
 - Trauma App will become operational.
 - Trakcare will be updated with the relevant documents including : Rehabilitation Prescription and Major Trauma Workbench
- Agree date for official opening of major trauma centre and finalise arrangements with First Minister.

Rehabilitation – work will continue in developing the operational policy for the specialist rehabilitation service, identifying training and development requirements and specialist workforce. Trauma Units will develop services to ensure that they work to meet the BSRM Level 2 standards which the funding allocated supports.

Financial Timeline

Scottish Government have provided a 5 year funding plan to release funding at which time all aspects of the national Scottish Network will be in place. There is a detailed plan of what will be provided within each of the years.

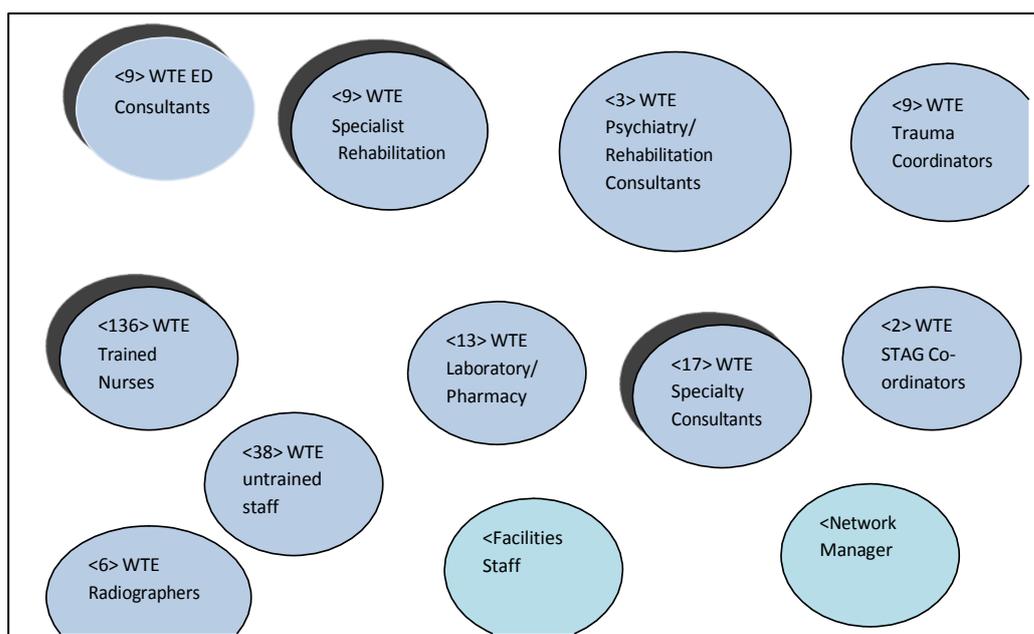
There will be £17m investment in West of Scotland to establish the major trauma network. This will see the creation of in excess of 330 new clinical posts across the system. For Greater Glasgow & Clyde the following table describes the release of funding in each of the years and the table below provides a summary of the new roles that this funding will support. *Note: Scottish Government have indicated that any slippage in each of the year's must be handed back and cannot be managed internally.*

There are aspects of the re-design of trauma receiving in Clyde which will incur capital and revenue costs that are not included as part of the funding allocation the Board will receive and therefore not included in the detail noted below. These costs are not currently known.

Major Trauma Network Funding		£				
	2019/20	2020/21	2021/22	2022/23	2023/24	
Major Trauma Centre - QEUH/RHC						
Major Trauma Co-ordinators	198,240	247,410	247,410	247,410	247,410	
STAG Coordinators	46,306	81,309	81,309	81,309	81,309	
Clinical Lead MTC	12,500	12,500	12,500	12,500	12,500	
Emergency Department	505,216	925,212	925,212	925,212	925,212	
Paediatrics RHC	0	784,008	784,008	784,008	1,124,948	
Critical Care	630,832	1,739,739	1,739,739	1,739,739	1,739,739	
Theatres	526,495	1,144,765	1,144,765	1,144,765	1,144,765	
MTC Consultant Specialists/admin	0	1,269,260	1,269,260	1,269,260	1,269,260	
MT Ward	231419	1,500,264	1,500,264	1,500,264	1,500,264	
Other specialty services (e.g. Plastics)	97914	649827	649827	649827	649827	
Laboratories	0	330260	330260	330260	330260	
Radiology	246484	406,170	406,170	406,170	406,170	
Pharmacy	0	126265	126265	126265	126265	
Facilities	0	286127	286127	286127	286127	
Rehabilitation - acute and specialist	83467	505648	505648	2983520	3346450	
Capital Revenue Cost Equipment	55687	104538	107903	107903	107903	
Maintenance costs	27681	73177	73177	73177	73177	
Major Trauma Centre Total	2,662,241	10,186,479	10,189,844	12,667,716	13,371,586	
Trauma Units						
Glasgow Royal Infirmary	38073	51146	51146	51146	51146	
Clyde RAH	38073	393710	393710	393710	393710	
Rehabilitation Trauma Units		537999	537999	537999	537999	
Total GGC Trauma Units	76146	982855	982855	982855	982855	
Total GGC	2,738,387	11,169,334	11,172,699	13,650,571	14,354,441	

Staffing

The funding above will create in excess of 258 WTE clinical roles within Greater Glasgow & Clyde along with a number of support services roles. The following provides a brief breakdown of the clinical roles.



17. Infrastructure and Estate

Significant infrastructure impacts on acute sites have been achieved in the last decade. These have included the development of the Beatson Oncology Service, new ambulatory care hospitals at Stobhill and Victoria, the transformation of the QEUH campus and the partnership developments with the university. The age profile of the estate has improved, with a reduction of 12% (since 2011) in buildings which are more than 30 years old. The service changes which affect Inverclyde Royal Hospital and the Royal Alexandra Hospital, coupled with significant backlog maintenance liability, have driven the need for a focused piece of work to maximise the opportunities to develop services in the Clyde area. This will be done in partnership with local HSCPs and the communities they serve. The MFT blueprint provides the opportunity to develop a future model of healthcare that is sustainable and high quality.

The GRI is the other hospital with significant infrastructure challenges in the medium term and older buildings on the site. Approximately 50% (448) of the total beds on the GRI site are within the 30 wards in the Castle Street buildings which date back 125 years and are now the oldest hospital buildings in Scotland. 22 of these 30 wards have just one single room available on the ward. This can lead to limitations in the ability to effectively manage infection control and prevention, specialist treatment and the provision of compassionate end of life care. In addition many of the wards are 'nightingale' style which cause single sex challenges when aiming to maximise bed capacity for flow.

The main theatre suite in GRI (20 theatres) is within the QEB/Jubilee Building with theatres dating between 19-35 years. There are indications that we will need to upgrade these theatres in future years.

The ED department footprint was extended in 2001/2 and some further adjustments were made when Stobhill Hospital closed in 2011. The numbers of patients going through the department each day has risen over this time. For the assessment and treatment of 'major' patients there are just 19 cubicles; local analysis would indicate on any given day the service requires up to 38 cubicles to effectively manage patient flow.

Cubicles throughout the department have restricted space for today's equipment and treatment requirements, impacting on patient privacy.

Whilst options for future reconfiguration on the GRI site are limited, the recent demolition of the Mortuary and the old Lister Building provides opportunity to modernise accommodation whilst retaining an important NHS presence close to the city centre and in a locality with significant levels of deprivation in the local population. This could also provide opportunity to further develop the provision of complex cancer surgery on the GRI site.

18. Beatson West of Scotland Cancer Centre (BWOSCC)

BWOSCC is located on the Gartnavel Campus. In December 2016 the GGC Board noted the recommendations of the Beatson West of Scotland Cancer Centre Steering Group Review. This review recommended that the co-location of non-surgical oncology services with acute services including Critical Care, medical and surgical specialties should be pursued at the earliest opportunity.

The MFT Blueprint (June 2018) identified four options which should be subject to formal option appraisal:

1. (Status Quo) Tier α Cancer Centre on the GGH site with enhanced high acuity facilities and transfer arrangements to support maximisation of cancer treatment.
2. Tier α Cancer Centre on the GGH site and co-locate Tier β complex surgical services at GGH which generate the requirement for an onsite critical care facility, emergency theatre and OOH medical cover.

3. Co-locate Tier α Cancer Centre and Tier β surgical services at QEUH.
4. Co-locate Tier α Cancer Centre and Tier β surgical services at another acute site.

In the last five years additional support and investment has been made in services to support the Beatson. This support includes the establishment of a High Acuity Unit, development of referral pathways for Critical Care and deteriorating patients, investment in the acute physician model, respiratory services, cardiology and acute oncology at the QEUH. In addition, a more local model for delivering chemotherapy (through the SACT) strategy is being developed and cancer units will receive investment.

These changes and developments have driven a refreshed piece of work to revisit the original options to ascertain if they remain valid and what other possible solution or options are available to support the BWOBCC. This will lead to an option appraisal.

19. Institute of Neurological Sciences (INS)

The INS service is provided across a number of blocks at the QEUH: Neurosurgery, Neurology, Spinal Injuries Unit and Physical Disabilities Rehabilitation Unit (PDRU). Over the last 10 years GGC has invested significantly to address a range of replacement and development work to support the Institute. This includes the development of 4 theatres in the ICE Building, a new entrance, recladding and window upgrade, replacement of the link bridge, redevelopment of existing theatres and an infrastructure support programme. In spite of this, there remain infrastructure challenges, particularly in the Neurosurgical building.

Development plans for significant refurbishment works have begun, but it is clear that the scale and scope of works required to address backlog and infrastructure issues would necessitate a lengthy and substantive decant programme.

This would require a location to be found on the QEUH campus as most of the services provided at the INS require to be co-located with trauma and spinal services.

A business case for capital investment is required to look at options for providing this regional service. An option for inclusion in the appraisal is a rebuild of an agreed schedule of accommodation that achieves the necessary adjacencies. The costs and timescales for delivery of any options will be variable depending on finalising the INS services to be included, the availability of decant provisions and the consequent phasing.

20. Gartnavel General Hospital

Gartnavel General Hospital will play a key role in the shape of health and care service in GGC in the next five years. It is co-located with the Beatson West of Scotland Cancer Centre, and currently has both clinical and non-clinical vacant space.

This could facilitate a number of other priorities, but needs to be done in a way that develops the hospital as a high quality facility which will attract clinical staff and serve the GGC population as a key part of our secondary Care Services.

Gartnavel General currently has the following services:

- | | |
|-------------|---|
| Inpatients | - older people's medicine
- older people's orthopaedic rehabilitation
- medical
- surgical (including ophthalmology) |
| Day Wards | - older people's day hospital
- rheumatology
- hepatitis |
| Outpatients | - diagnostics
- dental
- therapies |

- clinics
- day surgery

The site also has vacant wards, theatres and non-clinical areas.

Given the demands on estate across our Board area, there is a need to plan how to make the most effective use of the vacant areas. Current demands include:

- Beds to help address the elective programme challenges.
- Additional space requirements at QEUH for unscheduled care, trauma and stroke thrombectomy.
- Need for space for outpatient services currently at West Glasgow ACH site – orthopaedics, cardiology.

Gartnavel General could provide ambulatory clinical services, enhanced and complemented by a number of other services e.g. rehabilitation and older people's medicine and elective surgery to make effective use of vacant theatres. Development of the site in this way will positively impact on the Beatson WoSCC, with acute physicians being available on site.

Changes to Gartnavel General should address both accommodation challenges across GGC and also develop the hospital as rehabilitation, elective and ambulatory care site. It is proposed that two large clinical outpatient services from West Glasgow ACH are re-located to the site, moving existing general outpatients, orthopaedics and cardiology, to accommodate this. Capital investment associated with this programme of works will be in the region of £9m, and the work could be carried out in phases over 21 months.

Work is ongoing to identify the inpatient areas in the QEUH which do not need to be co-located with Trauma and ITU services. It is proposed that work commences now to upgrade a vacant ward floor in GGH in preparation for the completion of this work. Capital costs are expected to be circa £5m and this will make 52 beds available.

21. West Glasgow ACH (Yorkhill)

Following the move of children's services from Yorkhill to the new Royal Hospital for Children in 2015, the Board agreed that the site would be closed and decommissioned.

As a temporary position to support the completion of the ASR for adult services, a number of outpatients services from the Western Infirmary were located on the Yorkhill site, creating West Glasgow ACH, which also accommodates a high number of non-clinical services and offices. The cost of retaining this site adds a pressure of £3 million per annum to the acute budget, so vacating West Glasgow ACH has become a planning priority. A project group has been established to progress the programme.

Currently there are 22 outpatient services based on the WGACH site. It is proposed that 2 of the 3 large clinical services move to Gartnavel General as described in the Gartnavel section of this paper.

Work is currently underway to review the existing Board real-estate to determine if it is suitable for the remaining services. As part of this review the group has developed plans that would rehouse several of the services that remain on site;

- Orthopaedics – relocation site Gartnavel General Hospital.
- Cardiology – relocation site Gartnavel General Hospital.
- Diagnostics (imaging) – Gartnavel as part of Orthopaedic relocation.
- Dexa service (west catchment area) – Gartnavel General Hospital adjoining imaging.
- Pre Op service – relocation site Gartnavel General Hospital.
- Glasgow Weight Management service – relocation site Lightburn Hospital.
- Occupational Health Service – relocation site (old) Woodside Health Centre.
- Children's Mental Health Service (CAMHS) – relocation site (old) Woodside Health Centre.
- Douglas Inch Centre – relocation site Closeburn Street Clinic.

Plans to relocate the remaining clinical services are ongoing. The relocation of office staff and non-clinical support services is also part of the remit of the project group. The number of office based (non-clinical) staff that required rehousing was 596 and consisted of 22 teams. To date 277 staff have either been relocated or have a relocation site identified. The group are reviewing options to rehouse the remaining 319 staff. From the initial 6 non-clinical support services that required to be relocated, 2 have been allocated a new site with options for the remaining 4 being explored.

22. Financial Implications

The known financial implications of these priorities are noted in the preceding sections, and summarised in the table below. Many of the priorities have yet to be costed, and will go through national, regional and local business case processes.

	Funded		Unfunded	
	Revenue	Capital	Revenue	Capital
Costed Proposals				
Primary Care Improvement Programme	√ £10.2m)			
Mental health (Action 15 funding)	√ (£2.2m)			
Trauma (rising to £14.3m by 23/24)	√			√
Vacating West Glasgow ACH				√ (£9m)
Gartnavel ward areas (52 beds)				√ (£5m)
SACT			√ (1.9m)	√ (£1m)
Dedicated MIU space at GRI and QEUH				√ (£1m)
North East Hub		√ (47m)		
In Development				
INS Infrastructure				√
Urgent Care Resource Hub		√	√	
Public messaging			√	
Scoping				
Infrastructure – Clyde and GRI				√
Other hubs				√
Meeting unscheduled care demands			√	√
Addressing the elective challenge			√	√
Beatson				√

23. Conclusion

This paper describes the complex planning landscape within which health and care services are delivered. Moving Forward Together provides direction and a framework for our services, but this will be influenced and shaped by some of the immediate demands and pressures facing us. Given the constraints on both capital and revenue funding, we need to establish a phased approach.

Our three immediate priorities are:

1. To address the increasing demand for unscheduled care services.
2. To meet our elective waiting time commitments.
3. To implement the GGC elements of the West of Scotland trauma network.

These priorities drive us to identify ward and associated theatre and staff capacity.

Simultaneously, we need to develop the business case for the replacement/upgrade of the INS and to map out the further work required to develop the other priorities. Following that, further prioritisation will be required to ensure that our limited resources are best utilised.