



Item No: 11

Meeting Date: Wednesday 15th March 2017

Glasgow City Integration Joint Board

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UNSCHEDULED CARE STRATEGIC COMMISSIONING PLAN

Purpose of Report:

To consider the draft unscheduled care strategic commissioning plan.

Recommendations:

The Integration Joint Board is ask to:

- a) approve the draft plan attached; and
- b) note the further work underway including the development of an action plan.

Relevance to Integration Joint Board Strategic Plan:

Fulfils the IJB's responsibilities in respect of the strategic planning of acute unscheduled care services.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:

Contributes to:
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services

Personnel:

None at this stage.

Carers:

Carers are positively impacted through the designing of services around the needs of individuals, carers and communities.

Provider Organisations:	The plan ensures that HSCPs, with NHS Boards, local authorities and other care providers, make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings.	
Equalities:	The final plan should be supported by an EQIA.	
Financial:	The Integration Joint Board's budget for 2016 /17 includes a "set aside" amount for the commissioning of acute hospital services within scope (e.g. accident & emergency services). This amount has been estimated at circa £118m. Details are included in the draft plan. Scottish Government has advised that a review is being carried out of the process to estimate the set aside budget the results of which should be available later in 2017.	
Legal:	The integration scheme for the Integration Joint Board includes specific responsibilities for the strategic planning of certain acute hospital services.	
Economic Impact:	None	
Sustainability:	None	
Sustainable Procurement and Article 19:	The HSCP's strategic commissioning plan for unscheduled care will comply with these requirements.	
Risk Implications:	A risk analysis will be developed alongside the detailed unscheduled care plan.	
Implications for Glasgow City Council:	None	
Implications for NHS Greater Glasgow & Clyde:	The approach outlined in the draft plan attached will have implications for the planning and delivery of acute hospital services for Glasgow City residents. These are currently being discussed with the NHS Board.	
Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Glasgow City Council	
	3. NHS Greater Glasgow & Clyde	✓
	4. Glasgow City Council and NHS Greater Glasgow & Clyde	

1. Introduction

- 1.1 A report to the December 2017 meeting of the Integration Joint Board outlined progress in developing a Strategic Commissioning Plan for unscheduled care, and presented initial commissioning intentions for 2017/18 as developed by HSCPs in Greater Glasgow & Clyde.
- 1.2 Since that meeting further work has been undertaken on developing the Strategic Commissioning Plan for unscheduled care and a draft plan is attached for consideration by the Integration Joint Board.

2. Draft Strategic Commissioning Plan

- 2.1 The draft plan is a three year plan covering the period 2017/18 to 2019/20. The draft outlines the strategic context for unscheduled care, including the NHS Board's recent acute services strategy paper, and describes the current demands and pressures in the system. The plan goes on to focus on three main areas for action in line with the HSCP's priorities as set out in our Strategic Plan:
 - the HSCP's change programme in place across our services, including primary care, to better support people in the community and prevent admission to hospital e.g. neighbourhood teams, anticipatory care plans etc.;
 - the improvement programme in place to the support hospital discharge process and the transfer of patients home or to other appropriate care settings; and,
 - the HSCP purchasing intentions agreed at the IJB in December 2016 showing the estimated impact on acute activity.
- 2.2 The plan when finalised will fulfil the IJB's responsibility for strategic planning of acute unscheduled care services as set out in the Integration Scheme.
- 2.3 The plan incorporates the indicators recently discussed at the Ministerial Strategic Group and notified to IJB Chief Officers – these are referred to in the last section of the draft.
- 2.4 The draft plan has been developed by the Unscheduled Care Planning Group reporting into the Older People's Strategic Planning Group. Links have been made with the Primary Care Strategy Group and the Core Leadership Teams for Older People and Adults Services. Planning and clinical interface arrangements with the Acute Services Division are in place to take forward the proposals in the plan. The Strategic Commissioning Plan, whilst being a city-wide plan, will need to include specific programmes for the North and the South of the city, in recognition of the different service patterns and different patient populations. This detail is under discussion and linked to the NHS Board's improvement programme for unscheduled care.

2.5 Following IJB consideration of the Plan a further process of engagement particularly with primary care, but also the third and independent sectors, is being planned along with continuing discussion with the NHS Board and Acute Services Division. The purchasing intentions in the plan need to be underpinned by action plans with both primary care and acute clinical involvement.

3. Recommendation

3.1 The Integration Joint Board is asked to

- a) approve the draft plan attached; and
- b) note the further work underway including the development of an action plan.



DIRECTION FROM THE GLASGOW CITY INTEGRATION JOINT BOARD

1	Reference number	150317-11-a
2	Date direction issued by Integration Joint Board	15 th March 2017
3	Date from which direction takes effect	15 th March 2017
4	Direction to:	NHS Greater Glasgow and Clyde only
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	All functions as they relate to the delivery of services related to the commissioning strategy for unscheduled care, and are outlined with the appendix attached to this report
7	Full text of direction	NHS Greater Glasgow and Clyde is directed to design and deliver the integrated system of care for health and social care services that includes the strategic commissioning intentions for acute hospital services, as outlined within this report and appendix.
8	Budget allocated by Integration Joint Board to carry out direction	As directed by the Chief Officer: Finance and Resources, following the review being carried out of the process to estimate the appropriate 'set aside' budget, which will be available later in 2017.
9	Performance monitoring arrangements	In line with the agreed Performance Management Framework of the Glasgow City Integration Joint Board and the Glasgow City Health and Social Care Partnership.
10	Date direction will be reviewed	March 2018



Glasgow City Health & Social Care Partnership

D R A F T

Shifting the balance of care

**Unscheduled Care
Strategic Commissioning Plan
2017/18-2019/20**

February 2017

Contents

Summary	3
Introduction	4
Vision and purpose	6
National and local context	7
Population health	11
Balance of care	15
Shifting the balance towards a new system of care	21
Priorities for change	30
Resources and financial framework	40
Implementation	43

Summary

The purpose of this three year plan for shifting the balance of care and improving unscheduled care is to set out:

- the HSCP's change programme across our services, including primary care, to better support people in the community and prevent admission to hospital;
- the improvement programme in place to support the hospital discharge process and safely and smoothly transfer patients home or to other appropriate care settings; and,
- the changes we want to see in acute hospital services.

The plan outlines the strategic context for unscheduled care, and describes the current demands and pressures in the system. The plan when finalised will fulfil the Integration Joint Board's responsibility for strategic planning of acute unscheduled care services as described in the integration scheme.

Key priorities within this plan are:

- the need to retain and extend capacity of community resources to deliver shift in balance of care. This may require transitional funding sources to be explored;
- reduce and maintain delayed discharges further at low level (e.g. 20 for the city = bed day reduction to 1,200 by March 2018);
- roll out of the North East model for community based rehabilitation across the city;
- development of the new model of care to replace continuing care, commencing with the North East and Greenfield Park, to be managed solely by HSCPs;
- the introduction of arrangements for people who attend A&E and could be more appropriately seen within primary care;
- development of alternatives to admission for GPs including direct access to diagnostics and next day outpatient appointments; and,
- a 25% reduction deaths in hospital.

Overall it is estimated that this programme will achieve a significant reduction in acute bed days with more people being appropriately supported within the community and primary care.

Introduction

1. This draft outlines how we as Glasgow City Health and Social Care Partnership plan to shift the balance of care by reducing preventable admissions to hospital and supporting people better in the community. The draft describes the delivery of an integrated system of care for health and social care services and includes our strategic commissioning intentions for acute hospital services.

2. By unscheduled care we mean:

“... any unplanned contact with health and / or social work services by a person requiring or seeking help, care or advice. Such demand can occur at any time, and services must be available to meet this demand 24 hours a day. Unscheduled care includes urgent care and acute hospital emergency care.”

3. The integration scheme for Health and Social Care Partnerships includes the following statement and which forms the statutory basis for our strategic planning responsibilities:

“The Integration Joint Board will assume lead responsibility jointly with the five other Health and Social Care Partnerships within the Greater Glasgow and Clyde area for the strategic planning of the following:

- ***accident and emergency services provided in a hospital.***
- ***inpatient hospital services relating to the following branches of medicine:***
 - i. general medicine;***
 - ii. geriatric medicine;***
 - iii. rehabilitation medicine;***
 - iv. respiratory medicine; and***
- ***palliative care services provided in a hospital.”***

4. Scottish Government guidance on this strategic planning responsibility states that:

“Integration Authorities will be expected to set out clearly, in their strategic commissioning plans, how improvement will be delivered against the statutory outcomes and associated indicators. In addition, they should set out how rebalancing care will enable the delivery of key NHS targets in respect of A&E performance, the 18 Week Treatment Time Guarantee, and assuring financial balance.”

5. This draft plan aims to fulfil these requirements. This document begins by setting out the vision and purpose of the Health and Social Care Partnership and the national and local context for unscheduled care. In the next section we then assess the demographics and needs of our population and current trends. We then move on to assess the current balance of care within Glasgow before describing the new system of care to respond to the pressures and demands within the health and social care system. We go on to outline specific changes we wish to introduce working with acute colleagues, GPs and others and the estimated impact these changes might have, together with the benefits. Finally we

outline the resource framework that will support this work and the implementation arrangements to ensure success.

6. This plan should not be read in isolation to other plans being taken forward by the Health and Social Care Partnership including our primary care strategy, our reshaping care for older people strategy, our emerging mental health strategy, our workforce plan and our wider programme of integration, and our partner's plans such as the Strategic Housing Investment Plan and Single Outcome Agreement. We have also collaborated with the other Health and Social Care Partnerships in Greater Glasgow & Clyde in developing this, in particular the section on priorities for change.

Vision and Purpose

7. Our vision as a Partnership is that we believe the City's people can flourish, with access to health and social care support when they need it. This will be done by transforming health and social care services for better lives. We believe that stronger communities make healthier lives. We aim to do this by:
 - focussing on being responsive to Glasgow's population and where health is poorest;
 - supporting vulnerable people and promoting social wellbeing;
 - working with others to improve health;
 - designing and delivering services around the needs of individuals carers and communities;
 - showing transparency, equity and fairness in the allocation of resources;
 - developing a competent, confident and valued workforce;
 - striving for innovation;
 - developing a strong identity; and,
 - focussing on continuous improvement.

8. To take this vision forward there are a number of opportunities, which we will work towards, and these include:
 - sustaining existing good quality services;
 - removing artificial divisions between health and social care;
 - minimising duplication and waste by improved coordination between health and social care services;
 - the ability for a range of non-health agencies to act in concert to prevent illness and promote better health;
 - a renewed focus on families and communities, as well as individuals;
 - delivering transformational change in service provision, leading to positive health and well-being outcomes for Glasgow's citizens;
 - improving connections between strategic and locality planning;
 - the opportunity to develop and embed a shared culture and identity across the Partnership, breaking down traditional organisational barriers;
 - opportunities to engage with primary Care and acute services to support effective service planning and delivery;
 - joining up of Information and Communication Technology systems and processes to improve business and intelligence reporting;

9. While the scale of the City of Glasgow and NHS Greater Glasgow and Clyde area is significant, this also creates opportunities for us to work closely with the five other Health and Social Care Partnerships within the Health Board area to improve outcomes for patients and service users across the Board area.

National and Local context

10. In this section we outline the national and Glasgow context for shifting the balance of care, and the reasons why services need to change to improve service delivery and respond to new needs and demands.

National context

11. In February 2016 Scottish Government launched the National Clinical Services strategy that sets out a framework for the development of health services across Scotland for the next 10-15 years. The strategy restates the Government's vision for healthcare:

“Our vision is that by 2020 everyone is able to live longer healthier lives at home or in a homely setting. We will have a healthcare system where we have 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 person at the centre of all decisions. There will be a focus on ensuring that people get back to their home or community environment as soon as appropriate, with minimal risk of re-admission.”

12. The 2020 vision acknowledges that:
 - health and social care services are facing a rising tide of demand driven by demographic changes, advancing medical science and new technologies, at a time of constrained resources.
 - as people live longer, healthy life expectancy is not advancing at the same pace. This means that we will have more people, many of whom are older, living with multiple long-term conditions and often complex needs, more reliant on support and intervention from health and social care services.
 - we need to change our approach by shifting the balance of care away from acute hospital-focused care to one where there is a greater emphasis on prevention and community-based intervention.
13. It gives an evidence-based high level perspective of why change such is needed and what direction change should take. The strategy sets out the case for:
 - planning and delivery of primary care services around individuals and their communities;
 - planning hospital networks at a national, regional or local level based on a population paradigm;
 - providing high value, proportionate, effective and sustainable healthcare;
 - transformational change supported by investment in e-health and technological advances.

14. The full strategy is available at <http://www.gov.scot/Publications/2016/02/8699>. A road map setting out the implementation of the strategy is expected to be published in 2017.
15. National Delivery Plan published in December 2016 set out a programme to further enhance health and social care services. Working so the people of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:
 - is integrated;
 - focuses on prevention, anticipation and supported self-management;
 - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
 - focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
 - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.
16. The National Delivery Plan focuses on three main aims:
 - we will improve the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all ('better care');
 - we will improve everyone's health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management ('better health'); and
 - we will increase the value from, and financial sustainability of, care by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention ('better value').
17. Specifically the Plan includes the following actions to reduce inappropriate use of hospital services:
 - ensure Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings. This will be a key lever in shifting the focus of care across health and social care services;
 - agree with partners how to deliver an ambition of raising the performance of the whole of Scotland on delayed discharges from hospitals to the performance of the top quartile of local areas. This will be done as a step to achieving our wider commitments of eliminating delayed discharges, reducing unscheduled hospital care and shifting resources into primary and community care;
 - by 2018, we aim to: reduce unscheduled bed-days in hospital care by up to 10 percent (i.e. by as many as 400,000 bed-days) by reducing delayed discharges, avoidable

admissions and inappropriately long stays in hospital. A range of actions will be taken to achieve this, including improving links between secondary, primary and community care under integration, supported by further work to understand better and take action on the extent to which emergency admissions are currently inappropriate and avoidable. As a result, people should only stay in hospital for as long as necessary and get more appropriate care in a more homely setting. It will reduce growth in the use of hospital resources, support balance across NHS Board budgets and give clear impetus to the wider goal of the majority of the health budget being spent in the community by 2021 (as set out below). The annual reports produced by Health and Social Care Partnerships and regular monitoring data will enable progress to be tracked.

18. The full National Delivery Plan is available at:
<http://www.gov.scot/Publications/2015/05/8743>

NHS Greater Glasgow & Clyde Context

19. In NHS Greater Glasgow & Clyde the Board's Clinical Services Strategy (CSS) was approved in January 2015 and since endorsed by the six Integration Joint Boards. 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; and,
 - the pressures on hospital, primary care and community services are addressed.
20. The 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; and,
 - accessible, provided as locally as possible.
21. The Clinical Services Strategy is available at: <http://www.nhsggc.org.uk/about-us/clinical-services-fit-for-the-future/>
22. The NHS Board has also recently published an Unscheduled Care Improvement Programme to help meet the national target that 95% of attendees in emergency departments should wait a maximum of 4 hours to be treated. This standard is an important measure, not only of the efficiency of a service but it also of safety and quality of care for patients. The programme's key recommendations are that:

- medical capacity should be realigned to reflect patient demand in both the receiving areas and across the hospital system;
- options to improve Assessment Unit same day discharge efficiency should be progressed to reduce performance variation and avoid unnecessary short stay admissions. This should include considering either zoning down or closing the units overnight; and,
- improvement projects undertaken within various Sectors as ‘tests of change’ should be rolled out as part of a Board wide work programme over the next 12 months

23. In addition the following are also being pursued:

- improve discharge rates in assessment units – scheduling of GP referral activity and alternatives to admission;
- spread ‘Exemplar’ wards – improve earlier in the day discharge, reduce boarding and generate specialty capacity to facilitate movement in receiving units;
- implement the full suite of ambulatory care pathways across all sites - stream patients away from assessment units unless there is deemed to be value added activity; and,
- reduce low acuity demand – work with primary care to explore alternatives to admission

24. Further work is underway on developing the next stage of the NHS Board’s acute services strategy, and once finalised will shape the future delivery of acute hospital care. The proposals within this draft plan should be seen as a contribution to setting out that future direction.

Population health

25. In this section we look at the key population health and demographics that impact on the delivery of health and social care services, and acute hospital activity.

Population

26. According to the last census the population of Glasgow City currently stood at 593,245, and has increased steadily each year since 2006 largely as result of migration (insert ref and web link to DRS paper). The majority of the population of the City is of working age reflecting the fact Glasgow is a thriving city of work, education and culture. Only 16% of the City's population is under five, and only 7% are aged over 75 (see table 1 below).

Table 1 - Glasgow City population by age 2011 census

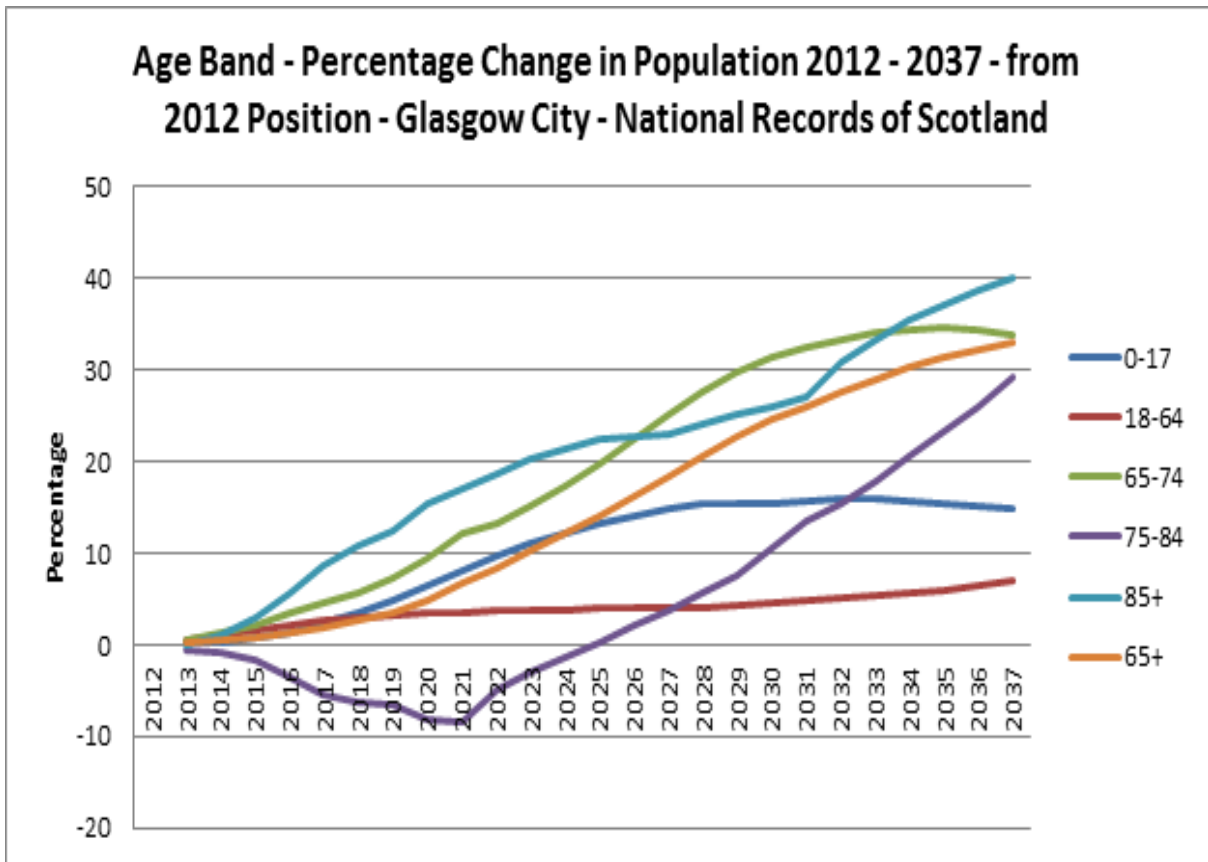
		%
Males	286,076	48.3
Females	307,169	51.7
age 0 to 15	95,627	16.11
age 16 to 24	89,722	15.12
age 25 to 34	101,183	17.05
age 35 to 44	83,127	14.02
age 45 to 54	81,835	13.79
age 55 to 64	59,586	10.05
age 65 to 74	42,410	7.15
age 75 to 84	29,397	4.96
age 85+	10,358	1.75
Total	593,245	100%

27. Recent estimates now put the City's population at 606,340, and it is expected that Glasgow's population will continue to grow by 3,450 per year to 2022 (<https://www.glasgow.gov.uk/CHttpHandler.ashx?id=35485&p=0>). There are significant changes in different age groups too with the number of children expected to rise by 1,300 per year to 2022, and the number of elderly expected to rise by 750 per year to 2022. Further changes are estimated beyond 2022 especially within the older age groups as shown in figure 1 below.

Table 2 - Population of Glasgow City - Percentage Change in Population over time 2013 - 2037

Age Group	Population 2013	Population 2020	2013-2020 % Variance	Population 2025	2020-2025 % Variance	Population 2037	2025-2037 % Variance
0-17	108,871	116,249	6.78%	125,348	7.83%	127,790	1.95%
18-64	405,205	418,035	3.17%	420,004	0.47%	433,078	3.11%
65-74	43,369	47,639	9.85%	53,673	12.67%	65,040	21.18%
75-84	29,300	27,239	-7.03%	29,510	8.34%	41,535	40.75%
85+	10,394	12,308	18.41%	13,402	8.89%	17,301	29.09%
Total	597,139	621,470	4.07%	641,937	3.29%	684,744	6.67%

Figure 1 - Glasgow City population projections 2012-2037



Life expectancy

28. We know that in Glasgow life expectancy is considerably below the national average for both men and women and compared to other cities in Scotland. But there is also a significant difference between the healthy life expectancy compared to other cities. The graphs below show the gap between life expectancy and healthy life expectancy for both men and women in Glasgow is significantly larger than that in other cities.

Figure 2 – male healthy life expectancy

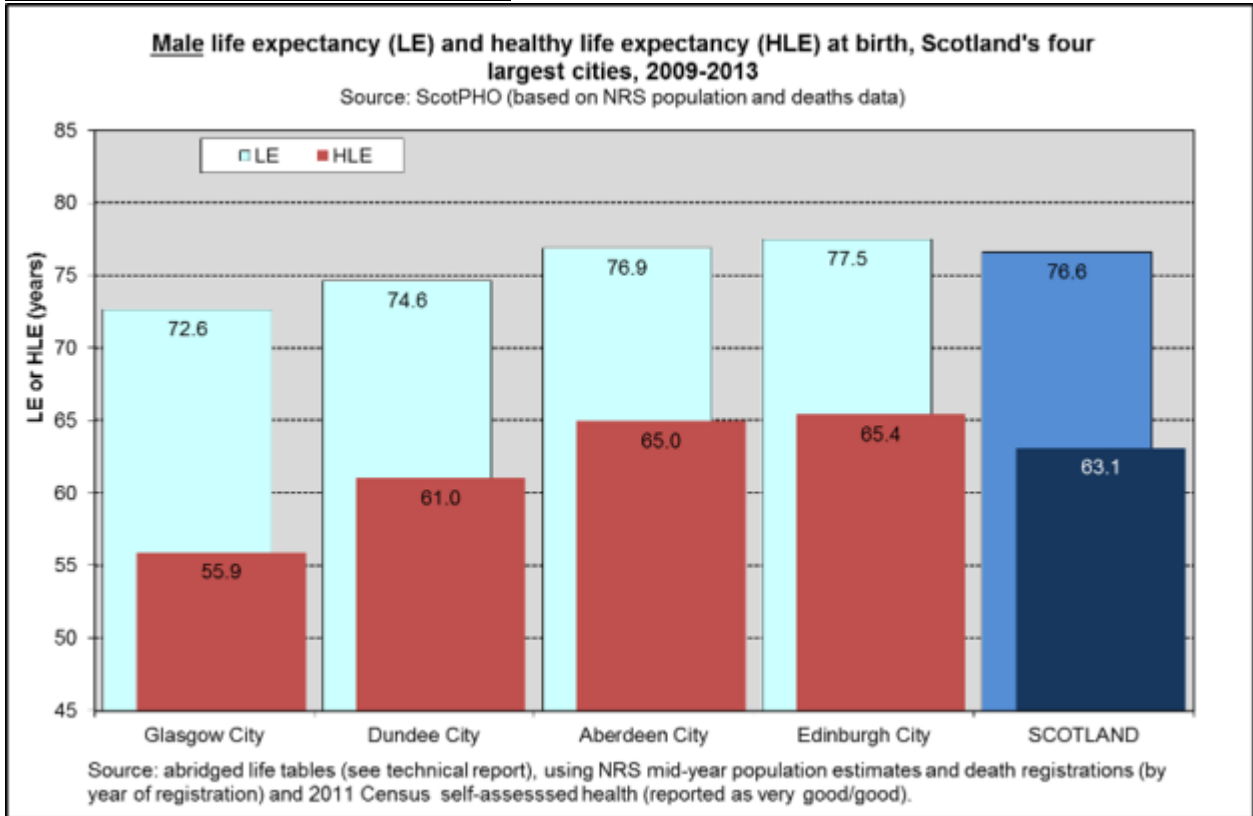
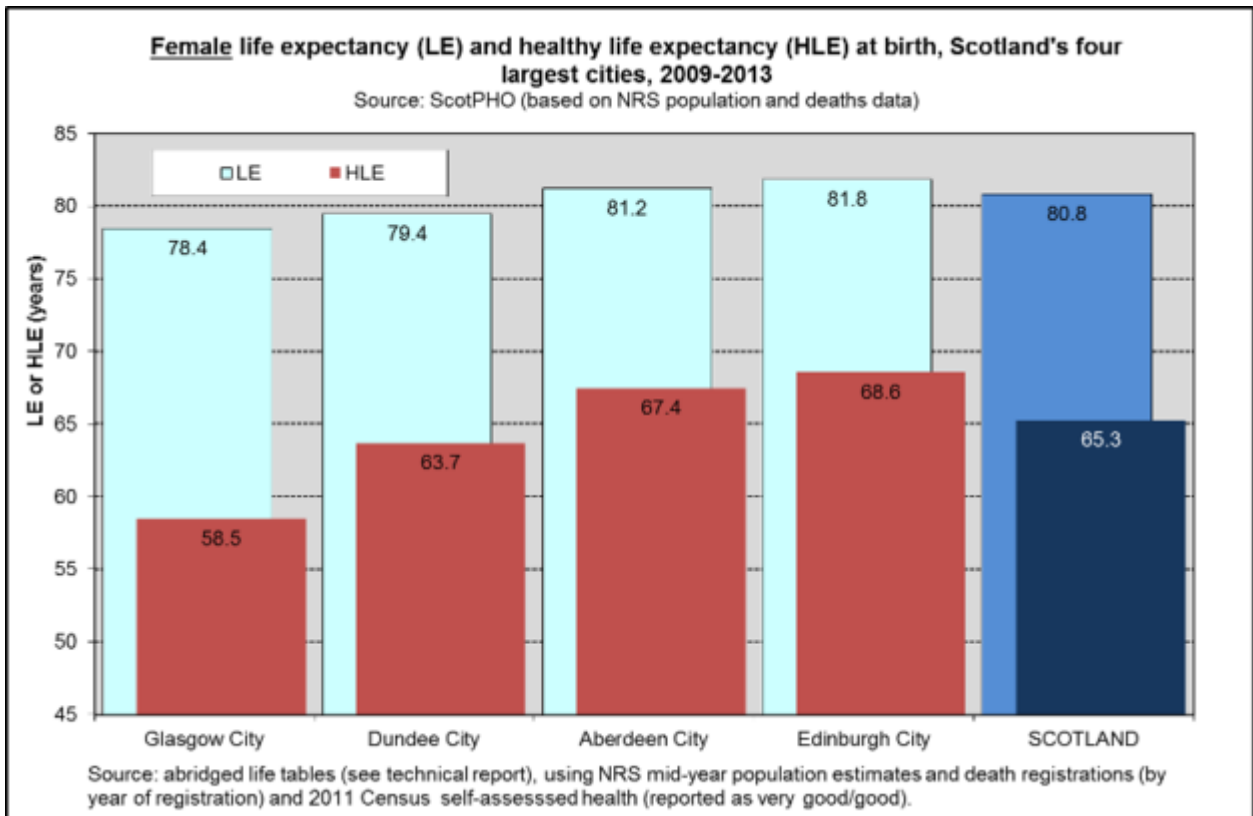


Figure 3 – female healthy life expectancy



Main causes of death

29. According to the most recent Director of Public Health report (2015-2017) for the NHS Board, in Glasgow City HSCP, the level of mortality was twelve percent higher than in the population of Greater Glasgow & Clyde taking account of the different demography of the two populations. For specific disease prevalence a number of issues were noted:
- the incidence of lung cancer in Glasgow City HSCP was twenty six percent greater than would have been expected assuming the pattern of incidence in the population of NHSGGC overall.
 - the incidence of colorectal cancer in Glasgow City HSCP was eleven point three percent greater than would have been expected assuming the pattern of incidence in the population of NHSGGC overall.
 - the incidence of breast cancer in Glasgow City HSCP did not differ significantly from that in the population of NHSGGC.
 - in Glasgow City HSCP, the incidence of ischaemic heart disease was twelve point eight percent greater than would have been expected assuming the pattern of incidence in the population of NHSGGC overall.
 - the incidence of stroke in Glasgow City HSCP was not significantly different from that in the population of NHSGGC.
 - the crude incidence of fractured neck of femur in Glasgow City HSCP was greater than that in the population of NHSGGC.
 - the incidence of falls in Glasgow City HSCP was greater than that in the population of NHSGGC.
 - the incidence of disability (visual / auditory or physical disability) was no higher than other areas in NHSGGC

Vulnerability

30. Older people living alone and / or on pension credit are defined as more vulnerable, and therefore more likely to required support from health and / or social care services. It is estimated that there are approximately 44,949 people considered to be vulnerable (see table 3) – just over half the elderly population in the City. This is important when considering the future demand for health and social care services.

Table 3 – vulnerability

Area	General pensionable age pop (60/65+)	Indicators of vulnerability				Vulnerable older person population (60/65+) (2 or 3 indicators)
		Older people aged 75+	Older people aged 65+ living alone	Older people aged 75+ living alone	Older people aged 60/65+ receiving pension credit	
North East	29,131	11,671	10,586	5,567	13,410	14,015
as % of gnrl pensionable age popn		40.1%	36.3%	19.1%	46.0%	48.1%
		29.4%	29.0%	28.2%	33.5%	31.2%
North West	31,034	13,020	12,346	6,647	12,305	14,534
as % of gnrl pensionable age popn		42.0%	39.8%	21.4%	39.7%	46.8%
		32.8%	33.8%	33.7%	30.7%	32.3%
South	36,324	15,064	13,576	7,529	14,345	16,400
as % of gnrl pensionable age popn		41.5%	37.4%	20.7%	39.5%	45.2%
		37.9%	37.2%	38.1%	35.8%	36.5%
Glasgow City	96,489	39,755	36,508	19,743	40,060	44,949
as % of gnrl pensionable age popn		41.2%	37.8%	20.5%	41.5%	46.6%
		100.0%	100.0%	100.0%	100.0%	100.0%

Notes: Figures for the social work areas and Glasgow City were calculated by aggregating calculations that were made at the multi-member ward level. 75+ living alone indicator was calculated by deriving prevalence rates from the 2001 Census and applying them to 2011 population figures. Source: Scotland's Census 2011 - National Records of Scotland (Tables KS102SC; LC1117SC; LC1109SC; QS103SC); 2001 Census; Department for Work and Pensions "Pension Credit 2012 Q4."

Balance of care

31. In this section we review the current balance of care in Glasgow and highlight the pressures in the system and why this needs to change to improve services for the people of Glasgow.

Current system

32. The health and social care system in Glasgow has faced considerable pressures in recent years. In particular there has been considerable pressure in delivering the national target to delivery care to 95% of accident and emergency attendees within four hours. The recent trends for Glasgow City residents are shown in figure 4 below.

Figure 4 – Accident & Emergency Attendees – 4 hour target – Glasgow City residents April 2011-October 2015 to December 2016

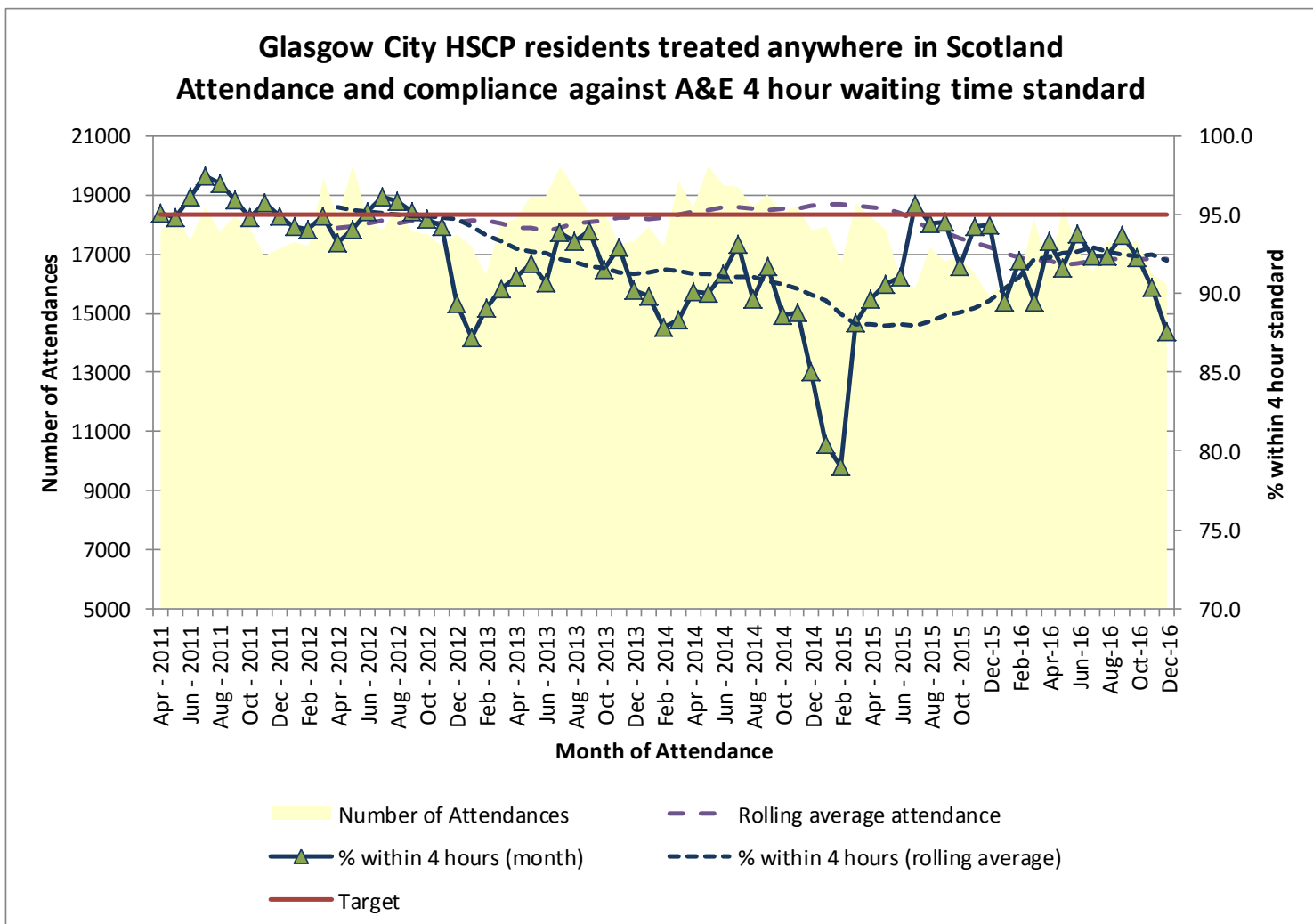
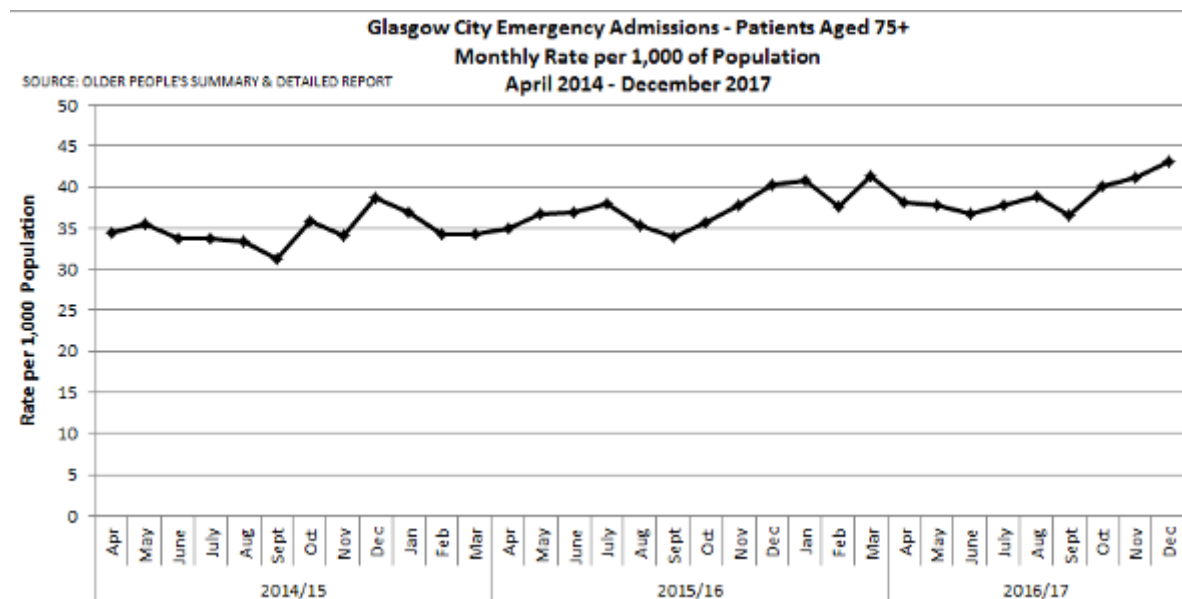


Figure 7 – Glasgow City emergency admissions patients aged 75+ rate per 1,000 of population April 2014 – December 2017



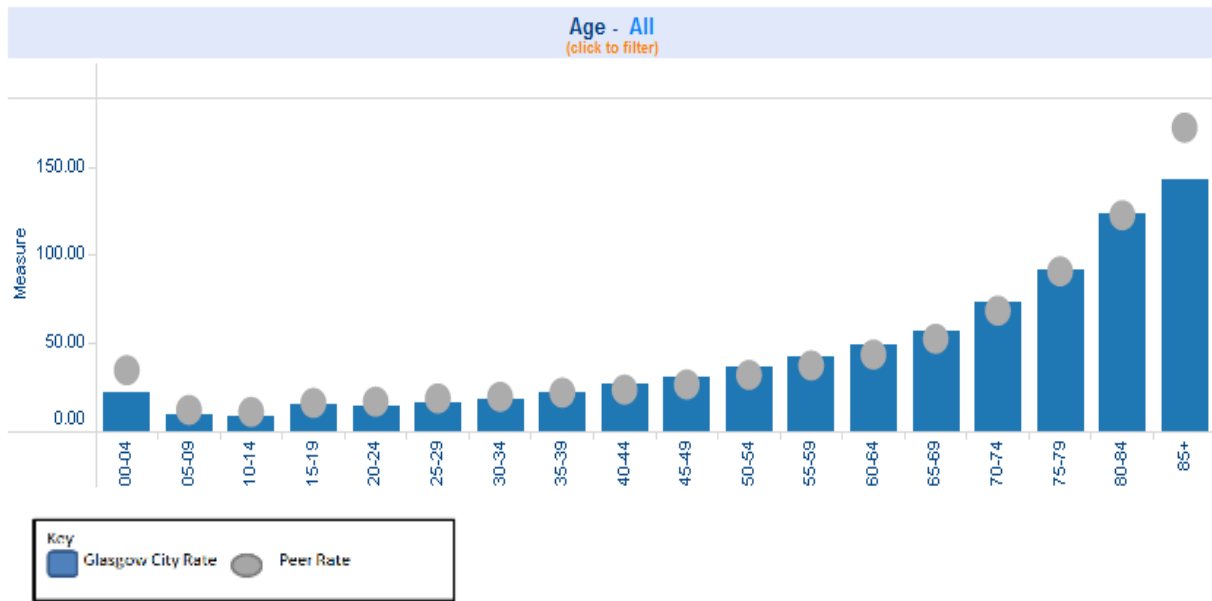
34. Further analysis shows that these attendances are influenced by deprivation with a greater rate of attendance from SIMD 1 areas as shown in table 4 below.

Table 4 – Glasgow City unplanned admissions by SIMD 2011/12-2016/17 (over 65yo)

	2009/10	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (to December)
Quintile 1	9,771	8,607	8,871	8,808	9,252	10,020	7,557
Quintile 2	7,292	8,439	8,228	7,757	7,096	7,363	6,018
Quintile 3	4,742	5,341	5,438	4,912	4,844	5,134	4,088
Quintile 4	2,954	3,494	3,637	3,459	3,345	3,670	2,800
Quintile 5	1,443	1,440	1,466	1,366	1,700	1,704	1,349

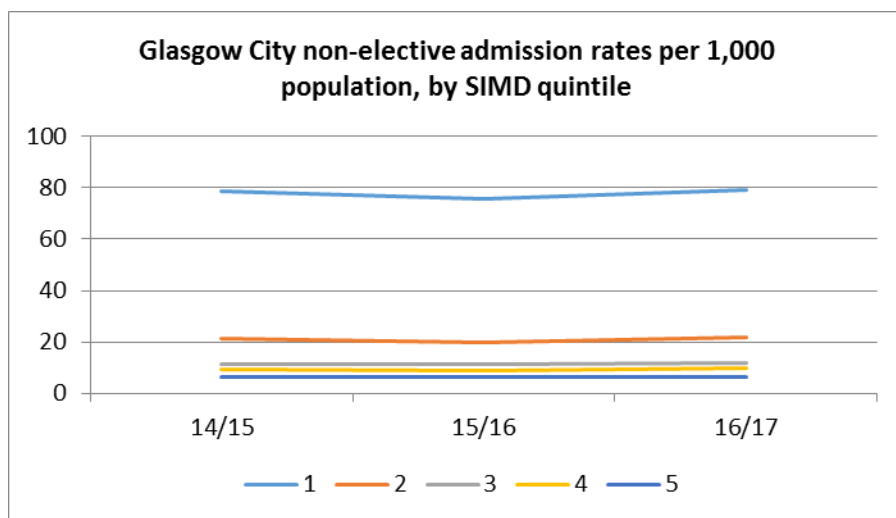
35. In comparing our performance against national trends it shows that non-elective admissions to acute hospitals across all age groups and all specialties is higher in Glasgow for those aged 85 and over than in other areas. For all other age ranges our performance compares favourably with others – see figure 8 below.

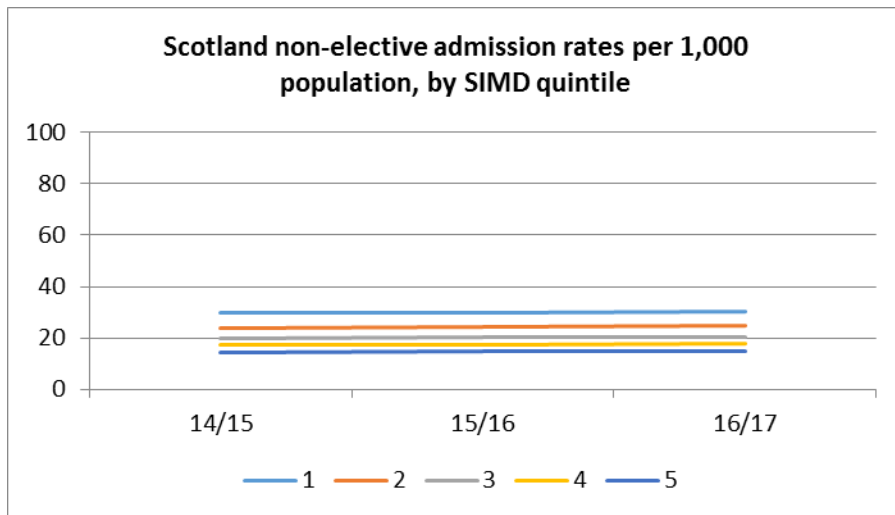
Figure 8 – non elective admissions per 1,000 population by age band July to September 2016



36. When looking at these rates by SIMD it is apparent that the rate in Glasgow across all SIMD areas is higher than that in other areas as shown in figure 9 below. So in broad terms, and as also highlighted in table 4, we can conclude that deprivation is a key factor in the consumption of acute hospital services in Glasgow, and significantly more so than other areas. The impact of deprivation will therefore need to be taken into account in our plans to prevent potentially avoidable admissions in the future.

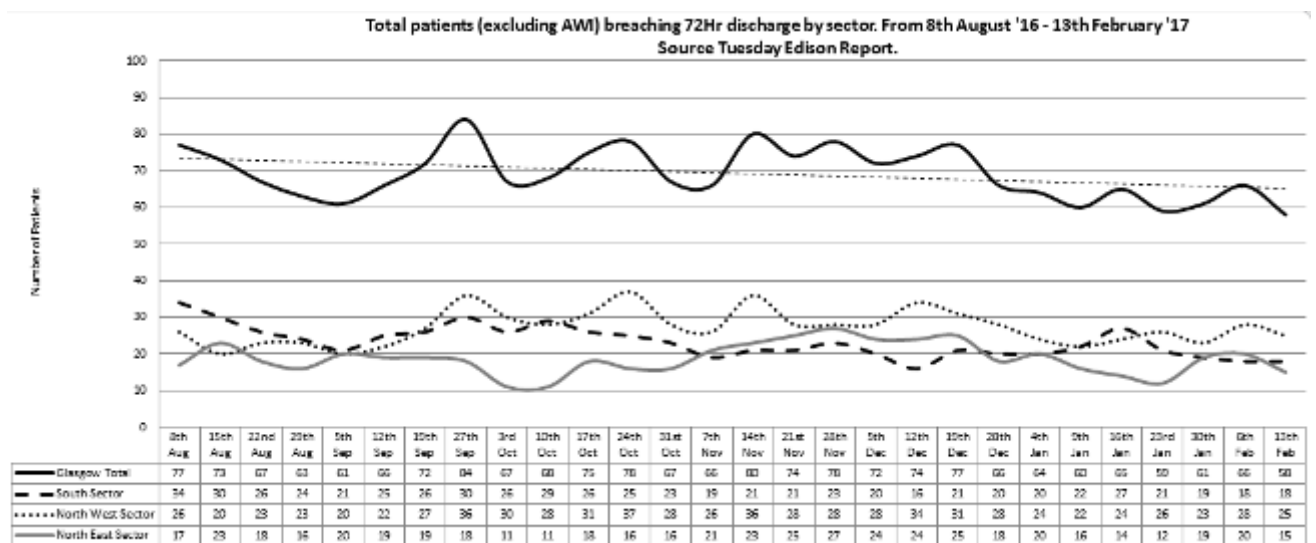
Figure 9 – non elective admission rates per 1,000 population by SIMD Glasgow City compared with Scotland 2014/15 – 2016/17





37. Another significant pressure in the system has traditionally been delayed discharges. Significant reductions have been made in recent years (see figure 10) - a key priority in this plan is the need for a continued focus on improving our performance in this area. More on this is outlined below.

Figure 10 – Glasgow City delayed discharges – number of patients breaching 72 hour target 8th August '16 – 13th February '17



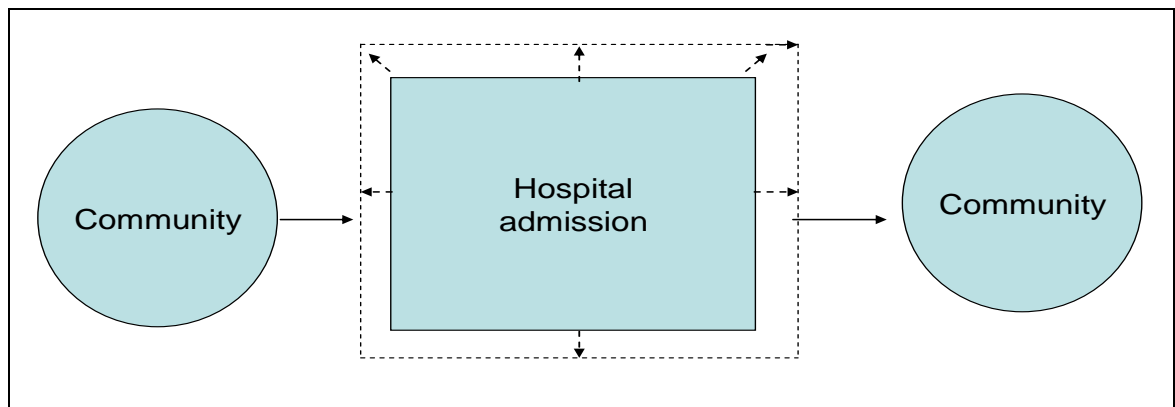
Shifting the balance towards a new system of care

38. The previous section presented an analysis of the current balance of care, system pressures and performance against key targets and indicators. In this section we describe the new system and services which are needed to shift the balance of care away from treatment in hospitals, to enable people to be looked after at home or in homely settings. It is important we do this, working with our partners in acute, housing and the third and independent sectors; so that the acute hospital system can focus on meeting the needs of those who need acute hospital care.

Current system of care

39. Figure 11 below shows the system now with separate ‘hospital’ and ‘community’ services.

Figure 11 – current system of care



40. For unscheduled care the current system can be illustrated as in figure 12 below showing the multiple points of entry, and in table 5 we show the levels of activity associated with each part of the system. Because there are multiple points of entry (and exit), it is important the system as a whole operates efficiently and effectively from the patient’s perspective with smooth, timeous and reliable transfers of care between different parts of the system. What will also be evident is that there is a significant level of activity out of hours and so our plan needs to include a model for these services too.
41. Table 5 shows in a simplified way the activity across the whole unscheduled care pathway expressed as a rate per head of population. What this illustrates is that the rate of attendance at emergency departments and out of hours for Glasgow city residents is much higher than the national rate by 23% for emergency departments (ED) and GP out of hours by 44%. Clearly there is much more detail that sits behind this information and the various pathways taken by patients to access services.

Figure 12 – current unscheduled care pathway

Glasgow City Health and Social Care System – Unscheduled care for adults
 Created by Living Well in Communities, iHub, Healthcare Improvement Scotland.

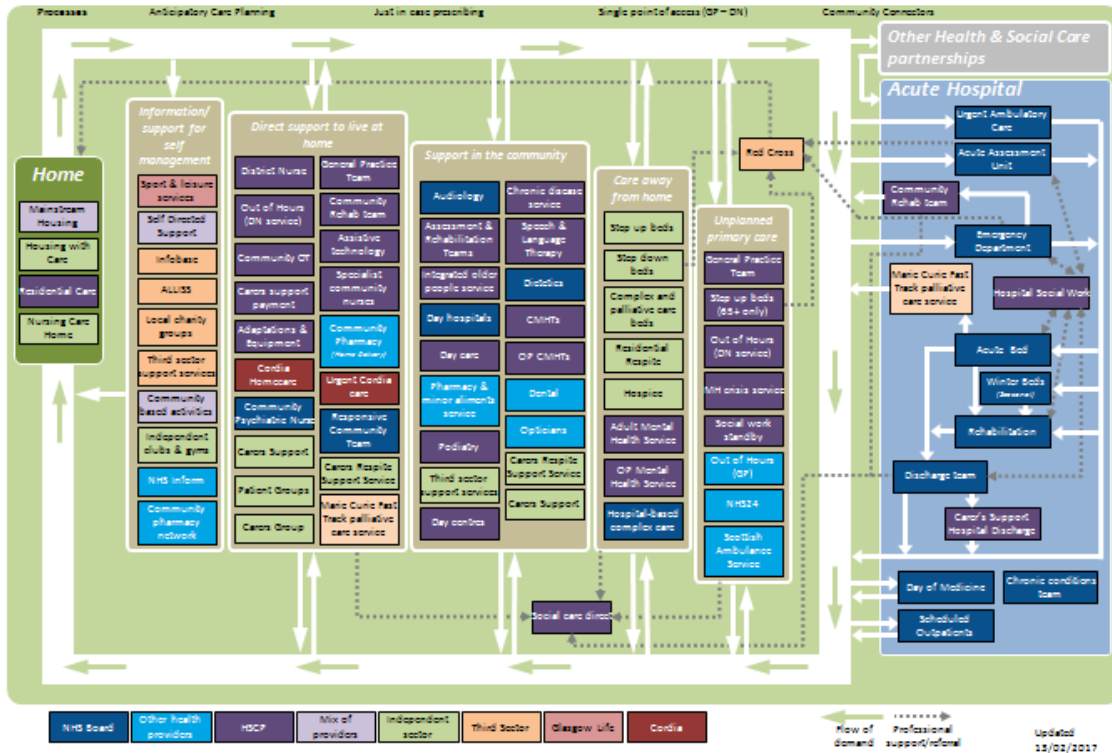


Table 5 – unscheduled care pathway activity rates per 1,000 population Glasgow City compared with Scotland 2014 – 2016

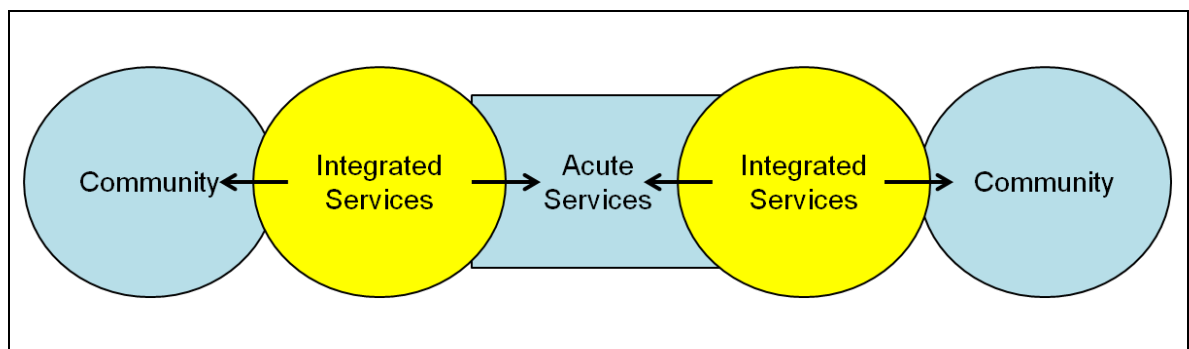
Pathway	2014			2015			2016*		
	Scotland	Glasgow	%	Scotland	Glasgow	%	Scotland	Glasgow	%
NHS 24	17,514	19,878	+13.5%	22,748	26,051	+14.5%	15,0422	17,295	+15.0%
GP OOH	2,203	2,856	+29.6%	2,830	3,970	+40.3%	1,843	2,654	+44.0%
SAS	5,191	5,938	+14.4%	6,594	7,548	+14.5%	4,264	5,071	+18.9%
ED	13,413	18,381	+37.0%	17,500	22,489	+28.5%	12,378	15,296	+23.6%
Acute	1,303	999	-23.4%	1,934	2,096	+8.4%	1,395	2,011	+44.2%

*2016 data April to September

New system of care

42. We need therefore to move rapidly towards a system which has services integrated between acute and HSCP services (figure 13 below). This system of care is based on strengthened, round the clock 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 will 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 13 – new system of integrated care



Integrated health and social care system of care

43. The HSCP is already embarked on a radical and ambitious programme of transformational change that will see integrated health and social care services focused on prevention and early intervention, supporting more people live independently in community settings and tackling inequality (see our Strategic Plan <https://www.glasgow.gov.uk/CHttpHandler.ashx?id=33418&p=0>). This new integrated system of health and social care will enable us, as well as supporting the hospital system and GPs to reduce pressure on acute services, to respond to the demographic changes outlined in the population health section above. The overriding aim is to ensure people get care in the right place at the right time from people with the right skills, working across the artificial boundary of ‘hospital’ and ‘community’ services.
44. Our integrated system of care comprises a comprehensive range of primary care and community services, integrated across health and social care and working with housing, the third sector and independent sectors to provide increased support at home, focused on preventing deterioration and supporting independence, responding to crisis (both in and out of hours), and working as part of a team with primary care for a defined patient population. This new system of care has several components:

- enhanced primary care and community services;
- prevention, anticipatory care and early intervention;
- specific care group based services to ensure community based health and social care services are responsive to the needs of older people and those with chronic disease;
- new model for out of hours care; and,
- improving discharge.

45. This programme of service development and change will accelerate over time to deliver a more extensive and innovative range of community health and social care services which reduce the demand for hospital care and meet the needs of patients who are currently admitted to hospital; while remaining safe and efficient.

Enhanced primary care and community services

46. Primary care is the focus of considerable change and is an integral part of the new system of care, and is where most patients have contact with the NHS be that in or out of hours. Our aim here is to have a system that gives 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. Primary care is the focal point for prevention, anticipatory care and early intervention.

47. The integrated health and social care programme described above will work closely with GPs to support the management of care where possible within a primary care setting, and ensure continuity of care, and co-ordination of care for people multiple conditions. We will be working with GPs and supporting the new GP quality clusters to analyse local needs and demands, including use of acute services and to better understand variations in activity with a view to improving service quality for patients.

48. Specific plans implemented or being implemented are:

- the introduction of health and social care direct access hubs including a single point of access to district nursing services, social care direct and single point of access for community rehabilitation services. Hubs will provide a single point of contact for all community health and social care services ensuring that service users and patients are directed to the right service or are given appropriate support and advice at the first point of contact;
- a programme of modernising our health and care centres with two new centres in Gorbals and Woodside delivered by 2018, plus proposals for a new centre in Parkhead to be submitted in April;
- developing the community orientated primary care programme (COPC) to support specific practices meet additional needs in the community;
- implementation of the new GMS contract and the additional resources available; and,
- take forward the learning from the Govan SHIP project and other primary care based initiatives designed to test new ways of delivering primary care services in areas of deprivation, including the role of link workers / community connectors.

Prevention, anticipatory care and early intervention

49. We have in place a comprehensive programme of prevention, anticipatory care and early intervention designed to better support people in the community by responding to specific needs and conditions to avoid unnecessary admission to hospital.
50. Specific plans being developed are:
- enhanced support to our directly provided residential care homes to reduce the rate of admission to hospital which will result in a consequent reduction in acute beds days;
 - enhanced support to nursing homes where we purchase care to reduce the rate of admission to hospital by 10% which will also result in a consequent reduction in acute bed days;
 - the continued roll out of the Glasgow Community Respiratory Service to support patients with COPD, and develop self-management strategies and anticipatory care plans; and,
 - roll out of the Glasgow model of anticipatory care plans, and introduction of the national approach for people with long term or multiple conditions who have an increased likelihood of hospital admission.

Specific care group based services

51. We have developed a coherent programme of community based services for specific care groups designed to support our approach to prevention and early intervention, and reduce admission to hospital based care, and ensuring community based health and social care services are responsive to the needs of older people and those with chronic disease. For older people and their carers in particular services can often seem disjointed, and for those who have been in hospital, discharge and transfer to a community setting is not always as smooth or as timeous as we would like it to be. We need to review the learning and best practice to improve our responses and focus on vulnerable populations which require support while delivering significant reductions in hospital admissions and improve timely discharge.
52. In older people our programme includes:
- the introduction in 2017 of integrated health and social care multi-disciplinary neighbourhood teams, including community rehabilitation, designed to better support older people and physical disabled people in the community and improve the discharge process. Ten neighbourhood teams (four in the South, three in the Northwest, and three in the Northeast) will be established comprising social work, district nursing, community rehabilitation services and older people's mental health staff. Teams will have links to a broad range of partner services including acute, the third and Independent sectors and housing;
 - from mid-2017 a redesigned integrated OT service that, as part of neighbourhood teams, better supports older people in community settings;

- the continued roll out of our supported living programme to support 1,000 users with complex needs continue to live quality lives in the community;
- the development of our accommodation based strategy with local housing and other providers designed to meet the housing needs of older people in the community;
- the further development of our assistive technology programme (tele care) so that we make the best use of the technological opportunities available to support people within their own homes;
- the continued modernisation of our directly provided residential and day care provision so that by 2018/19 we have 550 beds in five newly built homes and 1,700 weekday day care places, 125 weekend places;
- the introduction in 2017 of a comprehensive falls prevention programme designed to reduce the number of falls among older people;
- the development of personalisation for older people to increase the number of people choosing to live at home with the necessary support; and
- the development of the Glasgow model for meeting the needs of frail older people in the community.

53. For those with complex care needs:

- we will in 2017 introduce a sustainable complex care model and include provision for former NHS continuing care patients, and adults with incapacity.

54. For older people with mental health problems our programme includes:

- the implementation of our five year dementia strategy designed to improve the lives of people affected by dementia, and their carers. Key priorities within the strategy are an emphasis on early diagnosis and post diagnosis support, including consideration of social, physical, and psychological aspects of a person's care;
- the review of speech therapy services to better support people in the community; and,
- strengthening the liaison role with care homes with a view to preventing admission to hospital.

55. In adult mental health our programme includes:

- a specific unscheduled care programme within adult mental health working closely with acute emergency departments and community mental health services, crisis support services to better support people within a community setting.

56. For carers continued progress to increase access to carers assessments, and working with carers centres and others to take forward implementation of the new Carers Act.

Integrated out of hours system of care

57. Specific plans here include the development of an integrated model of our of hours services, in response to the Richie report, including primary care and social work stand by services, to better support people out of hours. The work will involve the Scottish Ambulance Service and NHS 24. A specific out of hours care pathway will be developed as an integral part of the design of our unscheduled care pathway.

Improving discharge – new models of care: slow stream rehab and continuing & complex care

58. Vital to the success of this unscheduled care plan is ensuring that those who are admitted to hospital, through whatever route, have a smooth and speedy discharge home or to another care setting with the level of support appropriate to their needs. We have made considerable progress in reducing delays in recent years. A sustained programme of work has delivered these improvements, and we intends to continue this focus into 2017/18 and maintain performance at a maximum of 20 delays per month (over 65s and excluding LD, mental health & AWI) across the City. We will continue to work with acute services, the third and independent sectors to ensure we focus on improving our performance.
59. Specific measures we will have in place include:
- the development of an integrated approach to admission avoidance and delayed discharge. A dedicated resource will be aligned to our acute hospitals in the North and South of the City to:
 - support the redirection of avoidable admissions by supporting 'front door' work. The 'team' will have access to telecare, homecare, supported accommodation, carers assessment & support, day care and intermediate care beds;
 - enable shared ownership of a whole system, person-centred care;
 - improve relationships with ward staff and wider teams as HSCP staff will be part of an integrated service; and,
 - improve communications with patients, carers as staff will be more available.
 - ensuring from 2017 an integrated hospital discharge process that speedily and safely transfers patients from hospital to community settings to achieve national targets (see below);
 - development of our step up / step down capacity;
 - develop models of Intermediate Care to reduce delays in hospital for patients who are under 65 including patients with complex physical health care needs, mental health and homelessness;
 - deliver improved performance management for AWI patients delayed due to guardianship applications and correspondingly reduce the number of AWI delays;
 - improved hospital interface arrangements including:
 - aligned dedicated Social Work resource and practice into acute hospital Teams;

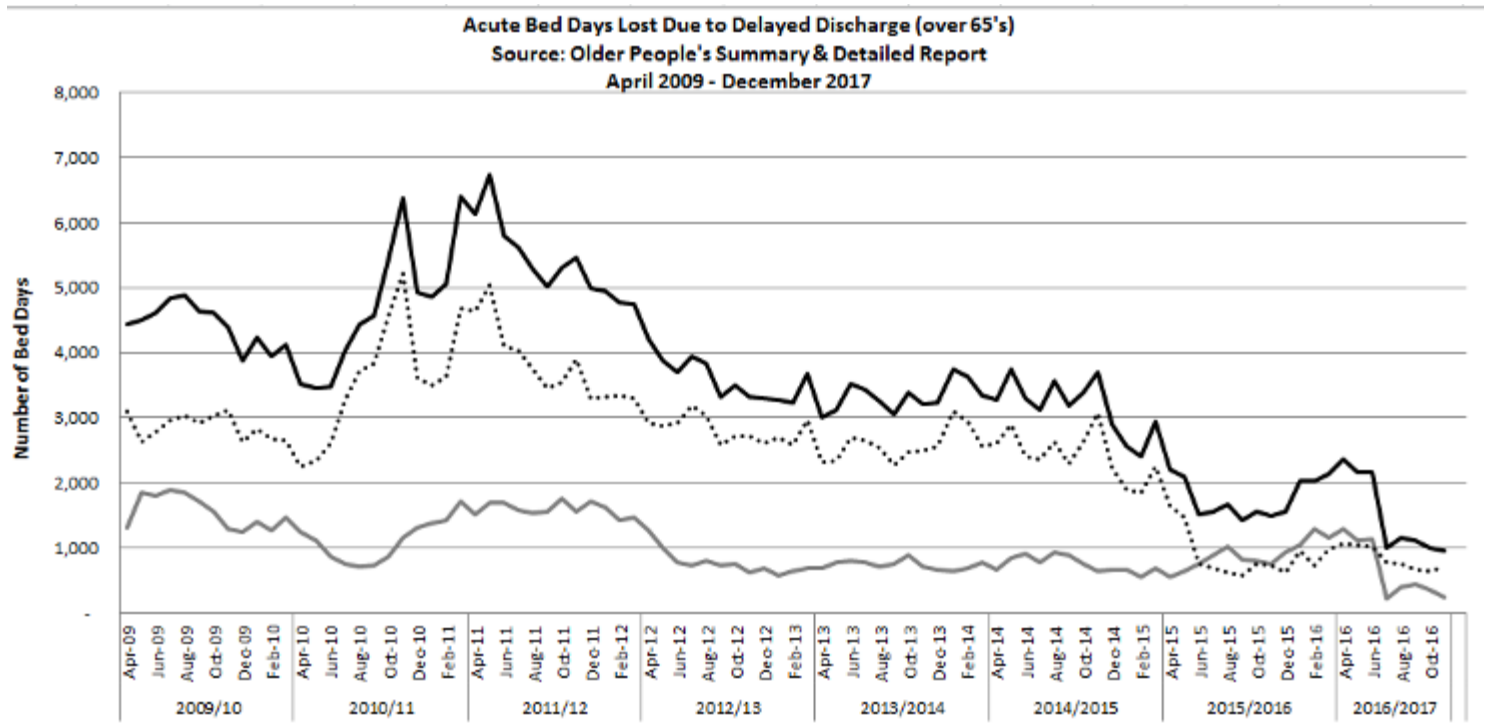
- move to improved early referral of patients who are unable to return home from hospital;
- development of the model of intermediate care including complex and palliative care hospital discharge pathway in North Glasgow; and,
- strategically manage care home placement allocations across the three localities to alleviate the areas of greatest pressure and maintain throughput in our intermediate care.

60. A key part of this programme of work includes introducing new models of care in:

- **community based rehabilitation** – rolling out across the City the new model of care being developed in North East Glasgow where those patients who no longer require inpatient care but still require rehabilitation would be transferred to local community facilities for their ongoing care, and with a strong focus on re-ablement within a homely setting;
- **continuing & complex care** - the HSCP with the NHS Board is developing a new model of care following changes introduced by the Scottish Government to NHS continuing care. Proposals was presented to the IJB on 31 October 2016.

61. Taking these changes together, and the existing programme of work to improve our performance, we estimate the impact on acute bed days as shown in figure 15 below. Subject to further refinement with acute, we could expect the impact of this to be in the region of 15,700 and 17,700 bed days (including AWI) in 2017/18.

Figure 15 – Delayed discharges acute bed days lost (Over 65’s) April ‘09 – December ‘17



End of life care

62. In 2015 we introduced the Glasgow Fast Track service, delivered in partnership with Marie Curie, to support people with palliative care needs to get out of hospital as quickly as possible. In addition, the contract with Marie Curie for Managed Care augments mainstream community nursing services for people with palliative care needs and avoids unscheduled admissions.
63. We are developing a palliative care action plan to take forward the national framework for Living and Dying Well. We are working with Health Improvement Scotland to further build on existing palliative and end of life care in the community, and thus reducing the number of people who spend the last six months of life in hospital. A key target in the action plan is to reduce the percentage of the last six months of life spent in hospital and increase the proportion who chose to die at home or in a community setting. Our current rate is shown in table 6 below. Through the implementation of our plan in response to the national action plan we aim to increase this rate in line with national trends.

Table 6 – the % of those who died spent the last six months spent at home or in a community setting

	Proportion of last 6 months of life spent at home or in a community setting				
	2011/12	2012/13	2013/14	2014/15	2015/16
Glasgow City	85%	85%	85%	84%	85%
Scotland	88%	87%	87%	86%	87%

Summary

64. Through these actions (and others described in the next section) we estimated that there will be the following:
- a 10% reduction in bed days due to unscheduled admissions and delays by 2018 in line with the national target;
 - an increase the number of people with anticipatory care plans;
 - an increase in the number of people with intensive care needs supported to live at home;
 - a 10% reduction in the number of admissions to hospital from nursing homes and residential homes;
 - delayed discharges maintained at a maximum of 20 per month; and,
 - a reduction in the number of people who spend the last six months of life in a hospital.

Priorities for Change

65. In this section we set out our priorities for change within the acute hospital service over the next three years to 2019/20. Below we outline each proposal and the rationale, with the benefits we seek to secure, and what this means for acute activity (see Appendix 1 - Proposed Common Acute Commissioning Intentions). In the next section we explain the financial framework that will underpin these proposals.
66. The proposals below are presented with a brief description (more detail will be included in each change plan accompanying each proposal) and an estimation of the anticipated impact on acute activity in 2017/18. The intentions assume a start date of 1 April 2017 and show the impact over a full year for Glasgow City as a whole – this is for illustrative purposes only and to show what potentially could be achieved. In reality each proposal will inevitably have a different start date in the North and in the South, and different impacts, and will not achieve a full year's impact in 2017/18. More detailed work with the NHS Board and acute will be needed to further test and refine the individual change plans.
67. In estimating the impact of these proposals, we have made an assessment of the level (within a range) of activity we anticipate to see in 2017/18. It will be for the NHS Board and acute to look at the impact of these proposals on service delivery, taking into account commissioning plans of other Partnerships, including those outside Greater Glasgow & Clyde. No account has been taken of the financial impact of these proposals. This too will be the subject of further work with the NHS Board and acute.
68. The remainder of this section focuses on the key areas where we wish to progress service improvements in 2017/18.

Key priorities

69. Our proposals focus on the key themes that emerge from our analysis of the population's health and the balance of care, learning from the Renfrewshire Development Programme, and as such are designed to take forward the Board's Clinical Services Strategy. The key priorities within these for the Health and Social Care Partnership are:
 - the need to retain and extend capacity of community resources to deliver shift in balance of care as described in the previous section. This may require transitional funding sources to be explored;
 - exploring what more can be done to prevent potentially avoidable admissions;
 - the introduction of arrangements to re-direct patients from A&E who could appropriately be seen in primary care;
 - development of alternatives to admission such as GP direct access to diagnostics and next day outpatient appointments; and,
 - increasing the contribution of consultant geriatricians and rehabilitation staff to support integrated care in the community.

70. In setting out these priorities we have focused on two key themes that follow through on the strategic direction outlined in the section on national and local context. The themes are:

- enabling acute care to be focused on patients with acute needs; and,
- changes to address service pressures and improve efficiency.

Enabling acute care to be focused on patients with acute needs

71. Patients in Glasgow access acute emergency and unscheduled care services at two main hospitals sites – the Queen Elizabeth University Hospital in Govan and Glasgow Royal Infirmary at Townhead, and a minor injuries unit the Victoria. Patients expect a consistency of service irrespective of which site they access, and so variation in waiting times and throughput is an area we wish to explore further.

72. There is a need for fast access to investigation, diagnostic services and pharmacy services to shorten lengths of stay and prevent potentially avoidable admissions. We need also to optimise bed use given demand pressures generated by scheduled and unscheduled care needs, and delivery of waiting time targets. Implementation of the NHS Board’s unscheduled care improvement programme is key to this, and the following should contribute to delivering these improvements for patients.

Potentially avoidable admissions

73. There are a range of diagnoses that are recognised as potentially avoidable admissions. So if we can make improvements here over the life span of this plan, we can make significant reductions in acute bed days. From this analysis COPD accounts for 8% of admissions and 6% of bed days following an emergency admission. Congestive heart failure, influenza, pneumonia and diabetes complications also account for significant numbers.

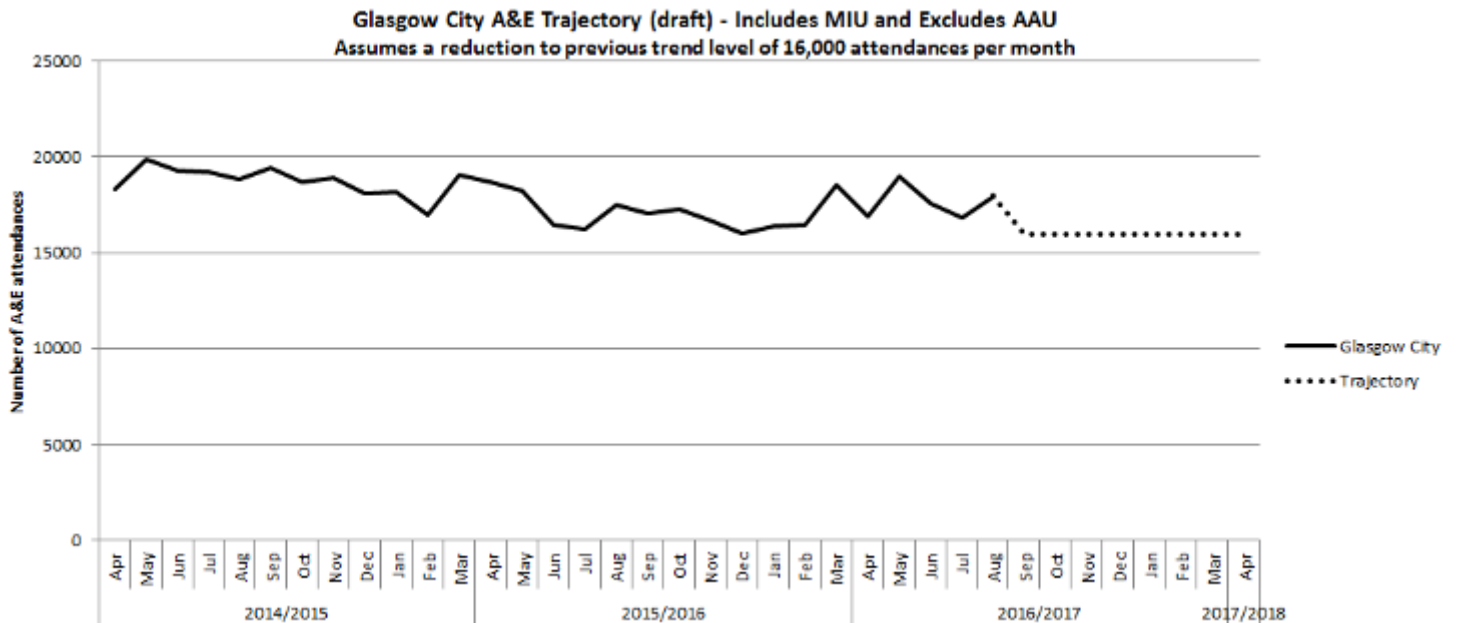
74. We will be working with primary care to share this data and consider what more might be done to achieve reductions in acute bed days.

A&E attendances

75. Recent trends in A&E attendances (see figure above 5), show that attendances have been declining although there have been recent changes in this trend. Various measures have contributed to this overall reduction in recent years including changes in primary care out of hours services, expanded role for community pharmacists, optometrists, and in acute the introduction of minor injuries units and acute assessment units. With these measures in place and other programmes aimed at reducing emergency admissions such as anticipatory care plans, and re-direction (see below) it is possible that this trend might continue although at some point it will bottom out.

76. In attempting to model this trend we have taken the latest full year data available (caution this is Greater Glasgow & Clyde data we don't have Glasgow City data at present) and applied this for the remainder of 2016/17 and into 2017/18 – figure 16. This shows a potential reduction in A&E activity from 17,500 per month in 2012/13 to approximately 16,000 attendances per month in 2017/18. Such a reduction in A&E attendances would assist in delivering the 4 hour waiting time target – see figure 4 above.

Figure 16 – Glasgow City A&E attendances projected 2014/15-2017/18



Re-direction

77. The accepted view is that there are a significant number of attendances at A&E who could be seen more appropriately in primary care. It is important therefore that we look at what can be done to re-direct patients safely and smoothly to primary care where we can.
78. We wish to work with acute clinicians to test re-direction arrangements at the QEUH and GRI so that emergency departments can focus on treating patients who need acute care. We will discuss with primary care how this might be done to ensure appointment slots are available timeously for patients re-directed from emergency departments. The impact of these arrangements we estimate will mean that a considerable number of patients who would have been seen in A&E are seen safely and appropriately in primary care.

Alternatives to admission

79. We need to look at potential alternatives to admission as the current system does not offer this to GPs – the only route for GPs at present is to refer patients to the acute assessment units. There are three measures we wish to test with acute clinicians to evaluate the impact on GP referrals and the acute system. These are:
- **GP access to consistent clinical advice:** to improve patient care and potentially to manage patients within the community would be the facility for GPs to obtain direct and timely consultant or senior clinical advice on individual patients' care. If such an arrangement was put in place this could potentially result in less GP referrals to hospital and avoid the transport and other arrangements that might need to be put in place for a patient to attend hospital. We would like to test such arrangements with acute clinicians at both the QEUH and the GRI so that within agreed parameters GPs are able to speak to a consultant or senior clinician to take advice about a patient's care. We could then evaluate this and assess its potential for wider application.
 - **GP direct access to diagnostics:** access to diagnostic tests are crucial in determining a patient's treatment and care plan. Currently GPs have to refer patients to acute assessment units for an acute clinician to then order the appropriate tests and review the results. If GPs had access directly to an agreed range of tests and the results, such as CT and MRI, with the facility to discuss the results with a senior acute clinician if appropriate, then patient's may not need to be referred and care and treatment managed within primary care. We wish to test this approach with acute diagnostics and evaluate its potential impact on GP referrals and acute activity.
 - **next day outpatient appointments:** GP direct access to next day out patient appointments, and links to transport, will provide GPs with another alternative to admission that should also result in a decrease in GP referrals to acute assessment units. Here we would be seeking the freeing up of an agreed number of appointments to allow GPs to book these direct instead of referring a patient to an assessment unit and potentially being admitted overnight. A small test of change to evaluate this should be set up involving acute clinicians on both sites.
 - **referral for assessment:** the ability for GPs to refer for assessment via SCI gateway with a view to preventing admission is another potential alternative that could be explored. We wish to set up a test to evaluate the potential for such a facility to be introduced across the city.

80. To assess the potential impact of providing GPs with alternatives to admission such as described above we can look at the current rate per 1,000 of GP referrals to accident and emergency units (see figure 17a), which shows that the rate in Glasgow is less than for the rest of the Health Board area. We would evaluate the impact of the above measures against the current trend. Figures 17(b) and (c) note the level of attendance at Acute Assessment Units – The detailed Glasgow City information is not yet available, so an assumption has been made of 60% of this being Glasgow City patients. A higher percentage of this activity is driven by GP referral and it is likely that alternatives to AAU would therefore yield a reduction in attendees and subsequent admissions.

Figure 17(a) – Rate of GP referrals to A&E – Glasgow City 2014/15-2016/17

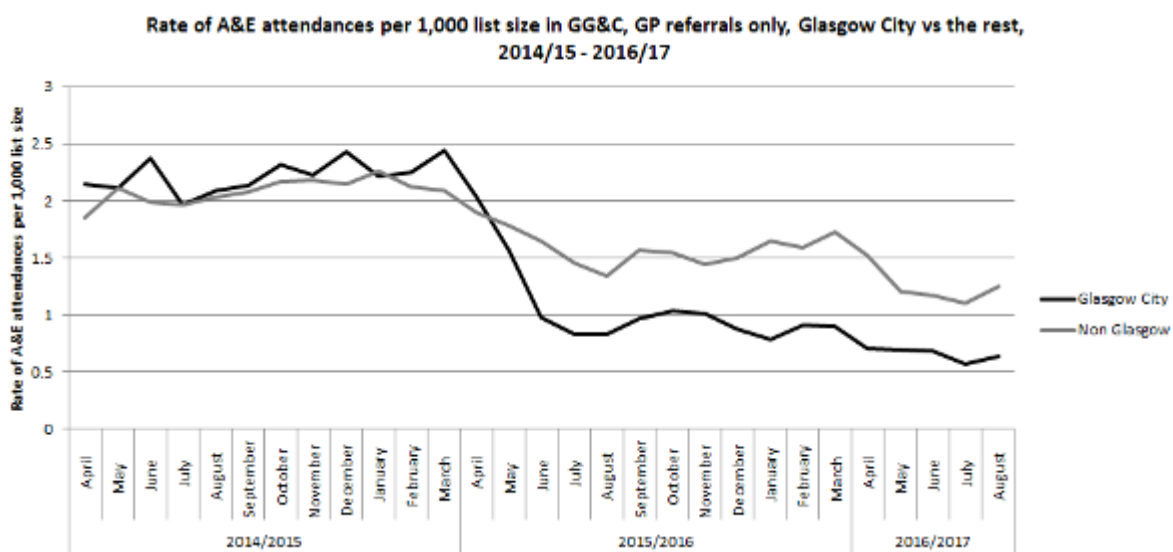


Figure 17(b) – Glasgow Royal Infirmary Assessment Unit Attendances (Glasgow City Activity Assumed as 60%)

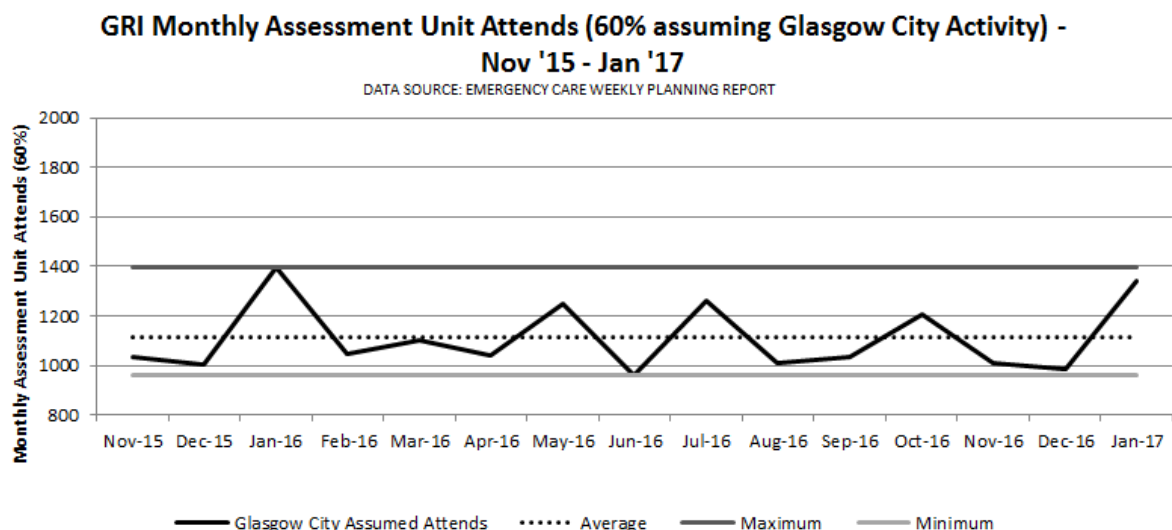
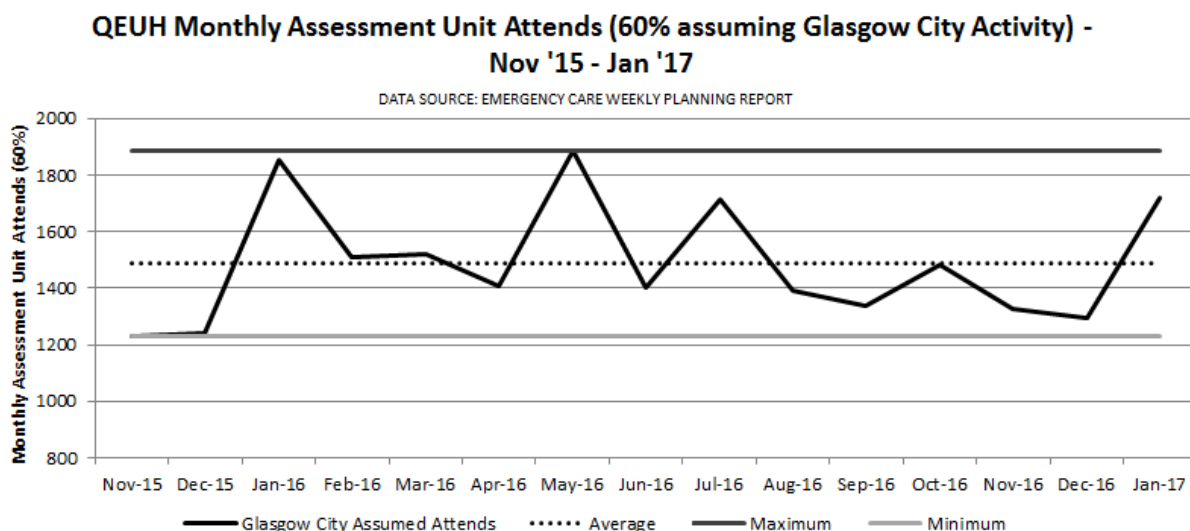


Figure 17(c) – Queen Elizabeth University Hospital Assessment Unit Attendances

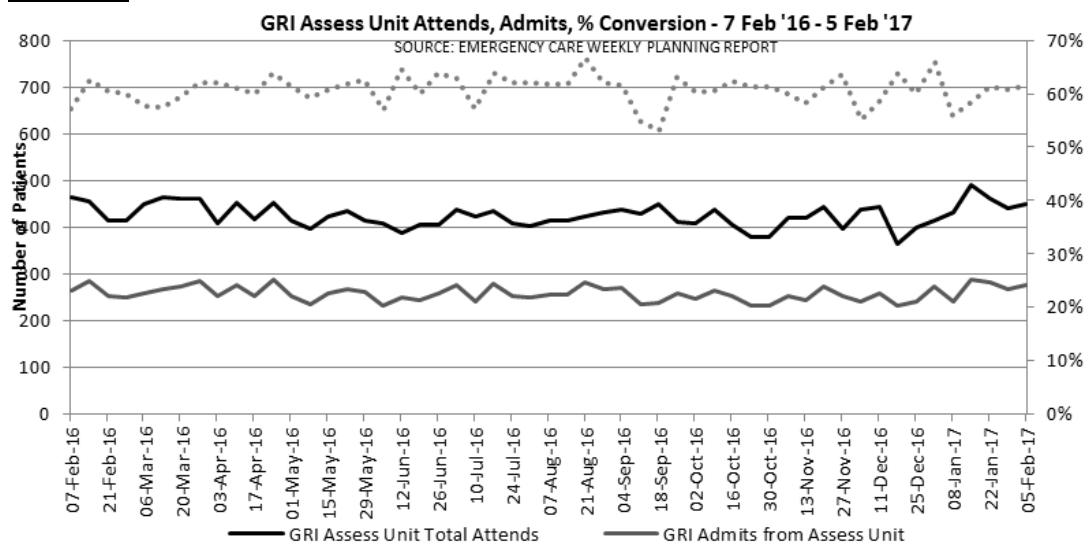
(Glasgow City Activity Assumed as 60%)

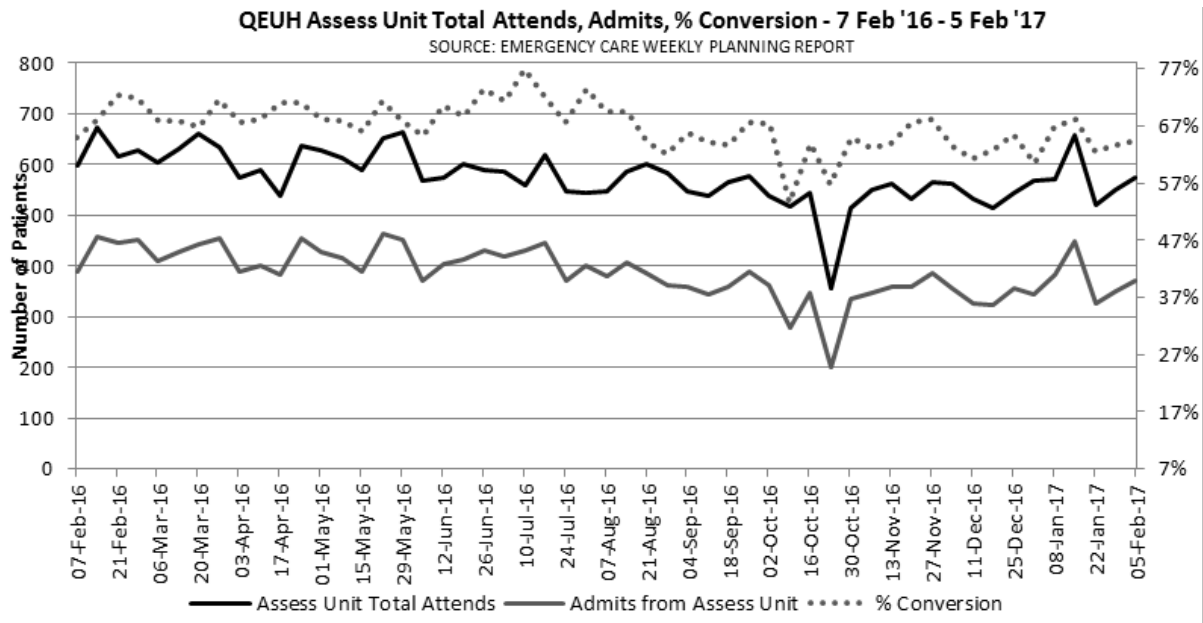


Admission / attendance ratio

81. There is currently a variation between the QEUH and the GRI in the ratio of those who attend acute assessment units as referred by GPs and those subsequently admitted (see figure 18 a & b). We wish to work with acute and GPs to improve this variation and improve the overall ratios. Providing alternatives to admission as described above will assist in achieving such improvements.

Figure 18 a & b – Acute Assessment Units’ ratio of attendance to admission for GRI (a) / QEUH (b)





Day of care survey

82. A Day of Care survey was carried out at the Royal Alexander Hospital, Paisley to provide an overview of in-patient bed utilisation at the hospital, Paisley. The survey involved 546 patients surveyed within a two hour period on one day in 2014. The results of the survey were that:

- 24% of in-patients did not meet survey criteria for acute hospital care;
- the main three reasons identified for patients not being discharged were:
 - awaiting social work allocation/assessment/completion of assessment;
 - awaiting consultant decision/review; or,
 - waiting for AHP assessment/treatment.
- According to the survey the most appropriate place of care for patients who did not meeting the survey’s criteria for acute care was:
 - for 51% it was a non-acute bed; and,
 - for 37 % home was assessed as the best place.
- the survey also found 74% of patients not meeting the criteria for acute care had a length of stay greater than 7 days, and 51% of patients had a length of stay greater than 14 days.

83. The audit also concluded that the older the patients were, the less likely they were to meet the criteria for acute care. So in extrapolating the results of this two hour survey for Greater Glasgow and Clyde as a whole the Board suggest the outcomes were that:

- 24% of all acute bed days do not meet acute hospital criteria;

- 50% of bed days in care of the elderly wards do not meet acute hospital criteria (many of these patients would require alternative provision for rehabilitation); and,
- 10-15% of bed days in non-care of the elderly wards do not meet acute hospital criteria.

84. We are keen to work with the NHS Board and the acute division to take forward the results of the RAH survey and assess the implications for the QEUH and the GRI. Our programme to improve discharge and our proposals to provide GPs with alternatives to admission should impact on these results going forward. We would wish to see an improvement in performance from current 24% of bed days not meeting the acute care criteria to 20% in 2017/18, and to 15% in 2018/19, and to 10% in 2019/20

Changes to address service pressures and inefficiencies

85. The NHS Board has developed an Unscheduled Care Improvement Programme to help meet the 95% unscheduled care compliance standard. A Programme of clinically led improvement work is being progressed, aligned to the national Six Essential Actions framework, to enable the Board consistently meet the national performance target going forward and deliver a better standard of unscheduled care to Greater Glasgow & Clyde. The key aspects of this programme are that:

- improvements to discharge rates in assessment units through scheduling of GP referral activity and alternatives to admission;
- improve earlier in the day discharge, reduce boarding and generate specialty capacity to facilitate movement in receiving units;
- Implement the full suite of ambulatory care pathways across all sites - stream patients away from assessment units unless there is deemed to be value added activity; and
- work with Primary Care to explore alternatives to admission.

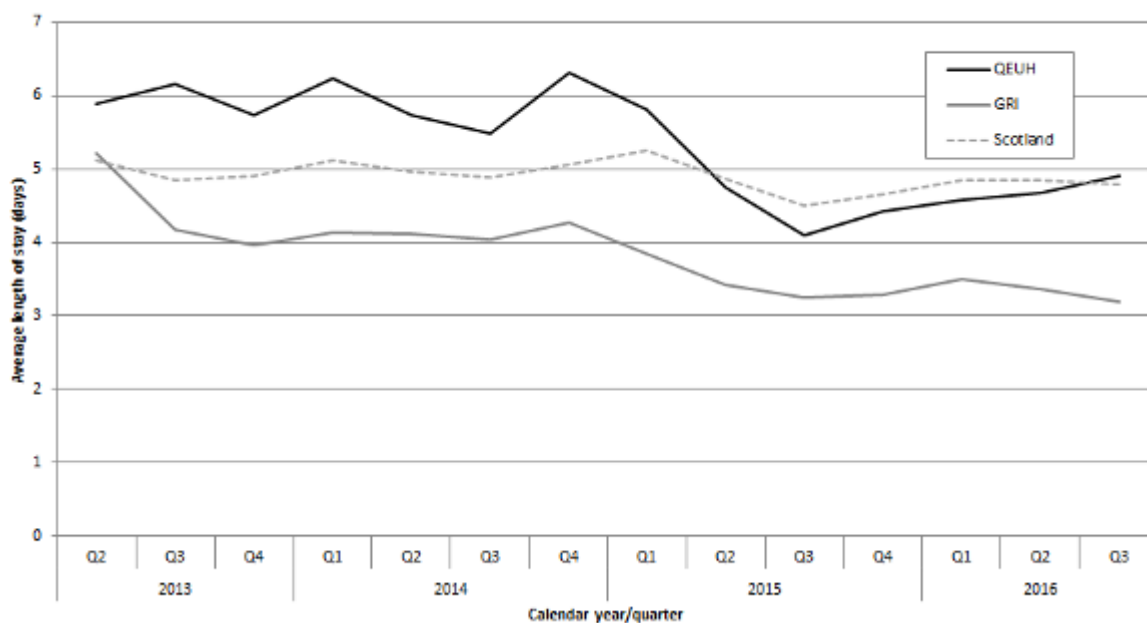
86. We will work with the Acute Division to take forward implementation of the Board's unscheduled care improvement programme through joint clinical leads in acute and primary care.

Length of stay

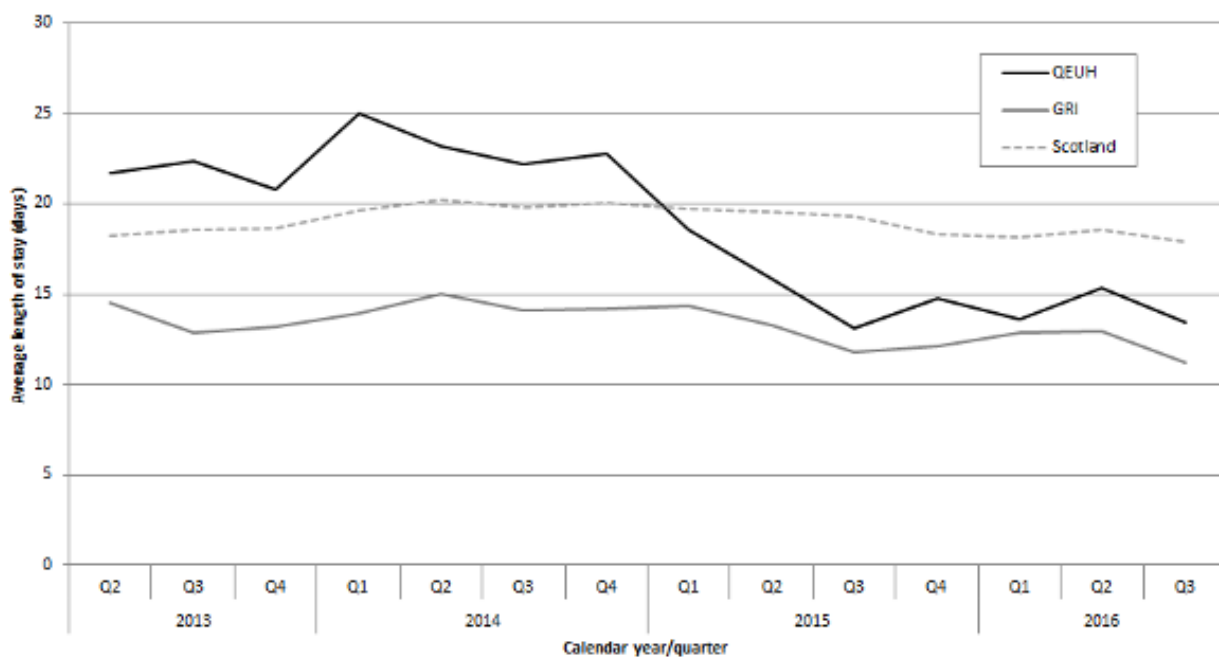
87. One area highlighted in the day of care survey that impacts on patient flow within the acute hospital system is the length of time patients spend in a hospital bed. There are variations in length of stay across specialties and hospital sites. When comparing Glasgow hospitals performance with others there is significant room for improvement (see figure 19 below).

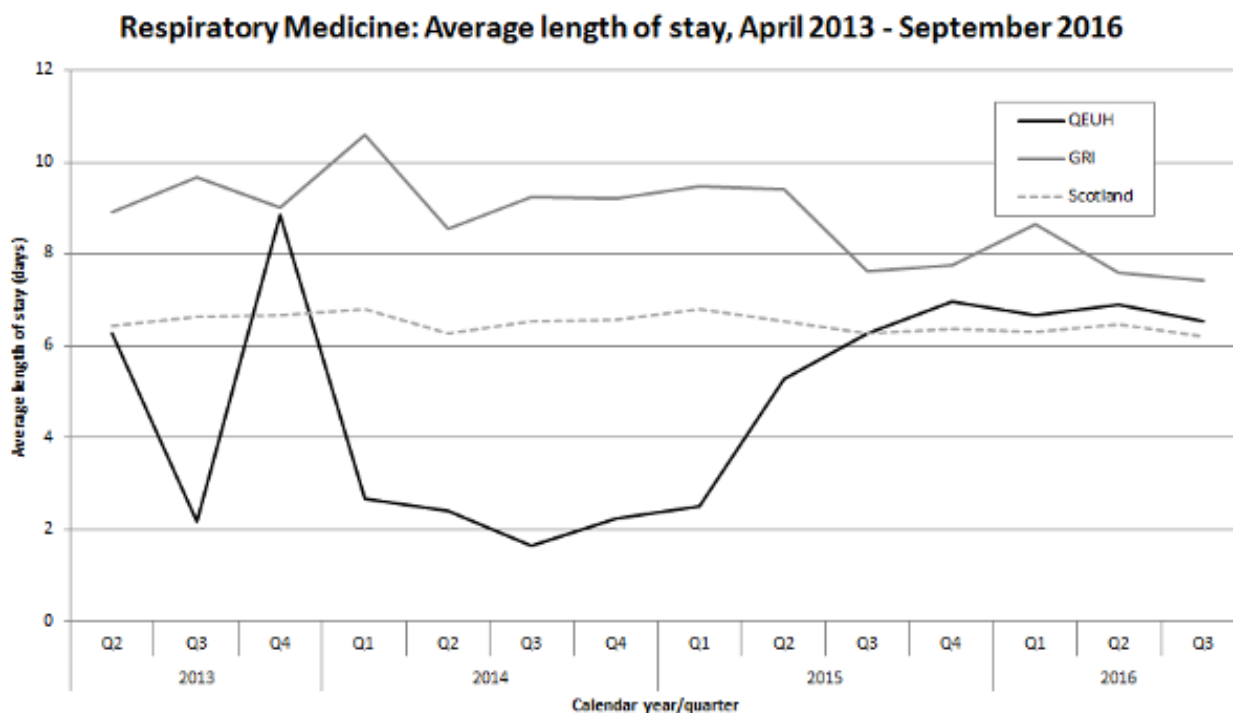
Figure 19 – length of stay by specialty by hospital compared with Scotland – General, Geriatric & Respiratory Medicine

General Medicine: Average length of stay, April 2013 - September 2016



Geriatric Medicine: Average length of stay, April 2013 - September 2016





Consultant geriatricians' community sessions

88. Consultant geriatricians currently undertaken a number of sessions in the community at a day hospital or other community setting. These sessions are important in supporting patients in the community after discharge or preventing potential future hospital admission, and providing integrated care with community based services including GPs. We would like to see more sessions provided in the community as part of developing an integrated approach to managing frailty within community settings working with the third and independent sectors, including housing. We will work with consultant geriatricians to explore the opportunities to take further steps to develop more integrated care pathways.

Summary

89. In this section we have outlined our priorities for change in the acute services to ensure patients receive the right care in the right location and at the right time. We have outlined proposals we would intend to test with acute to provide GPs with alternatives to admission, and where appropriate re-direct patients to primary care. There are also potential changes to be introduced following the day of care survey and reducing variation in length of stay that can yield further improvements in our health and care system.

Resources and financial framework

90. The resources that support the overall programme outlined in this draft plan are included in the Integration Joint Board's budget the details of which for 2017/18 are to be considered by the Board. That budget includes an element called the "set aside" budget for the commissioning of acute hospital services associated with the unscheduled care pathway. For 2016/17 the set aside budget is estimated as shown in table 7 below.

91. Over and above this, however, there remains work to be undertaken in relation to the resource release in the Acute system within this 'set aside' budget that arises as a consequence of the closure of beds (including the 150 highlighted above) that would be expected as a consequence of the actions identified, being delivered. This work necessarily includes agreement on the level of saving in financial terms that is able to be achieved to the system together with the level of resource shift to the HSCP with which to fund much of the initiatives identified on a sustainable basis.

Table 7 – Glasgow City estimated set aside budget 2014/15-2016/17

(see next page)

Comparison of 2016/17 Notional Set Aside Budgets with NRAC Share

	2013/14			2014/15			Average Activity £000	Average Activity			2014/15 £000	2015/16 £000	2016/17 £000	NRAC		NRAC £000
	Activity SMR Discharge	Activity OBD	A&E Attendanc es	Activity SMR Discharg	Activity OBD	A&E Attendanc es		Activity SMR Discharg	Activity OBD	A&E Attendanc es				%	£000	
Inpatients																
East Dunbartonshire	11,442	53,267		12,896	59,490		14,452	12,169	56,379		15,106	15,257	15,410	8.0089	14,869	(541)
East Renfrewshire	8,337	52,023		9,462	56,112		12,223	8,901	54,069		12,242	12,364	12,488	6.7413	12,515	27
Glasgow City	79,039	409,652		83,896	416,999		99,670	81,470	413,326		101,865	102,884	103,912	54.976	102,064	(1,849)
Inverclyde	10,277	62,135		10,504	61,284		15,896	10,393	61,709		13,836	13,974	14,114	7.2402	13,442	(672)
Renfrewshire	19,295	100,344		20,539	106,455		24,290	19,918	103,399		24,490	24,735	24,982	14.968	27,789	2,807
West Dunbartonshire	10,937	59,061		12,488	63,181		15,465	11,714	61,121		14,456	14,601	14,747	8.0656	14,974	227
	139,327	736,482	0	149,785	763,521	0	181,995	144,565	750,003	0	181,995	183,815	185,653	100	185,653	(0)
A&E Outpatients																
East Dunbartonshire			19,975			20,417	1,949			20,196	1,932	1,951	1,971	8.0089	2,417	446
East Renfrewshire			21,022			21,445	2,035			21,234	2,032	2,052	2,073	6.7413	2,034	(39)
Glasgow City			173,476			172,612	16,484			173,044	16,556	16,722	16,889	54.976	16,530	(299)
Inverclyde			23,458			24,191	2,315			23,825	2,279	2,302	2,325	7.2402	2,185	(140)
Renfrewshire			47,148			47,102	4,504			47,125	4,509	4,554	4,600	14.968	4,517	(83)
West Dunbartonshire			23,556			23,987	2,295			23,772	2,274	2,297	2,320	8.0656	2,434	114
	0	0	308,635	0	0	309,754	29,583	0	0	309,196	29,582	29,878	30,177	100	30,177	(0)
Total																
East Dunbartonshire	11,442	53,267	19,975	12,896	59,490	20,417	16,401	12,169	56,379	20,196	17,038	17,208	17,380	8.0089	17,286	(95)
East Renfrewshire	8,337	52,023	21,022	9,462	56,112	21,445	14,258	8,901	54,069	21,234	14,274	14,417	14,561	6.7413	14,550	(11)
Glasgow City	79,039	409,652	173,476	83,896	416,999	172,612	116,154	81,470	413,326	173,044	118,421	119,605	120,801	54.976	118,654	(2,148)
Inverclyde	10,277	62,135	23,458	10,504	61,284	24,191	18,210	10,393	61,709	23,825	16,115	16,276	16,439	7.2402	15,627	(812)
Renfrewshire	19,295	100,344	47,148	20,539	106,455	47,102	28,794	19,918	103,399	47,125	28,999	29,289	29,582	14.968	32,306	2,724
West Dunbartonshire	10,937	59,061	23,556	12,488	63,181	23,987	17,760	11,714	61,121	23,772	16,730	16,897	17,066	8.0656	17,408	342
Total Budget	139,327	736,482	308,635	149,785	763,521	309,754	211,577	144,565	750,003	309,196	211,577	213,693	215,830	100	215,830	0

Notes

- 1 2014/15 Notional Budget is based on the average of 2013/14 and 2014/15 activity
- 4 Cost based on PLICS applied to activity by ISD then reconciled to 2014/15 Cost Book
- 3 1% annual uplifts applied to 2014/15 budgets to derive 2016/17 budgets
- 4 NRAC shares for 2016/17 used as a comparison

91. The Scottish Government are in the process of reviewing the set aside budgets nationally and further information should be available later in 2017. Based on the current budget outlined in table 7, our assumptions are for the duration of this plan that this budget will increase by 1% over 2018/19 and 2019/20. The level of savings / efficiencies to be achieved has yet to be determined, and once this is agreed proposals will be brought back to the Integration Joint Board for consideration.

Implementation

92. This section to describe how we will take the plan forward, governance and oversight arrangements, timescales, leads, monitoring and evaluation

Targets and indicators

93. There are a number of targets and indicators that have been outlined in sections above that we will use to monitor our progress in delivering this plan. These are summarised in table 8 below. We will be reporting on these as part of our routine performance management arrangements

Table 8 – summary of key targets and indicators

Some areas of data subject to review - Some ISD data currently noting variance with local data			
Data Heading / Target / Source	Baseline	Current	Target
% Attendances Seen within 4 Hours			
Glasgow City (ISD)	91.6% (Jan-Dec 2016 average)	87.6% (Dec 2016)	95%
Glasgow Royal Infirmary (NHSGG&C Data)		85% (Feb 2017)	
Queen Elizabeth Hospital (NHSGG&C Data)		84% (Feb 2017)	
Reduce rate of A&E attendance per 100,000 population	2,284	2,303	
Reduce emergency bed days by 10% for all adults per 100,000 population *NB data under review	126,721		114,721
Reduce emergency bed days for over 75s per 1,000 population - * NB Data under review	5,619		
Reduce emergency admission rates for over 75s per 1,000 population - * NB Data Under Review	450		
Reduce total delayed discharges to 20 per month (inclusive of Under and Over 65 and AWI in acute beds) - From Weekly Report		56 (March 2017)	
Increase the percentage of those who die that spend the last six months at home or in a community setting	84%	84.9%	90% by 2019/20

94. Further targets and indicators will be added as the plan develops. For example we will include indicators on reduction in admissions to hospital from care homes.

Governance

95. The development of this plan has been overseen by the Partnership's unscheduled care planning group reporting into the older people's strategic planning group. The work has also involved the Partnership's primary care strategy group, and core

leadership teams and planning groups for adults and older people. The development of the plan has also been progressed with the other Health and Social Care Partnerships in Greater Glasgow & Clyde.

96. It is recognised that the next stage will need to involve wider partners, in particular primary care and secondary care clinicians. This process is currently under discussion as this will need to link closely with the Board's existing unscheduled care programme and the transforming delivery of acute services programme.
97. In the meantime oversight and governance of the delivery of this plan will be undertaken by the Partnership's unscheduled care planning group.

Evaluation

98. Key also to the success of this plan will be robust evaluation arrangements using small tests of change take forward the proposals in the key priorities section above. An evaluation framework will be developed to assess the impact of the proposed changes and the benefits derived. Work on this is in hand and will be reported later.

Action plans

99. Implementation of the plan will be underpinned by action plans identifying leads, timescales, key targets and deliverables and reporting and evaluation methods. Oversight of the programme once agreed will be undertaken by the unscheduled care planning group (see Appendix 2 - USC Action Plan).

Acute Commissioning Intentions**Proposed Common Directions from all six GGC IJBs @ 24th February 2017**

Note:

- This suite of (initial) actions have been framed on the basis that there is a shared acknowledgement of the joint responsibilities across Acute Services, Primary Care and HSCPs to effect change.
- This suite of actions will be augmented by locally-defined HSCP specific and (proposed) primary care actions.

Communication - acute and community services

- Establish mechanisms whereby GPs can access advice from senior acute medical staff pre-admission relating to the need for admission and/or options other than admission (e.g. potential hot clinics).
- Establish a consistent system whereby HSCPs are alerted by acute services, at the point of admission, of all patients already identified as at risk of unnecessary admission.

Unplanned admissions

- HSCPs and acute services will identify a joint scoring matrix for identifying patients at risk of unnecessary admission.
- Establish GP access to a range of options for patients at the point of pre-admission, for example urgent next day outpatient appointment by speciality and direct access to diagnostics.
- Review and optimise admissions pathways across acute sites with a view to reduce inappropriate variation.

Occupied bed days for unscheduled care

- Acute Services to demonstrate progress in working towards delivering the externally benchmarked upper quartile length of stay across all sites and specialties.
- Optimise discharge processes across all sites and specialties to create an earlier in the day discharge profile and increase weekend discharges.

A&E performance

- Create and implement redirection pathway back to minor injury units and primary care.. (Note: recognise that HSCPs need to agree with GP Quality Clusters and/or LMC [via Primary Care Support] a process for seeing redirected patients).
- Review the balance of staffing in A&E departments to ensure that frail older patients have speedy access to appropriate clinical support and imaging and investigations.
- Establish a process whereby GPs are able to access agreed imaging investigations to support diagnosis and decision-making.

Delayed discharges

- Establish a system whereby community staff, SSA and acute clinicians routinely use anticipatory care plans and the summary recorded on ekiss as part of assessment process to avoid admission and to expedite discharge.
- Strengthen discharge planning between acute discharge planning and community hospital teams including rehabilitation communication.

End of life care

- Establish a consistent system in place whereby HSCPs are given early notice by acute services of patients who require end of life care.

Balance of Spend - for both HSCP and Acute

- Acute services to review and ensure effective medicines management at point of admission and discharge.
- Agree a way of working between acute sites and all six HSCP community services through which a proportion of set aside budgets is used to support development of interface services out-with acute sites.

APPENDIX 2 – DRAFT WHOLE SYSTEM UNSCHEDULED CARE ACTION PLAN

This appendix presents by theme a summary of the specific actions detailed in the body of this plan; which part of the whole system will lead the delivery of said actions; the patient/ service benefit; the measures of impact that will be applied; the risks associated each action; the projected cost/ benefits; and, the timescales for delivery.

There is a recognition that not every action in this plan will deliver what is expected at this stage of development of the whole system approach to improving unscheduled care performance and permission is sought to apply a tests of change approach that has worked well in other complex change programmes. Where specific actions prove ineffective the action plan will be adjusted accordingly over time.

It follows that the identified targets and projected cost/ benefits remain indicative at this stage of the process and those will become more robust and updated as the action plan is implemented.

As per the table below, measures/ targets are applied against each individual action, but at the whole system level their cumulative impact is intended to deliver a reduction in the 150 above capacity beds in the Acute system on the following timescales:

Reduce to 120 – April 2018

Reduce to 90 – October 2018

Reduce to 60 – April 2019

Reduce to 30 – October 2019

Reduce to 0 – April 2020

These timescales align with the three-year scope of the Plan to 2020 and recognise lead-in times for anticipated system impact.

Area	Action	Workplan	Patient / Service Benefit	Measure	Risk	Anticipated Cost/ Benefit	Timescale
Reduction in Care Home Admissions	1. Acute to agree recording mechanism to enable consistent identification	Acute	Reporting of care home admissions	Data Set created and reported			June 2017

	<p>of any attenders from Care or Residential home</p> <p>2. Targeted support to Nursing and Residential homes (purchased and provided), including access to anticipatory care planning/ support from care home liaison service and falls team.</p>	HSCP	Fewer residents subject to the distress and upheaval of avoidable hospital admissions.	Reduce A&E presentations from care homes by 10% in each year of this Plan; i.e. a cumulative reduction of c30% by 2020.	Capacity of primary care to meet additional demand.		Ongoing over lifespan of plan
Redirection	<p>1. Devise and implement re-direction from A&E policy for non-urgent cases that are assessed as appropriate for GP to see next day or later.</p> <p>2. Communicate widely to general public as part of communications / media strategy.</p> <p>3. Create GP capacity to absorb re-directed demand – which will include the displacement of some existing GP activity to other parts of the health and care</p>	<p>Acute</p> <p>Joint Acute/ HSCP</p> <p>HSCP</p>		Reduce admissions following A&E assessment by 5% per annum – c15% by 2020	<p>Potential growth in complaints</p> <p>Clinical risk</p> <p>GPs' ability & tolerance to meet this demand.</p>		<p>Potential roll out by Acute site – to be completed by March 2018</p> <p>In place for Winter 2017</p> <p>Ongoing over lifespan of plan</p>

	<p>system.</p> <p>4. Optimise the impact of closer links between neighbourhood teams and resources with GPs to reduce onward referrals to A&E.</p>						October 2017
Alternatives to Assessment Unit/ A&E	<p>1. Create capacity and process for same day or next day emergency out-patient slots for assessment as alternative to A&E examination.</p>	Acute	Maintain person at home	Reduce A&E assessments by 10% per annum – c30% by 2020.	Insufficient transport availability.		Roll out by site/ speciality (eg respiratory or cardiology) Fully implement by June 2018
	<p>2. Establish system for planned and emergency access to consultant specialist advice for GPs as an alternative to A&E.</p>	Joint Acute/ HSCP/ clinical leads	More robust clinical decision making within primary care	Reduce A&E referrals from GPs by 10% per annum – c30% by 2020.	Insufficient consultant capacity		Roll out by speciality, concluding by 2020 Begin with geriatric medicine - conclude by October 2017
	<p>3. Establish system of GP</p>	Joint HSCP/ Acute/ clinical		Reduce GP			October 2017

	<p>access to urgent diagnostic tests (eg bloods) as an alternative to A&E referral for the same purpose.</p> <p>4. GP rapid access to community supports as alternative to A&E referrals and/ or pending planned outpatient appointments.</p>	<p>leads</p> <p>HSCP</p>	<p>Support person and carers at home to avoid admission</p>	<p>referrals to A&E for diagnostic tests by 10% per annum – c30% by 2020.</p> <p>Contributor to reduced GP referrals to A&E of 10% per annum identified above.</p>	<p>Diagnostic services' capability to meet demand.</p> <p>Capacity of community services to timeously respond to demand given resource pressures – particularly out of hours.</p>		<p>Cordia/ home care – October 2017</p> <p>Full range of community health/ third sector services by 2020.</p>
<p>Alternatives to admission</p>	<p>1. System-wide provision of step-up intermediate care capacity.</p> <p>2. Roll out of COPD/ respiratory support service</p>	<p>HSCP with support from Acute geriatricians</p> <p>HSCP</p>	<p>Short term support to avoid hospital admission</p> <p>Access to specialist support</p>	<p>Contributor to reduced GP referrals to A&E of 10% per annum identified above.</p> <p>Reduce the number of respiratory-related presentations to</p>	<p>Clinical confidence in model.</p> <p>Clinical capacity to support model.</p> <p>Governance around communication / prescriptions /</p>		<p>October 2017</p>

	<p>3. Revised model of assessment at home by Scottish Ambulance Service</p> <p>4. Enhanced transport such as Red Cross model to provide access to specialist outpatient services / discharge</p>	<p>SAS/ HSCP with support from Acute</p> <p>HSCP / Acute</p>	<p>Ease of access to get to and from hospital with reduced reliance on SAS</p>	<p>A&E by 10% per annum – c30% by 2020.</p> <p>Reduced SAS transfers of A&E of 10% per annum from 2018 – c20% by 2020</p> <p>Contributor to reduced SAS transfers reference above</p>	<p>discharge / criteria for use.</p>	<p>April 2018</p> <p>October 2017</p>
<p>Reduced admissions from identified potentially preventable admissions</p>	<p>1. Review frailty data and cases to identify and target specific conditions</p> <p>2. Target individuals diagnosed with conditions to ensure anticipatory/</p>	<p>HSCP</p> <p>HSCP/ GPs</p>		<p>Contributor to reduced GP referrals to A&E of 10% per annum identified above.</p> <p>Meet HSCP specified performance</p>		<p>August 2017</p> <p>April 2017 onwards</p>

	<p>emergency plans in place</p> <p>3. Develop care pathway for conditions where patient is stable and does not require admission</p> <p>4. More effective use of palliative care pathway and resources (including Marie Curie managed care and fast track services) to minimise hospital admission, accelerate discharge and provide effective support in the community</p>	<p>HSCP</p> <p>HSCP</p>		<p>targets for anticipatory care plans.</p> <p>Reduce the current number of people dying in hospital by 25% by 2020</p>			<p>April 2018</p>
Reduction of available	1. Phased closure programme of above	Acute		Reduce to 120 – April 2018	Whilst beds remain open		Progressive reduction from

admission beds	capacity (150) beds.			Reduce to 90 – October 2018 Reduce to 60 – April 2019 Reduce to 30 – October 2019 Reduce to 0 – April 2020	admission thresholds adjust to ensure always full. Political tolerance for (temporary) reduced A&E 4 hour target performance		April 2018
Raising awareness, managing expectations and changing behaviours	<ol style="list-style-type: none"> Local and national campaign to increase awareness of function of ED and other unplanned services and also access to alternative services such as pharmacy / Optician. Practice level communication with patients to make them aware of local services and what may happen if they attend A&E or require urgent appointments. 	Board / HSCPs	Clarity of what services are available		Community capacity Delays and compliance with diagnostic and follow up		
Day of Care Audit – Measure of	<ol style="list-style-type: none"> Undertake a programme of audits 	Acute		Reduce % of inpatients			From April 2018

acuity in acute hospital	and review with clinical staff to identify patients who could be discharged to have diagnostic or follow up by specialist out-patient or via GP			assessed as non-acute from current 24% to: 20% by April 2018 15% by April 2019 10% by April 2020			
ALOS in Acute hospitals post-admission	1. Programme of improvement in ALOS performance across medical specialisms.	Acute		Reduce ALOS by 10% per annum from 2018 – c20% by 2020. Contributor to reduced beds capacity referenced above.			From 2017, with priority given to Geriatric, Respiratory and General Medicine.
Delayed Discharges	1. Reduce delayed discharges through a range of approaches, including utilising former continuing care resources transferring to HSCP management from Acute; and, ensuring the most effective interface between the HSCP Home is Best and Acute	HSCP/ Acute		20 for Glasgow City.	Complex (particularly under 65) and AWI delays undermine overall performance/ consume significant bed days.		March 2017

	Discharge teams.						
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