Introduction and Welcome

Jennifer Armstrong
NHSGGC Medical Director
The Three Horizons: Developing a sustainable and high quality NHS

Horizon 1
Present Day: Maintain and Continuous Improvement

Horizon 2
2-5 Years: Implement Innovation and emerging opportunities

Horizon 3
5+ Years: Transformative Change – building on Horizon 2 and future opportunities

Adapted from McKinsey and Co
Whole System
Moving Forward Together

GGC Health and Social Care
Transformation Programme

30th January Programme Update
David Stewart
Moving Forward Together Progress Update

- Our Approach
- Our Phases
- The Tiered Framework
- Service Modelling Progress Report
- Emerging Themes
- Next steps
Our MFT Approach

- Aligned to National Strategic Direction
- Concordant and complementary to WOS Programme
- A whole system programme across health and social care
- Using the knowledge and experience of our wide network of expert service delivery and management teams
- Engaging with and listening to our staff and working in partnership
- Involving our services users patients and carers as early as possible
- Embracing technology and the opportunities of e-health
- Looking beyond today’s constraints for tomorrow’s solutions
WOS Programme Key Messages

• This is a unique opportunity to come together across the organisational boundaries of 15 IJBs, 16 Local Authorities, 5 Territorials Boards, 3 National Boards
• There has been lots of individual organisation progress but there is a compelling case for change in the region
• We are united as a region in a common purpose to address this case for change, with different levels of planning and delivery to meet this purpose at national, regional and local levels
• We are exploring a stratified model for local and acute care in order to implement evidence-based care and make best use of existing workforce, estates and financial resources
• Submit draft WOS Report on 1 March 2018
PHASE ONE – October to November 2017 COMPLETE

- Review the current range of relevant National and Regional Strategic Documents;
- Review the outputs of the GGC Clinical Services Strategy for comparison with National and Regional Guidance to create and amalgamated set of principles on which Transformation Strategy will be based
- Obtain mandate via NHSGGC Board Approval and IJB endorsement via a comprehensive Transformation Programme Paper
- Update the predictions on population changes to develop a demand picture up to 2025
- Review and quantify the impact of the delivery of the IJB strategic plans and commissioning intentions
- Carry out a stakeholder analysis and develop engagement plan
Moving Forward Together: Cathedral of Care

By 2020, everyone is able to live longer, healthier lives at home, or in a homely setting.

- Integrated Health and Social Care
- Prevention Anticipation Supported Self Care
- Home/community or day case care versus inpatient

Better Health
- Look after and improve their own health
- Live in good health for longer
- Able to live independently and at home or in a homely setting in their community
- Have positive experiences of those services, and have their dignity respected
- Care is centred on helping to maintain or improve the quality of life of people
- Services contribute to reducing health inequalities
- Unpaid carers are supported to look after their own health and wellbeing and to reduce any negative impact of caring
- Service users are safe from harm
- Our staff feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Resources are used effectively and efficiently

Better Care
Better Value

Quality
Safe
Patient Centred
Effective
MFT: Programme Road Map

PHASE TWO December 2017 to February 2018 ONGOING

• Prepare the Phase 1 principles framework, case for change, care stratification model and evidence base to enable a structured discussion with small clinical groups from and then across primary community secondary and tertiary care.

• Commission specialty groups to review Phase 1 predicted service demand and produce proposals for future service requirements, the impact of which can be modelled.

• With clinical groups produce a matrix of stratified clinical interdependencies for each service which will inform options development and a plan for enabling changes and/or supporting services which are required to sustain the new service models.
Tiered Service Population Approach

• To develop and agree a **tiered level of service delivery** and supporting infrastructure which is characterised by:
  – In the upper tiers; the need for **complexity and higher acuity** services with relatively low incidence to be **provided for a population** at the minimum number of locations commensurate with the size of population served
  – In the lower tiers; the need for **low complexity and lower acuity** services to be provided **at home or as close to home** as possible

• Carrying this approach **through the entire health and social care system** across primary, community and social care into acute scheduled and unscheduled care.
GGC Working Unscheduled Care Tiers (V3)

- **Tier 1**
  - Major Trauma Centre
  - Population Base: 2-3M
  - Service Model: 24/7 Access to major trauma services

- **Tier 2**
  - Trauma Unit
  - Population Base: 400-600K
  - Service Model: 24/7 access to the full range of emergency services below that only provided in the MTC

- **Tier 3**
  - Local Emergency Hospital
  - Population Base: 100-200K
  - Service Model: Consultant led A&E with access to a range of emergency services and transfer arrangements to MTU and MTC

- **Tier 4**
  - Emergency Care Centre
  - Population Base: 50-100K
  - Service Model: GP led emergency care centre with access to a range of assessment and treatment services and transfer arrangements to MTU and MTC

- **Tier 5**: Community Based Services

**TIER 1**
24/7 access consultant delivered A&E, Neurosciences, Cardiothoracic, Hyper Acute Stroke, Vascular. Full range of emergency surgery and acute Medicine. Full range of support services, ITU/HDU etc.

**TIER 2**
24/7 access. Moving towards 24x7 consultant delivered A&E, Full range of emergency surgery and acute medicine, Full range of support services, ITU/HDU, CGA and assessment beds. Access to intermediate care network.

**TIER 3**
Front door services with Acute medicine. No onsite emergency surgery. Access to critical care/HDU and surgical opinion via network, Outpatients and diagnostics.

**TIER 4**
18/7 Access GP-led urgent care incorporating OOH. GP and community based services. Access to community based step up/step down beds possibly with 48 hour assessment unit. Outpatients and diagnostics.
Tiered Service Population Approach Methodology

- **Step One - Top down approach**
  - With wide clinical engagement
    - Sharing **tiered approach** with service modelling groups

- **Step Two - Bottom up approach**
  - Working tiers used as a basis for primary care, community service, social work and acute **specialty level engagement** to develop tier stratified services

- **Step Three - Joined up approach**
  - Infrastructure allocated to tiers and services aligned into infrastructure
  - Population access to tiered services correlated for each HSCP locality
  - Revision of allocated infrastructure where identification of gaps in infrastructure as required
Phase Two Process

- **Establish a series of cross system specialty based groups**
  - Virtual groups brought together for a single physical meeting in this Phase
    - Acute clinicians nurses and AHPs
    - GPs
    - Community nurses and AHPs
    - HSCP Heads of Service
    - Acute and HSCP Planning
    - Public Health
    - E-health

- **Issue preparation materials ahead of the meeting**
  - Results of global literature search on new or alternative models
  - Activity projection using synthetic estimates based on demographic change
  - Briefing on the tiered approach to service planning
  - Survey issued to all group members based on preparation material

- **HSCP Locality Level Meetings in each area**
Phase Two Service Modelling Groups

**Already met**
- Cardiology
- Endocrine/Diabetes
- ENT
- Gastroenterology
- General Surgery
- Geriatrics
- Respiratory
- Rheumatology
- Orthopaedics
- Urology
- Haemato-oncology
- Breast Cancer
- Dermatology
- Glasgow HSCP
- Vascular
- Diagnostics

- Urological Cancer
- Gynaecological Cancer
- Upper GI Cancer
- West Dun HSCP
- Renfrewshire HSCP
- ACH OOH Model Group

**Scheduled**
- East Dun HSCP
- East Renfrewshire HSCP
- Inverclyde HSCP
- Colorectal Cancer
- Lung Cancer
- Head and Neck Cancer
- Critical Care
- Palliative Care
- Infectious Diseases
- Tier 3/4 Unscheduled Care
Phase 2 so far; emerging themes

• Tier 4/D services
  – All specialty groups have identified service provision that could be moved from the hospital base to local or community delivery models
  – Each specialty groups have identified a need for more and better supported specialist nurses and AHPs to deliver this transformation
  – Models could be based on physical community or local assets or virtual teams with no fixed infrastructure
  – Support links into the acute consultant body and also into GP clusters enhance this model and are enabled by e-health solutions

• Access to Comprehensive Records and Improved Cross Sector Communication
  – This has long been a desire but now there are e-health solutions that can make this a reality
Phase 2 so far; emerging themes

• **Working to the top of a licence**
  – All specialty groups have identified service provision that could be done by more appropriately qualified staff which would allow each practitioner to spend more time doing only the work that they can do

• **Cross System Team Working**
  – Many of the specialty groups have already shown areas of good cross system working but there is a real enthusiasm that this could be expanded and rolled out to be universal practice
Phase 2 so far; emerging themes

• **The opportunities of integration**
  – Most of the specialty groups felt that the gap between primary community and acute service delivery had closed and that the transformational programme was an opportunity to bring about a much more integrated health and social care system.

• **Developing ‘generalism’**
  – Multi-morbidity and frailty driving a recognition of the need to support and develop generalist approaches both in hospital and in community, and to have clear structures and governance for how generalist and specialist services interact.
MFT: Programme Road Map Next Steps

PHASE THREE March to April 2018

• Review current **WOS planning and other Health Board** strategic intentions and assess the impact on GGC options

• Review all the work of Phase 1 and 2 and adjacent relevant workstreams to **develop a description of new service models** or options across Health and Social Care

• Describe the required changes, supporting and enabling work to support **future outline delivery plans** with options where relevant

• Use this basis to prepare an **outline of the strategic plan** with options to be discussed during the **wider clinical and public engagement** programme through an **open and transparent effective dialogue** process supported by a series of wide ranging conversations
Transforming Care with E-Health and Technology

William Edwards, Director of eHealth
Dr Andy Winter, eHealth joint Clinical Lead
Vision

• Technology as an enabler for transformational change
• Innovative and ambitious solutions supporting service change
• Maximise opportunities for collaborative working regardless of organisational boundaries or settings
• Enabling citizens to become active in their healthcare through the use of digital tools and access and contribute to their health and care information
eHealth Themes

**Requirement**

1. Access to comprehensive patient records for those that need to see
2. Improved pathways
   - Support workflows across tiers and MDTs, Dashboards.
   - Clinical dialogue, Anticipatory Care Plans
3. Virtual clinics, telemedicine / remote consultations, home diagnostics/wearables
4. Self management, patient-held records, signposting
5. Clinical decision support, cohorts, safety nets, genetics and precision medicine
6. Safer use of medicines, HEPMA, Care Assurance, support efficiency and sustainability, safe systems

**Theme**

1. Electronic Patient Record
2. Supporting Workflow & Teams
3. Remote Monitoring
4. Patient Self Care
5. Clinical Informatics
6. Efficiency & Safety
Electronic Patient Record

- Access to comprehensive patient records for those that need to see
- Clinical Portal
  - An electronic system which allows clinicians and health professionals to view a patient’s clinical record
  - Underpinned and fed by a range of technologies
  - Integrated with >30 other systems
  - Over 12,000 front line level clinical users, 10yrs clinical data
  - West of Scotland Portal to Portal allowing sharing of patient records with clinicians caring for the patient across the region
  - Covers over 2 million residents
Electronic Patient Record

**View**
- Clinical Documents
- Appointments
- Worklists, ECS, KIS
- PMS
- Letters
- Scanned Documents
- Diagnostic orders
- Results

**Capture & Share**
- Workflow
- Pathways, Alerts, ACPs
- Allergies, Problem Lists
- Medicines Reconciliation
- IDL
- eForms
- Guidance

**West of Scotland Portal to Portal**
Launch clinical systems

**Connect**

**Primary Care**

**Acute Services**

**Community Services**

**Social Care**
Patient Self Care – NHS Scotland Digital Strategy

I maintain and **improve** my health and wellbeing through access to digital information, tools and services

I expect **service staff** and **carers** to **improve** my health and wellbeing by **using** and **sharing** my digital health and social care information securely

I also expect that my **digital information** will be used appropriately to **plan** and **improve services** and to help improve the health and wellbeing of others.
Patient – Health Technology (Tec)

Remote Monitoring

Moving Forward Together.
Welcome to Scotland’s Health and Social Care Portal
Take control of your healthcare

Welcome to the portal. Manage your appointments, correspondence, complete forms, and view your care details.

Register  Sign in
Patient Portal – Manage appointments

Your forthcoming appointments

Last updated on Friday, January 12, 2018 at 1:11 PM

Your forthcoming appointment activity is detailed below. Please respond if required.

Monday 15th January 2018
13:40 at Royal Alexandra Hospital
Mr Rashid Abu-rajab - Orthopaedics
I have confirmed that I will attend

Friday 19th January 2018
14:30 at Royal Alexandra Hospital
Mr Zak Latif - Urology
I have requested a change of date/time

Friday 19th January 2018
15:30 at Royal Alexandra Hospital
Dr Ken Lai - Ophthalmology
You have received a new appointment request
Welcome to Scotland’s Health and Social Care Portal
Take control of your healthcare

Welcome to the portal. Manage your appointments, correspondence, complete forms, and view your care details.

Moving Forward Together.

Patient Portal

Your forthcoming appointments

Last updated on Friday, January 12, 2018 at 12:45 PM

Your forthcoming appointment activity is detailed below. Please respond if required.

Monday 15th January 2018
13:40 at Royal Alexandra Hospital
Mr Rashid Abu-rajab - Orthopaedics

I have confirmed that I will attend

Change

Friday 19th January 2018
14:30 at Royal Alexandra Hospital
Mr Zak Latif - Urology

I have requested a change of date/time
Supporting Workflow & Teams

- TIER A
- TIER B
- TIER C
- TIER D
- Home

DATA

Moving Forward Together.
Example: a common medicines list
Supporting Workflow & Teams

TIER A

TIER B

TIER C

TIER D

Home

‘Advice’ Referrals

Clinical Dialogue

e-Workflow between sectors / silos

Convergence of systems?
Supporting Workflow & Teams

TIER A

TIER B

TIER C

TIER D

Home

‘Virtual’ clinics / MDT support

Condition ‘dashboards’
### Parkinson's Current Inpatients

#### Time Elapsed Since Admission

<table>
<thead>
<tr>
<th>Hospital</th>
<th>7 Days or Less</th>
<th>8 to 14 Days</th>
<th>Over 14 Days</th>
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<tbody>
<tr>
<td>Glasgow Royal Infirmary</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Queen Elizabeth University Hospital</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Royal Alexandra</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Garnethill General Hospital</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Greenfield Park</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Lightburn Hospital</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Mearenskirk Hospital</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Parkhead Hospital</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rowantree Home</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Stobhill Hospital</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>6</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

#### Current Admissions by Hospital

- **Garnethill General Hospital**: 6 admissions
- **Glasgow Royal Infirmary**: 6 admissions
- **Greenfield Park**: 1 admission
- **Lightburn Hospital**: 4 admissions
- **Mearenskirk Hospital**: 1 admission
- **Parkhead Hospital**: 1 admission
- **Queen Elizabeth University Hospital**: 12 admissions
- **Rowantree Home**: 2 admissions
- **Royal Alexandra Hospital**: 3 admissions
- **Stobhill Hospital**: 4 admissions

### Current Inpatient Breakdown

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ward</th>
<th>Consultant</th>
<th>CHI</th>
<th>Patient</th>
<th>Admission Date</th>
<th>Days Since Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedics</td>
<td>QEUH Ward 10C</td>
<td>Mr Andrew Marsh</td>
<td></td>
<td></td>
<td>09/01/2018</td>
<td>1</td>
</tr>
<tr>
<td>General Medicine</td>
<td>QEUH Ward 6A</td>
<td>Dr Ronald Seaton</td>
<td></td>
<td></td>
<td>09/01/2018</td>
<td>1</td>
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<tr>
<td></td>
<td>RAH 6 Geriatric Medicine</td>
<td>Dr Iain Keith</td>
<td></td>
<td></td>
<td>09/01/2018</td>
<td>1</td>
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<tr>
<td>Orthopaedics</td>
<td>GRI Ward 61 Orthopaedics</td>
<td>Mr Martin Davison</td>
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<td>08/01/2018</td>
<td>2</td>
</tr>
</tbody>
</table>
Patient self-care & remote monitoring

‘Wearables’

On-line tools

Anticipatory care
Making sense of it all

Clinical Informatics

DATA -> FACTS
Questions

• In terms of **transformational opportunities**; what opportunities do advances in e-health and technology offer?

• What are the **three top priority changes** which we should be securing?
Transformation of Older People’s Services

Susanne Millar, Morven McElroy, Richard Groden
Introduction

• Context of MFT
• Examples of achievements so far
• Potential further areas of transformation
• Reflections on features of successful Transformation
HSCPs Transformation Programme – Older People

- All aspects of health and care system subject to change
- Residential and Day Care Modernisation
- Home Care – re-ablement
- UCC – new models, improved performance
- Integrated operational teams – around clusters
- Technology Enable Care
- Sheltered Housing
- Supported Living
HSCPs Transformation Programme – Older People

• Continuing Focus on:
  – Early intervention, prevention and harm reduction
  – Providing greater self determination and choice
  – Enabling independent living for longer

• Setting clear expectations – not mitigating all risk

• Demographic, resource changes and practice imperatives mean we need to continue shifting the balance of care towards community
MFT programme – Older people

- Develop more preventative/anticipatory care to support more people in community – exploit new technology
- Managing more complex cases in community – improved responses and co-ordination of care – enhanced roles
- Further develop role of geriatricians working closely with GPs
- Condition specific care pathways across primary and secondary care
- Assess implications of future changes in demand and potential response to shift balance of care
Key Messages

• Build on MFT sessions to improve dialogue between primary and secondary care

• Capitalise on opportunities in new GP contract

• Exploit new technology

• Access and networks of services and support for Older People must involve third and independent sector
Conditions for Innovation and Transformation – Reflections

• Clear vision – beyond sorting out today
• Willingness to set aside old assumptions
• Guided by evidence
• Time to think and debate
• Change attitude to risk – enablement
• Organisational permission for staff to undertake tests of change – trust with accountability
• Creating right incentives in system
• Celebrate success, positive reinforcement of progress
• Shift power bases
Table Discussion One
Table Discussion One

- In terms of transformational opportunities; what opportunities do advances in e-health and technology offer? What are the three top priority changes which we should be securing?
- In terms of transformational opportunities; what opportunities does the integration of health and social care offer? Are we realising these opportunities?
- What impact do these opportunities have on your own services, and for services working together?
Michael Smith,
Associate Medical Director,
Mental Health & Addictions Services,

Transforming Mental Health Services

Michael Smith,
Associate Medical Director,
Mental Health & Addictions Services,
1978

4,370 Glasgow inpatient beds

Consultant-led outpatient clinics
MH system, 2018 -

- Unscheduled Care
  - Crisis resolution & home treatment

- CMHTs
  - Schizophrenia, bipolar, chronic depression

- PCMHTs
  - Depression, anxiety

- Specialist
  - Borderline PD
  - 1st episode psychosis
  - Perinatal
  - Eating disorder
  - Adult autism
  - Trauma

- Unscheduled Care
  - Crisis resolution & home treatment

- beds

- Recovery & Supported living

- Rehab
Transitions

- Triage
- Screening
- Gatekeeping
- Signposting
- Link workers
- Joint working

- Assessment without treatment
- Routine review
- Outcome measurement
Stepped care using CORE-Net

- Inpatient beds
- Recovery
- Unscheduled Care
- Specialist
- CMHTs
- PCMHTs

Graph showing stepped care using CORE-Net with assessment and therapy stages.
prevention

- inpatient beds
- Recovery
- CMHTs
- PCMHTs
- Specialist
- Unscheduled Care
- Rehabilitation
- Recovery
- intensity, £
Prevention

- 50% of adult MH problems have begun by 15y
- Once started, MH problems often persist

Marryat L, et al. J Epidemiol Community Health 2017

% children in Glasgow with probable psychological problems

- 4.1% at 4y
- 3.6% at 7y

least deprived
Prevention

- 50% of adult MH problems have begun by 15y
- Once started, MH problems often persist
- Childhood MH problems in Glasgow get worse from 4y to 7y
Prevention – Public Health

Preventing ACEs in future generations could reduce levels of:

- Heroin/crack cocaine use (lifetime) by 66%
- Incarceration (lifetime) by 65%
- Violence perpetration (past year) by 60%
- Violence victimisation (past year) by 57%
- Cannabis use (lifetime) by 42%
- Unintended teen pregnancy by 41%
- High-risk drinking (current) by 35%
- Early sex (before age 16) by 31%
- Smoking tobacco or e-cigarettes (current) by 24%
- Poor diet (current; <2 fruit & veg portions daily) by 16%
There’s more to good health than just having fewer symptoms

Confidence, relationships, employment, retraining better supported outside the clinic

England ahead of Scotland in developing services

Recovery communities, hubs in Glasgow addictions services

Peer support (RoI £4.76)
Recovery

- Unscheduled Care
- Specialist
- Beds
- Reha
- Recovery

CMHTs

PCMHTs

Prevention
<table>
<thead>
<tr>
<th>balance of care</th>
<th>Reduce inpatient beds and invest in alternative forms of health and social care</th>
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</thead>
</table>
| **Productivity:** specialisation & matched care | Enhance **capacity** in CMHTs, PCMHTs  
**Extend role** of specialist teams  
Rationalise, consolidate unscheduled care |
| **Transformati onal** | **Task & Resource Shifting:** recovery-oriented models of care  
**Quality Improvement:** BPD, bipolar disorder  
**Culture change:** compassionate, trauma-sensitive care |
| **Prevention** | **Focussed investment** in early years, conduct disorder, bullying, ACE reduction |
2018 GP Contract

- Different from England
- Informed by New Ways and other tests of change
- Negotiated by Government and BMA
- Changes already underway – Cluster Working
Aims

- Improve being a GP
- Secure income
- Reduce Workload
- Reduce Risk
- Improved patient outcomes and experience
Improve being a GP

- Focus on “Expert Medical Generalist” role
- Undifferentiated Presentations
- Quality Improvement
Reduce Workload

- Remove vaccinations
- Board/Partnership employed staff to take some workload from GPs e.g. Pharmacy teams/Physio/ANPs
- 3 yr Plan
Inverclyde New Ways

- Tests of change
- Some across Partnership others based in GP Clusters
- MSK Physio; ANPs; Paramedics; Pharmacists; Phlebotomy
Example - ANPs

• 1.4 wte ANPs (c. 23,000 patients across 5 practices in 1 cluster)
• Experienced registered nurses, masters level, full prescribers (per GGC Advancing Nursing Practice Strategy)
• Currently covering 40% of home visits across East cluster
• Shared across practices - flexible & responsive
• Propose scaling up to 50% of home visits across Inverclyde
Example - ANPs

- Workload allocated via GP triage
- Average 7 visits per day – 35 minutes each
- Can consult in practice if required
- Cover whole range of presentations - depending on GP requirement (e.g. end of life)
- Holistic, care co-ordination following assessment
Challenges

- Recruiting staff to new roles
- Retaining staff
- New role for GP’s
- Sustainable services
Table Discussion Two
Table Discussion Two

• What lessons can we learn from the experience in mental health and how could the approach taken in Mental Health apply across other services?

• In terms of transformational opportunities; what do the possible new models of Primary Care enable in supporting the transformation of services?
A Cross System Approach to Respiratory Care

Marianne Milligan, Team Leader, Community Respiratory Team
Pamela Vaughn, Advanced Respiratory Physiotherapist, GRI
Catherine Dunnet, Clinical Service Manager Speech and Language Therapy
Dave Anderson, Consultant Respiratory Physician, QEUH
A Cross System Approach to Respiratory Care

• Examples of good practice
• Potential In Patient Service
• Potential Out Patient Services
• Collaborations
The Size of the Problem

- COPD affects 129,000 people in Scotland
- Predicted increase of 33% in twenty years
- Most common cause of presentation to hospital in Scotland
- Responsible for 46,346 bed days in GG+C
- Bed occupancy increasing
- Accounts for 6% of all deaths in Scotland (4,500 / annum)
Specialist, reactive, coordinated

Advanced assessment
Breathlessness Strategies
Chest clearance
Medication Review
Nutritional health

Emotional Wellbeing
ADL/ equipment
Self Management

Virtual Ward – secondary review
Home PR
Community links
Impact of CRT

• Comparable readmission and mortality with IP management
• Clinically and statistically significant improvements in disease impact (CAT)
• Clinically and statistically significant improvements QOL (EQ5DL)
• 85% person centred goal attainment
• GPs 75% reported reduced home visits
• 22% reduction in hospital admissions post intervention
• Est Net savings: £463,780 to £1,087,564 per annum
GG+C COPD (J40-44) Bed Days Change from 2013

Predicted trend

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<td>CRT</td>
<td>23877</td>
<td>21488</td>
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<td>23741</td>
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<td>10121</td>
<td>11289</td>
<td>11184</td>
<td>11006</td>
</tr>
</tbody>
</table>
1.0 WTE Band 7  Team Lead/ Physiotherapist
7.0 WTE Band 6  Physiotherapists
3.0 WTE Band 6  Respiratory Nurses
1.4 WTE Band 7  Pharmacist
1.0 WTE Band 6  Occupational Therapist
0.5 WTE Band 5  Occupational Therapist
1.0 WTE Band 6  Dietician
1.5 WTE Band 3  Rehab Support
1.0 WTE Band 3  Team Secretary
0.05 WTE  Resp Consultant
Integration of Services

- Prolonged period to next exacerbation
- Anticipatory Care Plan
- Secondary Care Review
- Formal Rehab Program
- Early Introduction of Rehab
- Managed at Home
- Contact RNS (IP) or CRT (OP)
- Exacerbation
Multidisciplinary Advanced Clinical Practice

Vision
To enable a skilled and knowledgeable Advanced Clinical Practice workforce to be used effectively to enhance the capacity of the existing health workforce to ensure a quality service for patients, now and in the future

Drivers
- Increased service and workforce demand
  Medical workforce shortages
- AHP led clinics, improve pt journey, reduced/appropriate prescribing, non pharma Rx.
- To reduce or avoidance of A&E admission
  - Tier 4 AHP review, Rx, D/C, support, refer
- To enable care closer to home
  - Community Respiratory Team
- 24/7 services,
  flexible working, extended services
Consider Allied Health Professionals

11,154 AHPs in Scotland – 8% of total 140,000 workforce
Lowest vacancy rate - 3.9%(7.4% Dr, 4.5% Nurse)
Third largest workforce in NHS
Assess, diagnose, treat and discharge
Independent practitioners
Advanced practice specialist and generalist skills
Prevention / improving health and wellbeing
Non pharmacological means in conjunction with traditional approach

Workforce transformation is key for sustainable service models.
Upskilling / utilising existing workforce
Future workforce models with new roles to be developed.
Invest in training to save
GLs and evidence supporting AHP management to favourably influence outcomes in bronchiectasis(1), asthma(2), chronic cough(3).

Triage patients to AHP led clinics – advanced practice skills, training & knowledge – equal or better effectiveness

Increase consultant NP/return appointments – more complex cases

Cost saving – suggested £240 per consultant slot v’s £55 advanced practice AHP

Save 2 weeks of in pt bed – bronchiectasis – IV antibiotics - CRT.

Community clinics – AHP led – bronchiectasis, breathlessness, VCD etc

Examples of Respiratory Physiotherapy led clinics

- Physiotherapy led bronchiectasis clinic - Lancashire
  - Patients triaged from HRCT to clinic
  - Complete case management with advanced practice skills
- Chronic cough clinic – Lancashire, Ipswich, London
  - Patients triaged from referral
  - Advanced practice skills allows for investigation referral and Rx
- Difficult asthma and breathlessness clinic – Manchester, London, Lancashire
- Physiotherapy led NIV, long term ventilation and complex airways service. In conjunction with SLT - Lancashire
Speech and Language Therapy role in Respiratory Services

- Key role in assessment and management of oro-pharyngeal dysphagia
- SLT-led VF clinics per week (NMR status under IR(ME)R) (14% referrals from Respiratory)
- Chronic cough and vocal cord dysfunction
- Complex airway management
- Lung cancer
- Growing body of peer-reviewed evidence
Examples of SLT impact in practice

• Identification and management of dysphagia in lung cancer (Guy’s and St Thomas’)

• Dysphagia and COPD (Yorkshire)

• Vocal cord dysfunction in complex airway management (Lancashire)
Pharmacy Intervention

- Domiciliary pharmacy intervention in end stage COPD
- Review compliance, inhaler technique, drug interactions
- Ensure adherence to guidelines / phenotyping of patients
- Compared to control reduced
  - Admissions by 28%
  - Exacerbations by 33%
  - Antibiotic Use by 40%
A Cross System Approach to Respiratory Care
Discussion Points

• Multiple Respiratory conditions which benefit from MDT approach-
  – COPD, Lung Cancer, Asthma, Non-CF Bronchiectasis, Chronic cough

• Role of Cross System approach for Prehabilitation in patients for surgical intervention (eg ENT, lung cancer, AAA repair)

• Role of Cross Speciality working- breathless clinics, cough clinics
• 57 yr old female
• Exertional chest pain and SOB
• Referral from Cardio, symptoms for 10yrs- lxl at ANO
• Multiple meds with SEs
• 4 x Cardio clinic appointments last 2 yrs
• 1 x A+E
• Echo, ETT, thallium, CT Coronary Angio, 24 hr tape, 24 hour BP, PFTs, HRCT
• Referred Resp-
• CPET- impaired ventilation- Physiology led test
• 57 yr old female
• 3 physiotherapy sessions
• Able to cycle from Glasgow to Edinburgh
• Stopped all medications
The Future of Surgical Services

Prof CJ McKay: North
Mr M McKirdy: Clyde
Mr K Qureshi: South
“GGC” provision of General Surgery 1995

<table>
<thead>
<tr>
<th>Sub-Speciality</th>
<th>No of Sites</th>
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<tr>
<td>Pancreatic</td>
<td>4</td>
</tr>
<tr>
<td>Oesophagogastric</td>
<td>7</td>
</tr>
<tr>
<td>Acute sites</td>
<td>8</td>
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</table>
## "GGC" provision of General Surgery 2015

<table>
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<tr>
<th>Sub-Speciality</th>
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<tr>
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<td>Acute sites</td>
<td>5</td>
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</tbody>
</table>

**GREATER GLASGOW NHS ACUTE SERVICES REVIEW**

**22nd July 2005**

- **Vascular Surgery**
  - Single site, colocation with A&E and renal services
  - New SGH

- **General Surgery**
  - Colorectal surgery - collocate with major A&E services, large volume, two sites.
  - New GRI and SGH
  - Upper GI surgery - major resections, low volumes, specialist equipment, collocate with major A&E single site.
  - New GRI
Future of Surgical Services

- Increased demand from region for **regional specialist services**
- Increasing complexity
- Networks rather than hub and spoke
- Need to maintain local services
- Evidence based care/realistic medicine
- Different models of emergency care
Tier A Scheduled Care

**TIER A**
7 day access
Regional service for OG, HPB, rare and complex cancers
Full range of complex elective surgery and medicine
Full range of support services, ITU/HDU
24/7 interventional radiology
On site laboratory services
Research infrastructure
Scheduled care for general surgery

**Tier A surgery**
- Complex cancer (and benign) surgery
- HPB, oesophagogastric, sarcoma, lower third rectal cancer

**Tier B surgery**
- All intermediate surgery (laparoscopic surgery, most colon cancer)
- Tier C cases that need possible HDU support

**Tier C surgery**
- Short stay surgery, most laparoscopic surgery, minor surgery
- Potential for some bariatric surgery, antireflux surgery
WoS Tier B Scheduled Care Network
Tier C scheduled care
Increase utilisation of ACH facilities

- **Resource**
  - Overnight and weekend cover - ?SNP role

- **Attitudes**
  - BMI restrictions
  - Availability of airway support
  - Management of deteriorating patient
  - Transfer arrangements
Unscheduled care: General surgery

- No general surgery specifically requires Tier 1 care
- Tier 2 care appropriate for emergency general surgery.
- Some patients may require specialist transfer
- Tier 3: Role in ambulatory care models
- Tier 4: No role seen in emergency care
Specialist support to front door – early involvement of senior decision makers

- GP access for discussion/early review with surgical team
- Ambulatory pathways
  - Abscess
  - Dysphagia
  - Obstructive jaundice
  - Rectal bleeding
  - RIF pain
- Hot clinics
- IMAGING
Breast Diagnostic Clinics

- High volume of referral
- Diagnostic team in one stop clinics
- Complex episode
- Specialised radiology
- Provision can be in any tier
- Efficient to focus demand and resource
  - Supported by patient engagement
Breast Cancer Surgery

• 85% day cases

• Tier C ideal except:
  – oncoplastic procedures
  – comorbidities

• 2015 lesson:
  – RAH only facility in GG&C for impalpable cancer patient with comorbidities
UROLOGY

- Not all hospitals need to deliver ALL aspects of urological care
- Rationalisation of urological services will improve outcomes and efficiency
- Complex surgery = centralised/regionalised
- WoS robotic prostatectomy service has succeeded in delivering a regional service at the QEUH
Scheduled care for urology

Tier A
RPLND and complex renal surgery [40 cases/year]

Tier B
All other major urological surgery

Tier C cases that need possible HDU support

Tier C
The majority of urological elective cases [80%]

Tier D
CNS/Consultant led diagnostic services
Unscheduled care for urology

Tier 1
No requirement for urology

Tier 2
The majority of emergency urology

Tier 3
Hot clinics

Tier 4
Catheter related issues
Table Discussion Three
Table Discussion Three

• What lessons can we learn from the experience in respiratory medicine and how could the approach taken in other services?

• What would it take to deliver these approaches on a system wide basis?

• How do we balance the increasing sub specialist nature of complex surgery with local access?
Closing Remarks

Jane Grant

NHSGGC Chief Executive
Outcome from today

• Come together as a whole system across health and social care

• Plan for our population – WOS and GGC together

• Challenge ourselves to describe and then implement whole system transformation

• Harness innovation

• Seek ideas from, and listen to, our staff

• Enhance current and build new partnerships

• Seek opinion from our service users, patients and carers

• Imagine, and begin to design, an improved health and social care system optimised for safe, effective, person centred and sustainable care to meet the current and future needs of our population