Annex 1

healthfit
caring • listening • improving

NHS Grampian

Health and Care Framework

The NHS Grampian 2020 – A Possible Future

1. NHS Grampian has agreed its Health Plan and has embarked on its Health and Care Framework (H&CF) process to determine in detail how health and care will change over the next 5-10 years.

2. The following is **not** an agreed plan but a description of a possible future based on the discussions and ideas put forward during the development of the Health Plan and the various stages of the H&CF process. It is written from the perspective of someone in 2020 describing the health system and looking back at how it was achieved.

3. It is also not intended to be comprehensive and cover every part of the system but aims to give an indication of the level of detail that is necessary to move forward.

In 2020……..

4. The health of the people of Grampian, and the health service in the area is radically different compared with how it was in 2011. People are healthier because they take responsibility for their own health and participate in screening programmes. There has been a reduction in premature death in conditions such as cancer, heart attacks and stroke and a reduction in incidence of depression. This in turn has meant that the people of Grampian are less dependent on the health service – primary care, community care and acute care. When health services are needed, they are more efficient and tailored to individual needs. This focus on the individual has been made possible by the release of staff, funding and buildings from more traditional ways of working to create the new NHS in Grampian today in 2020. The focus on the individual has been undertaken in partnership with local authorities and the third sector who, since 2012, provide a cohesive service specifically for children, older and vulnerable people.

Previous Major Change in Grampian

5. The health service in Grampian is almost unrecognisable compared to how it was in 2010. The changes to acute, community and primary care are similar in scale to those which transformed mental health, learning disabilities and long stay care for older people in the 1980's and 1990's. For those services in the 1980's large sections of the public, staff and patients could not believe that patients could be safely cared for in the community with little need for traditional inpatient care and centralised treatment.

6. Acute, community and primary care in 2020 has gone through a similar transformation following the agreement of the Grampian Health Plan in 2010 and the decisions made in the H&CF process in the following years. The health service in Grampian is now regarded as the model for a caring, listening and improving health system in the UK and is regarded internationally as a model of integration, partnership working and public participation.

Integrated and "Person Centred"

7. In the early years of the transformation, the NHS Grampian Board responded to the call from the public, staff and partners to be clear, honest and straightforward – the impact of the global economic situation was clear and there was agreement on the need to move on from stating high level aspirations like "shifting the balance of care" to specific actions which created certainty of change within Grampian.

8. The main theme which guided the transformation was integration. People in Grampian have not used the term "shifting the balance of care" for many years. The term implied moving from one part of the system to another. Integration of treatment and care was the real issue, and the need to bind together the work of all partners in health and care in a simple and practical way was the main priority. The "shift" agenda also implied movement from hospital to community care whereas the H&CF process established that care at home or in a patient's community was the unequivocal aim with the most appropriate person with the right skills delivering the care. This has also generated greater public and community responsibility, which has been supported by joint working between the NHS, local authorities and other partners.

Primary and Acute Care Integration

9. During 2011, it was recognised that the integration of primary and acute care was essential, and the need for clinicians in one part of the health service to have a stake in the other was a major objective. Also during 2011 a number of initiatives in Grampian relating to the grouping of practices – clusters in Aberdeen City, areas in Aberdeenshire and the GP federation in Moray – were taking shape. These initiatives sought to share resources, integrate primary care teams and align with acute services. In 2012 these initiatives were developed on a Grampian basis and there are now nine practice groupings, now known as primary care groups which have catchment populations of between 40,000 - 90,000 and are geographically based on natural communities.

10. The primary care groups are now the fundamental building blocks for health and care within Grampian to organise care on a local basis, integrate community health and social care, and integrate primary and acute care on a Grampian basis.

11. Each of the groups has aligned acute clinicians to support the development and delivery of pathways and protocols. The alignment has proved to be extremely successful – it was not highly structured but started to provide a mechanism for communication, information sharing and feedback on referral rates, clinical practice and the deployment of resources. In general it provides the benefits of commissioning without the bureaucracy and transaction costs.

12. The terms "acute" and "primary care" are never used in 2020 as the acute hospital resources at Aberdeen Royal Infirmary (ARI) and Dr Gray's are, in effect,

owned collectively by the clinical community with the primary care group lead clinicians and lead acute clinicians acting as the clinical management board for the hospital. This dynamic created the opportunity to significantly reduce the number of inpatient beds in these hospitals partly through greater efficiency and partly through the release of resources to invest in maintaining people at home or in their communities. Resources released from the organised reduction of inpatient beds were also used to invest in technology and diagnostic services to improve screening and speed up the treatment and discharge processes. This approach was not only applied at ARI but to all services provided by NHS Grampian.

Access to Treatment

13. Attendance by patients at Foresterhill and Dr Gray's for traditional return outpatient clinics stopped in 2015. Before 2011 a number of clinicians used telemedicine or telephone consultations for routine outpatients. Whilst there were some patient and clinician concerns, it was agreed during 2011 that this method should be applied for the vast majority of return and routine outpatients. The impact of this was to decentralise access to acute clinics as specialist clinical advice was, in effect, accessible from patient's homes, health centres and a wide range of community locations. A further effect was to significantly reduce the capital funding needed to invest in upgrading outpatient clinic facilities at ARI. In 2020 it is interesting to look back at the early years when tens of thousands of people travelled to Foresterhill, and had the anxiety of finding a parking space or travelling by bus, to see a clinician for only a very short time.

14. The change in approach to routine outpatients was followed by an agreement in 2013 that all ambulatory care at Foresterhill and Dr Grays should be organised on a "one stop" basis. This one stop approach streamlines access to diagnostic facilities and clinical decision making with the result that 90% of all patients attending one stop clinics are given a diagnosis and treatment plan on the day of attendance. This approach further reduced the number of patients travelling to the Foresterhill and Dr Gray's Hospital and the need for admission to hospital.

Application of Technology

15. NHS Grampian made progress in the years 2011 to 2013 to develop an electronic health record system that allowed clinicians to share information about patients and allowed patients to access some of their data. This record system enabled new workflows between the hospital and the GP practices and changed the nature of the referral process. GPs were able to ask for advice by email and to share their decisions with patients electronically. A request to attend a face-to-face clinic appointment came from the consultant directly to the patient. "Please book yourself an appointment in X clinic within the next four weeks".

16. These changes allowed the hospital sector to develop booking systems for clinics that could be accessed directly by people from their phone or computer. A call centre handled requests for those without computers. This method reduced anxiety about waiting times and allowed much more personal links between the patient and the professional services. It was part of a general trend towards personalisation of care in the local authority and health sectors.

17. The Clinical Guidance Internet (CGI) which was developed in Grampian in 2011 became fully operational in 2012. The success of the CGI resulted in its adoption across the whole of Scotland from 2014. CGI has revolutionised the way that

clinicians, health and care professionals, patients and carers obtain clear and comprehensive information about health and care services by acting as a health and care "Wikipaedia". CGI has been a major influence in integration by allowing everyone to know what is available, when, and how to access it. The many discussion forums also mean that it is an active and lively method for clinicians and care staff to provide feedback and change practice.

18. Technology has also revolutionised the working lives of non clinical staff. NHS Grampian in 2020 spends only one tenth of what it spent in 2010 on office accommodation and health records storage. No one has a dedicated office with all other managers and administrative staff working from home, hot desk, on the move, or a combination of all methods.

Community Responsibility and Support

19. The new approach to primary and community care could not have been possible without the participation of the public and communities in the whole system of care. The work done through the H&CF resulted in communities taking ownership of their part of health and care services by using services and facilities responsibly, actively promoting health and healthy living, and providing a network of community support aimed specifically at maintaining people in their own homes for as long as possible.

20. A range of community support organisations were established by 2014 – some of these have a paid organiser and they are the focus for voluntary sector activities within communities. They provide a range of support from help with telemedicine clinics, transport to healthcare facilities and looking after patients who live alone thereby avoiding admission to an inpatient facility. The support organisations' care workers are largely voluntary but they participate in a discount scheme developed in 2015 by local and national businesses as part of their contribution to the health of Grampian.

21. The person centred NHS which was a feature of the NHS in Scotland Quality Strategy in 2010 has been taken forward with enthusiasm in Grampian. A major effort was made to not only to put patients at the centre but also their carers. Through a number of initiatives, linked to the focus on communities, carers are now regarded as a fundamental part of the health and care system and a high level of personal support is provided by the NHS and partner organisations.

New Model of Care for Older People – the Change Fund

22. A major contribution to the transformation came in 2011 when the opportunities presented by the Change Fund were exploited by NHS Grampian together with Aberdeen City, Aberdeenshire and Moray Local Authorities, the third and independent care sectors. When the Change Fund was introduced in 2011, NHS Boards and local authorities were urged to be bold to meet the challenges posed by the increasing numbers of older people requiring care and support. The Fund supported innovation in the following key areas:

    - Supporting informal carers in their caring role at home

    - Reducing unplanned admissions to hospital through greater anticipation of need

- Increasing the ability to provide specialist planned care closer to home

- Reducing the length of stay in hospital by creating additional services to support older people at home following discharge

- Increasing rehabilitation and re-enablement services to enable older people to remain independent and self-caring for longer

- Providing additional resource to establish telehealth and telecare technologies as a key part of the health and social care support to older people

23. Eager to build on a strong history of joint working, the NHS and local authorities adopted a system of anticipating the health and care needs of older people. This created plans which significantly reduced the need for urgent admission to hospital. Personalised plans for each frail older person summarised their health and health care needs, identified how those needs might increase over time and how those needs should be met, without admission to hospital. The older persons' preferences for care, particularly at end of life were identified and shared with appropriate parts of the service such as the out-of-hours services. GPs led a process of multi-disciplinary reviews which brought the expertise of Consultants, nurses, allied health professionals and social work care managers together to ensure the needs of patients could be met at home.

24. The Change Fund provided additional funding to the Department of Medicine for the Elderly and following recruitment of two additional Consultants in 2012, all the Consultants in the department were able to spend almost half their time working with General Practice and in community settings bringing specialist services out to the patient in their own home. This immediately reduced the percentage of older people being admitted to hospital.

25. The needs of those with dementia were not overlooked, and additional services were created within ARI and Dr Grays and ensured that now everyone admitted to an acute hospital who also has dementia has access to appropriate support minimising the distress caused by hospital admission and also ensuring that they can return home immediately after their acute treatment and care is concluded, in a well planned manner.

26. Local Authority, third sector and NHS staff also worked closely to enable all patients with complex discharge needs to go home as soon as their acute illness or condition enabled them to be safely discharged. Long term decisions about the need for nursing home care are no longer made in hospital, but those decisions are made at home, when the patient and their family have time to consider their options and make the right decision for them. The Change Fund supported the provision of additional support from the third sector, social care, and community health staff immediately following discharge in the short term.

27. Back in 2011, Older People were asked where they wanted to live as they became more frail, the majority expressed a preference to remain in their own homes, and only to be admitted to care homes if there was no safe alternative. The independent care sector accepted this position, and worked in partnership with the local authorities and NHS to redesign the way they supported older people and this led to the creation of more short term admissions for respite, rehabilitation or 24 hour nursing care under the supervision of the health and

social care team. Many independent providers also provide more home based care and are now a key partner in the support available to older people in their own homes.

28. Between 2011 and 2014 the important role of family or friend carers as partners in the delivery of health and care was fully acknowledged and the NHS and local authorities worked in close partnership with Carers to develop appropriate training to ensure all carers have access to the skills necessary to support them in their caring role. Caring Together – The Carers Strategy for Scotland 2011 – 2015, was implemented in full and has supported many more people to successfully participate in the care of their family member or friend without damage to their own health and wellbeing.

29. The Change Fund provided funding to allow new services to become established, to modernise other services to work more efficiently and to give capacity to the third and independent sectors to redesign and reorganise the services they offer. The results of the investment reduced demand for inpatient services in ARI, Dr Gray's and community hospitals allowing inpatient areas to be closed, and the resources released from this now fund the services on an ongoing basis.

30. The significant reduction achieved in in-patient admissions and the shorter length of stay for those essential admissions has reduced complications arising from hospital stays for older people such as confusion, institutionalisation, falls and hospital acquired infection. The combination of these effects resulted in improved quality of individualised care and a dramatic reduction in the requirement for inpatient beds in Grampian.

Unscheduled Care

31. After the Emergency Care Centre in Aberdeen was completed, the Grampian unscheduled care network service became operational in 2013. The network initially involved telelinks between the community resource centres with emergency departments in Aberdeen, Elgin, Orkney and Shetland. Ambulance vehicles also link in to the network and paramedics and GMED clinicians can link in from patient homes. The information platform is provided by NHS 24 supplying emergency clinicians with data in the form of emergency care summaries, medication lists, details of next of kin (carers if appropriate) and patient preferences relating to treatment. The emergency clinician links in to the network for decision support relating to immediate treatment and destination of the patient. Treatment is provided at home, in the nearest community resource centre or in one of the emergency departments. The emergency departments provide decision support to each other in terms of the interpretation of radiology, treatment of heart attacks, stroke, and trauma. In 2015, emergency departments in Highland and Western Isles joined the network and plans are afloat to expand the network further afield. The unscheduled care network allows instant treatment for patients, has reduced unnecessary transport, and has greatly enhanced the sustainability of local emergency stations.

Living and Dying Well

32. In 2011, palliative care was thought of by many as a specialist service, provided mainly to patients who had cancer. People with other conditions were often less likely to have their palliative care needs met, especially if they lived in rural or remote areas.

33. In 2020 the support for people who are dying has been transformed. High quality general palliative care is part of the routine care and support of patients and carers. It is provided wherever the patient is and can be delivered by many professionals, and often by those in the third sector. Today nearly three quarters of people who die do so in their own homes or communities where the focus is on meeting individual needs – physical, psychological, social or spiritual in partnership with the patient, carers, families and others.

34. Those people who need complex and specialist palliative care are recognised and have their care delivered by generalists and specialists as necessary depending on their needs and regardless of the condition they have.

Re-shaped Infrastructure and Targeted Capital Funding

35. The new health and care system in Grampian not only reduced the need for inpatient care in hospitals like ARI but also in community hospitals across the area. The period from 2011 to 2020 saw a redefinition of community hospitals, community resources and public involvement. During the H&CF process it became clear that many community hospital buildings were not fit for purpose and their distribution in Grampian in many cases was the result of decisions made decades before.

36. Many health centres and other community facilities were also outdated and inappropriate for the delivery of modern clinical care. This stimulated the formulation of a community infrastructure programme in 2013 which, by 2020, has replaced all ageing health centre facilities with multi agency resource centres. These centres are the hub of health and care in Grampian delivering NHS and social care, and are a focus for community participation. The resource centres are different in different communities but all have the core function of supporting a level of treatment and care consistent with the size and needs of the community's population.

37. The clarity of vision inspired and mobilised communities to create certainty for their own facilities has allowed NHS capital investment to be combined with the local authorities and other public sector bodies, voluntary sector, private sector and, in some cases, community fundraising. In 2011, NHS Grampian was facing the need for huge expenditure in many outdated facilities. The new approach stimulated community participation and much better value for the NHS and other public sector funding that was available. In some areas existing community hospitals were used as resource centres, in others completely new facilities were developed often including the replacement of outdated health centres. This approach was not new – it had been done successfully in Maud in 2008 with the opening of the Maud Resource Centre and the subsequent closure of the community hospital.

38. The rationalisation of facilities in Aberdeen took a major step forward in 2014 when the plan for older people's services was fully implemented. This resulted in the closure of the outdated South Block building at Woodend Hospital. This inpatient facility was replaced by a range of community services developed through the Change Fund process, and supported by the Aberdeen Health Village which opened in 2013.

39. ARI itself was transformed by 2017. Until 2011 the Infirmary struggled to maintain a focus on specialist treatment for the most ill patients or those requiring care which can only be safely delivered in specialist facilitates in Grampian. ARI was

always regarded as the option of last resort i.e. admission to ARI was the default if other parts of the NHS system did not work. As a result of the alignment with primary care groups and the co-ordinated approach of the primary care group leads, the skills and resources at ARI are now only applied as part of an integrated pathway of care – whilst continuing in its role as a major teaching and tertiary centre in the UK, ARI is regarded as a focus for providing specialist care within the integrated system with the aim of getting people back home as soon as possible. In physical terms ARI now has the most modern facilities available, with around half of the inpatient beds needed compared with 2011, and a well resourced ambulatory care centre in the former Phase 1 building focusing on one stop clinics.

40. Other major facilities, including Dr Gray's hospital, the Children's Hospital, Maternity Hospital and facilities for mental health services all benefited from a much more focused approach to treatment and care in the community. This allowed the facilities to concentrate on the delivery of specialist care, in addition to further developing their roles as major teaching and tertiary centres in the UK.

41. The health infrastructure in Grampian is the most efficient and highest quality of any health authority in the UK. The service changes over the past ten years have entirely eliminated the buildings risks valued at £300m in 2011. Through innovative ways of developing community ownership, the use of the hub public/private mechanism and the partnership with local authorities, voluntary and the private sector, NHS Grampian now has only two directly owned facilities i.e. the Foresterhill/Cornhill campus in Aberdeen and Dr Gray's Hospital in Elgin.

42. Between 2011 and 2020 the resources that would have been used to repair outdated buildings and equipment were instead used to support the new model of community care and to provide extensive information and communications technology across Grampian. It has been the routine for many years for people to receive specialist clinical advice and care using this technology in their own homes. If it requires the support of a healthcare worker, the technology in a community resource centre can be used. GPs and other primary care staff have access to imaging facilities in the community resource centres and the images can be sent electronically for a radiologist opinion anywhere in the country within 24 hours. People who are acutely ill can be maintained in their own homes safely and effectively with the use of remote monitoring and support as appropriate.

Conclusion

43. The health system in Grampian now fully reflects the high level aspirations of the first Healthfit in 2002 and expressed in subsequent health plans. This was achieved by our staff working jointly with the public, communities, local authorities and other partners by being clear and honest about the challenges, the needs of the population, the opportunities available and working together to agree and deliver the changes required.