Transformational Change Improvement Plan
2017-20
**Transformation** is a deliberate planned process that sets out a high aspiration to make a dramatic improvement and irreversible change to how care is delivered, what staff do (and how they behave) and the role of patients that results in sustainable, measureable improvement in outcomes, patient and staff experience and financial sustainability.

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1. Introduction

NHS Ayrshire and Arran is committed to the principles of the triple aim as it moves through this process of transformational change; improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. Our intent is to make use of the national policy and strategy framework that has been defined and enhanced since the launch of the Quality Strategy in 2010, recognising the influence and direction that the latest drivers provide:

- National Clinical Strategy;
- Health and Social Care Integration;
- Public Health Reform; and
- Getting it Right for Every Child.

Set against that framework, we have defined a set of guiding principles to support us in planning for the future. Our approach makes best use of data to understand our population, to allow us make decisions and to plan services that will be sustainable at a local, regional and national level.

This Transformational Change Improvement Plan (TCIP) describes our programmes of transformational change and sets out our intention for this period of transformation 2017 to 2020.
2. Transformational Change

In 2010, the Scottish Government outlined in the “Quality Strategy” its vision to deliver sustainable quality in the delivery of health care services. That healthcare should achieve the three quality ambitions, providing person centred, safe and effective care. In 2011, the Scottish Government described the strategic vision for the delivery of health care services in Scotland in the “2020 Vision”. This provided the context for implementing the Quality Strategy, recognising the need to be transformative in approach to build an NHS in Scotland fit for the future.

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 into their home or community environment as soon as appropriate, with minimal risk of re-admission.

NHS Ayrshire and Arran’s local health and wellbeing framework, Our Health 2020, was approved by the Board in February 2014. The framework provided a strategic overview with a locally relevant interpretation, describing how NHS Ayrshire and Arran would work towards the 2020 Vision, linking the various strategies and programmes into an overarching strategic framework.

Since 2014, within NHS Ayrshire and Arran there has been significant progress in a number of areas where work has focussed on setting our culture, embedding improvement, developing our people strategy and strengthening our governance. We have also progressed important changes such as the establishment of the Health and Social Care Partnerships and delivered key capital developments, talking forward Building for Better Care and Woodland View.

In the early part of 2016/17 we focussed on understanding the ongoing challenges we face in the system and the paper, “Managing a Balanced Health and Care System”, recognised those challenges and outlined proposals to begin the necessary process of transformational change. The paper acknowledged the context described in the National Clinical Strategy that sought to build upon the aims set out in the Quality Strategy and the strategic direction of the 2020 Vision.

In June 2016, the Chief Executive shared the paper, “Delivering a Balanced Health and Care System” with the NHS Board. This paper was an extension and culmination of the work to date to set the context for the need for change in Ayrshire and Arran. It described the
challenges of providing health and social care to the population of Ayrshire and Arran and summarised the programmes of transformational change that had been established at that time. This paper recognised the wider changing landscape in which health and social care services would be provided in the future, noting the impact of the following national drivers:

- National Clinical Strategy;
- Health and Social Care Integration;
- Public Health Reform; and
- Getting it Right for Every Child.

NHS Ayrshire & Arran has acknowledged this framework, which has more recently been expressed in the Health and Social Care Delivery Plan and has planned transformational change that will deliver health and social care designed to meet the needs of the local population.
3. Our Vision, Purpose, Values & Objectives

Against this national context for transformational change, a new vision and new corporate objectives have been developed to reflect our organisational intent in this period of change.

Our Vision has been defined as:

“Meeting the health and social care needs of our population by transforming what we do.”

Our Objectives are:

**Working together to ...**

*deliver transformational change in the provision of health and social care through dramatic improvement and use of innovative approaches.*

*protect and improve the health and wellbeing of the population and reduce inequalities, including through advocacy, prevention and anticipatory care.*

*create compassionate partnerships between patients, their families and those delivering health and care services which respect individual needs and values; and result in the people using our services having a positive experience of care to get the outcome they expect.*

*attract, develop, support and retain skilled, committed, adaptable and healthy staff and ensure our workforce is affordable and sustainable.*

*deliver better value through efficient and effective use of all resources.*

The diagram below shows how these relate to our existing purpose and values.
Our Vision
Meeting the health and social care needs of our population by transforming what we do

Our Purpose
Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

Our Values
Caring Safe Respectful

Our Objectives
Working together to...
- create compassionate partnerships between patients, their families and those delivering health and care services which respect individual needs and values; and results in the people using our services having a positive experience of care to get the outcome they expect.
- attract, develop, support and retain skilled, committed, adaptable and healthy staff and ensuring our workforce is affordable and sustainable.
- deliver better value through efficient and effective use of all resources.
4. Our Guiding Principles

The NHS is undergoing significant transformation as we work towards the 2020 vision, and integrate health and social care. Services in NHS Ayrshire and Arran will need to change substantially over the next two decades: in the way that we work, where our services are provided and by whom. This section outlines our guiding principles to underpin the planning of services.

Safe, effective, person-centred
The NHS Quality Strategy identified three key elements that define a high quality service: effectiveness, patient safety and person-centredness. These remain priorities against which service changes should be assessed. Quality incorporates timeliness as part of effectiveness.

Anticipation & prevention, care at home, reducing inequality
The integration of health and social care provides the opportunity to refocus care from reaction to anticipation, from treatment to prevention and from acute services to community services. It also highlights the need to address inequality of outcomes across Scotland.

Maximising health gain, sustainability
Demand for health and social care will always exceed available resources, even in the absence of austerity. Resources spent on health and social care are unavailable for education and infrastructure development, which will in the longer term improve the health of the population through economic growth, more than any healthcare intervention can. We therefore have the moral responsibility to use the available resources in the most cost-effective way, to maximise the health of our population.

4.1. Which Principles Are Most Important?

The principles outlined above are not controversial, but will sometimes conflict with each other. Which takes precedence? We believe quality has to be the first priority for public services. Inextricably linked with quality, is maximising health gain within available resource, as that reflects the total value of healthcare provided to our population. Given a choice between two treatments, we should invest in the one that gives the most improvement in population health per pound invested. We also consider that to be a first order principle.

The second rank principles include the reduction of inequality, anticipatory care, prevention and moving from acute services to community services. These are important goals for the health and social care sector, but would not be delivered at the expense of quality or maximising health gain. For example, one way to reduce inequality is to reduce the quality of service provided to the least deprived – but this would not be acceptable. Similarly, almost all healthcare could be delivered at home or nearby, but would be so costly, as to compromise the health gain for the whole population. Investment in prevention only makes sense if it is cost-effective – we cannot treat tomorrow’s patients at the expense of today’s.
Sustainability is considered a third rank principle, as it is more about how a service is provided, rather than whether it should be provided. As part of sustainability, and recognising the Government’s strategic objectives and likely demographic pressures, we will aim to employ fewer, more highly trained and highly paid staff, where it is cost-effective to do so. Employing lower paid staff to perform a role may seem less costly when simply considering pay scales, but may be a false economy, when assessing the true cost-effectiveness of the service.

4.2. Assessing a Service – Sequential Challenge

When planning services for the next two decades, teams will naturally focus on improving quality within the available resources. We support that approach, and expect our teams to take a patient-centred approach to designing their services to maximise effectiveness and safety. We expect them to identify where they spend the majority of their resources, and to match that to the burden of need within their specialty. We expect an outcomes-focussed approach, driven by data, especially patient reported outcome measures. But how do we challenge our services to embrace the new paradigm of care described in the 2020 vision, and to accelerate change within available resources?

1. Population health

We will think in terms of population health, not just in terms of the patients who attend our clinics or wards. For example, how can we assess the overall eye health, or urological health within our population? Where are the biggest needs, and which of them are amenable to healthcare? What impact are demographic trends expected to have on demand?
2. **Prevention**
   Long-term prevention of disease has the potential to substantially improve the healthy life years of our population. Prevention is a key component of our system wide approach to health care, and whilst prevention may not be directly provided by our hospital teams, we expect them to provide a leadership role in defining what is possible within their area of expertise. Redesign of our models of care in partnership with patients, to enhance anticipatory care is also an important part of short term prevention. For example, a clinic might move to a demand-led service rather than providing routine six monthly appointments.

3. **Promoting community and home treatment**
   What care that is currently provided in the hospital setting could be provided at home, or in the community cost-effectively? Would this improve quality, reduce cost, or both? Who should provide such care – the hospital team working in the community, or community-based staff? What are the requirements for provision of such care? Would it require additional staff, additional training, additional equipment or buildings?

4. **Low volume, high risk activities**
   Some activities, especially surgical procedures, are provided in low volume, and some have significant risks. Such services may not be sustainable, particularly if dependent on individual surgeons, and there may be better outcomes in higher volume centres. For low risk procedures, it may be acceptable to continue. However, for higher risk procedures, teams should consider whether we have the expertise to offer such a service as a regional or national service (e.g. the cochlear implant service), or whether we should be negotiating with other boards to provide the service. The impact on the sustainability of interdependent services needs to be considered.

5. **Low value treatment**
   Some therapies that we provide are of relatively low value to patients, and some treatments are provided to a larger group of patients than the evidence supports (e.g. proton pump inhibitors). Better decision aids will let patients have a more realistic understanding of the trade-off between risks and benefits, and in some cases they may choose not to have treatment. Are the team aware of examples within their own specialty (some of these may be provided in primary care)? What action is required to stop providing low value services or therapies?

6. **Horizon scanning**
   Are the team aware of any major new developments that are likely to occur in their field over the next decade, and what implications would those have for the service?

7. **Hospital care**
   Having been through the steps above, it should be clear what residual activity has to be provided within an acute hospital setting, and what the likely shifts in demand will be over the coming two decades. There should be a presumption that unscheduled care services will be provided across seven days per week.
Expected bed numbers and theatre requirements can be estimated from the predicted activity. This may prompt reconsideration of the model of care, if the current model seems unsustainable. For example, if the rise in demand is likely to lead to a substantial increase in the need for beds, we may need to consider more radical solutions if evidence allows.

Likely staff requirements can also be estimated from the predicted activity. This may prompt reconsideration of the model of care, if the current model seems unsustainable. For example, rotas of consultant staff with fewer than five members are unlikely to be sustainable if they involve any significant out of hours component. Rotas of fewer than ten resident junior doctors are also likely to be unsustainable.
5. What does our data tell us?

People in Ayrshire and Arran are living longer but fewer children are being born. Population projections suggest this pattern will continue at an even more accelerated rate over the next 10 years. The implications for health and social care services demand are significant, especially as the working age population declines.

Health and Social Care services within Ayrshire and Arran treat and care for huge numbers of people every year. However, Ayrshire and Arran has the 3rd highest number of years in poor health of the 14 NHS Boards for both men and women. In terms of health behaviours, there are clear indications that the Ayrshire and Arran population has higher levels of smoking and a greater prevalence of diabetes than other health board, which evidence shows places increased demand for health services at an earlier age than might normally be the case. Chronic illnesses and long term conditions are also increasing, particularly in the ageing population, and data on deprivation would suggest that this is felt most acutely in our more deprived communities.

We have seen a rise in the survival rates of people born with serious congenital conditions or surviving illness and accidents within Ayrshire and Arran. Whilst this highlights the commitment of health and care professionals to prolonging and protecting life, the ongoing demands for health and social care provision are often considerable. The national prevalence in some of the neurological conditions such as Multiple Sclerosis is also significantly underestimated for the West of Scotland, and Ayrshire and Arran in particular, placing further demands on health and social care provision which, with tightened resources, may not be fully available to those who need it.

From most recent census data, the proportion of the population reporting one or more long term health condition in NHS Ayrshire and Arran is higher than the national figure. This is supported by data from GP practices, which reports on the prevalence of specific long term health conditions in their practice area. This data suggests that the prevalence rates for all reported conditions in NHS Ayrshire and Arran are higher than or equal to the national rate. This is most prominent when considering deaths due to Chronic Heart Disease (CHD), Cancer and Smoking as well as when considering the much higher rates in Ayrshire for hospitalisation due to Chronic Obstructive Pulmonary Disease (COPD) and Asthma.
In addition, the Scottish Public Health Observatory (ScotPHO) profiles data on Child and Maternal Health show that within Ayrshire and Arran there are potentially significant challenges in terms of demand for health services as a result of maternal health behaviours. The ScotPHO profiles show that across all Health and Social Care Partnerships (HSCPs) in Ayrshire and Arran breastfeeding rates at first visit and at the 6-8 review stage are significantly lower than the Scottish average. This is further exacerbated by pregnant women in Ayrshire and Arran being more likely to smoke and consume alcohol during pregnancy. This is significantly worse across all Ayrshire HSCPs with the exception of South Ayrshire where the proportion of women smoking during pregnancy is lower than the Scottish average, although not significantly so. The percentage of Primary 1 children at risk of overweight or obesity is also significantly higher for all children living in Ayrshire than the Scottish average. These significant health behaviours both of pregnant women and in how the early years are affected by obesity suggest that in the longer term demands will increase for health and care services as a result.

Furthermore ScotPHO profiles on Mental Health reveal that over the last half decade, local rates of episodes of acute care with a primary mental health diagnosis increased substantially. The largest part of this increase was undoubtedly the contribution from patients of retirement age. This is almost certainly reflecting an increase in cases of dementia and Alzheimer’s disease within that older population. This matches the primary care data findings where dementia levels were noted as having risen over the last decade in Scotland. This shows that growing episodes of mental illness – and physical illness for that matter – arising from an increasingly ageing population are significantly impacting local healthcare services across the primary and acute healthcare settings.

While the older population has placed increased demands on services, the working age population within Ayrshire and Arran also place demands on Mental Health Services. One explanation for this trend may be a more rapid increase in depression and serious forms of mental illness. Primary care data trends showed increases in the crude rates of those
illnesses across Ayrshire and Arran as a whole, but with marginally higher rates generally observed in North.

Deprivation is also a contributing factor with the two most deprived Scottish Index of Multiple Deprivation (SIMD) quintiles contributing about two-thirds of the total increase in acute care mental health related episodes. If the trends continue, the greater burden of mental illness on the acute healthcare system in future will therefore arise from the poorer sections of the local population, showing that inequalities in mental (and physical) health within our local communities are still far from being resolved.

Moreover, over the last decade, the most striking trends in alcohol and drug related harm across Scotland - and in Ayrshire and Arran in particular - are a clear decline in alcohol related deaths counterbalanced by a clear rise in drug related deaths. A strong cultural shift appears to have occurred, and may still be occurring, with problem drug use and associated harm coming to the forefront, a phenomenon likely to be arising through younger sections of the population.

Rising numbers of older people, frailty, people living with one or more long-term conditions, and people experiencing mental health issues, all increase demand for urgent care and can give rise to increased presentation at emergency departments and also admission. ‘Multimorbidity’ is now more common in the population than living with a single condition leading to an identifiable need for active long term conditions management including timely access to specialist support.

In terms of mortality, the three major causes in Scotland, namely cancer, heart disease and stroke accounted for more than half of all deaths in Ayrshire and Arran with slightly higher rates of premature mortality (deaths under the age of 75) than the Scotland wide average. East and North Ayrshire in particular have significant health challenges, with high levels of smoking attributable deaths and hospitalisation rates for COPD patients. Drug related mortality also appears to be on the rise right across Ayrshire and Arran.

When benchmarked against Board peers such as NHS Lanarkshire the differences and uniqueness of our challenges become even clearer. Whilst the deprivation mix in
Lanarkshire is similar to that in Ayrshire, a smaller proportion of the population within Ayrshire and Arran reside in the middle quintile, suggesting more polarisation of deprivation and affluence in this area compared to Lanarkshire. Furthermore, a higher proportion of GP referrals to hospital emergency departments result in an inpatient stay in Ayrshire, with longer lengths of stay and notably higher rates of readmission of patients compared with Lanarkshire.

With all this knowledge to hand it is apparent that our population’s health is unique, and that the subsequent demands placed on our health and social care services within Ayrshire and Arran are significant. The following section demonstrates the extent to which the particular health needs impact on demand for services within Ayrshire and Arran.

NHS Ayrshire and Arran Emergency Departments continue to experience ever increasing numbers of attendances. As numbers of attendances have increased, the proportional spread of categories of seriousness of the attendances has remained unchanged. This suggests that increased attendance is not just attributable to a cultural phenomenon of more people turning to emergency health services when they feel unwell but also suggests evidence that there is rising acuity or complexity in people attending emergency departments. In fact, data shows an increase in the proportion of people being conveyed to emergency departments by ambulance. There is also evidence to suggest that increased unscheduled pressure can result in even higher levels of admission. Given NHS Ayrshire and Arran experiences the highest conversion rate of all NHS Boards in Scotland this is a crucial area of concern.

2015/16

119,282 ED Attendances  51,725 Emergency Admissions

The number of emergency admissions is projected to continue to increase over the next 20 years, particularly for the 70+ population. The pattern is similar in each of the Health and Social Care Partnerships within NHS Ayrshire and Arran with the greatest overall increase projected in South Ayrshire and the greatest 70+ age group increase projected in East Ayrshire. Should current practice continue, early modelling work has suggested that NHS Ayrshire and Arran would need an additional 398 beds by 2035 to meet this demand.

Whilst the creation of the combined assessment unit has the potential to positively impact on unscheduled care performance at University Hospital Crosshouse, it is important to note that average lengths of stay for admissions are also likely to be impacted and will increase as the more challenging and complex cases remain in the system. It is anticipated that the patient experience will however be much improved with shorter waiting times in the emergency department already beginning to be seen as a result of the combined
assessment unit opening in April 2016. A new combined assessment unit will open at University Hospital Ayr in May 2017.

Increased demand for emergency care can have a negative impact on elective care particularly during periods of high demand for emergency care. This has been particularly challenging for NHS Ayrshire and Arran over the course of this year where the expected decline in demand for emergency services following the winter period has not been seen and surge capacity (60 unscheduled care beds) has had to be maintained through the year to ensure that demand is met and that impacts on elective care have been minimised.

Data for elective care also suggest that whilst demand is also increasing, that it is in the specialties particularly prevalent in older people, or those living in our more deprived communities which are increasing at the fastest rate. This includes Orthopaedic and Vascular surgery, as well as Pain Service, Respiratory, Diabetes and Ophthalmology Services. Demand for outpatient appointments is also up for a number of specialties resulting in capacity shortfalls. Recruitment problems remain a major issue, with expensive short term arrangements in place while permanent recruitment continues or alternative models for service delivery are explored. Diagnostic waiting times are also under pressure and this leads to increased referral to treatment waits for patients.

There is also a continuing rise in demand for primary care and mental health services across all areas of the service spectrum, in line with increases in demand for Unscheduled Care Services. This pressure on primary and community services exacerbates the challenges faced by all Health and Social Care services across Ayrshire and Arran.

References


NHS Ayrshire & Arran (2017) Mental Health Needs Assessment, Volume 1, [In draft]

6. Integrated Health & Care System in Ayrshire and Arran

Improving the health of the population is a challenging process, especially in an economic environment that mitigates against the determinants of good health. Of fundamental importance is the recognition that health and health inequalities are the result of a complex and wide-ranging network of factors. People who experience material disadvantage such as poor housing, insecure employment, low income, lower educational attainment, poor access to services or are living in fear are among those more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population. Addressing these underlying determinants is essential if we are to sustain an improvement in health status and a reduction in health inequalities in the longer term.

Supporting people to choose a healthy lifestyle can have an impact on their health and wellbeing. For example, smoking remains the single most preventable cause of ill health and addressing alcohol issues is important for individuals, families, communities, local services and society in general. Recognising that it is easier for some sections of society to make healthy lifestyle choices than it is for others, the NHS has an important role to play in improving health, preventing ill-health and supporting optimum health for those with long-term conditions.

People living in Ayrshire will live at home supported by their families and communities. Health and social care partners, including those from third sector organisations and the independent sector, will work together with communities to strengthen resilience and ensure local services that maximise people’s independence and support families. We will achieve this joined-up approach to community health and social care by building the services that people need around health and social care hubs.

Our aim is that everyone should live a healthy life and where necessary will access the high quality care they require to live a safe, active and healthy life – either at home or in a homely setting. We will draw on support from neighbourhood organisations and local communities – groups and networks. This extensive network of health and social care services will operate on a shared care and inclusive basis.

Where planned interventions are required, diagnosis and treatment will be delivered from an accessible diagnostic and ambulatory centre. To complement this, regional specialist centres will be developed where people can access experienced specialist professionals and skilled care. Following diagnosis and treatment, people will return for rehab and intermediate care at a local centre as close to home as possible.

In cases of emergency, trauma and unplanned care will be provided from a District General Hospital. Patients will be assessed and treated in an assessment unit and only those critically ill patients will be admitted to the hospital for ongoing diagnosis and treatment.
Communication and engagement with stakeholders will be a key component of this work and to enable this vision for health and social care, extensive use of technology enabled care will be employed.
7. How Are We Going to Deliver Transformation?

7.1. Strategic Service Change Programmes

**Mental Health**
This programme aims to create seamless journeys for people requiring access to timely, safe, high quality and effective mental health care and to join services together more effectively so stakeholders have a single point of contact which enables their decision making.

The current, local, Mental Health aims, objective and outcomes will be influenced by the new National Mental Health Strategy issued in March 2017 by Scottish Government. At this time the local objectives are to focus on early intervention and prevention approaches for people experiencing low level mental health issues; place those experiencing mental health issues at the heart of decision-making about their assessment, treatment, care, rehabilitation and support, with a focus on maximising independence; create a fully integrated, community-based mental health and social care team within each Partnership; create a Crisis Resolution service which supports acute, community and partner need responding effectively to people in distress; and establish models of care for specialist mental health in-patient hospital services.

In respect of Learning Disabilities the local approach is in the process of development and the outcome of this may influence the current objectives of offering consistency and continuity of care for individuals at home; developing appropriate supported living models in community; creating a fully integrated, community-based learning disability and social care team within each Partnership; making use of technological advances to support those with complex care needs; supporting the individual receiving care and their family in planning, securing and delivering the highest quality of person-centred care; and connecting people with learning disabilities to a local community based support network.

The planned outcomes are to:
- Reduce social isolation;
- Reduce hospital admission;
- Reduce length of stay;
- Meet waiting times;
- Increase number of people supported in home/homely environment;
- Reduce hospital re-admission rates;
- Reduce need for enhanced observations;
- Reduced need for restraint;
- Reduce levels of UNPACS; and
- Increase levels of independence.
Unscheduled Care including Older People and People with Complex Care Needs and Acute Services - IHO (Institute of Healthcare Optimization) Whole System Patient Flow Programme

Unscheduled Care
The aims of the Unscheduled Care Programme are to reduce unscheduled acute care demand in Ayrshire and Arran and work on a whole systems basis to consider interventions and improvement work that will help sustain and improve public sector performance in relation to the 4 hour A & E standard and the achievement of the 72 hour delayed discharge target. This is being undertaken in the context of the national programme, “6 Essential Actions”.

There are many strands to this comprehensive programme of work with the main objectives of the programme are set out as follows:

• Consider interventions and improvement work that will help sustain patient experience with the 4 hour A & E standard as an indicator;
• To eliminate the delay in peoples’ discharge and the achievement of the 72 hour discharge target;
• Improve outcomes for the population of Ayrshire and Arran and ensure that people receive the right help, at the right time, in the right place, every time;
• Reduce unscheduled attendance and admissions at University Hospitals Ayr and Crosshouse by engaging with localities and services within community, primary care, commissioned and acute environments;
• Where possible monitor and develop clinical pathways on an Ayrshire and Arran basis;
• Achieve the 4 hour A & E standard by ensuring whole system capacity and flows are aligned;
• Support MCNs to review pathways for Respiratory, Cardiac, Falls and Diabetes;
• Benchmark current arrangements including costings, workforce and future pathways;
• Work with partners to set improvement targets to help reduce unscheduled care demands; and
• Consider the current performance management framework and reporting requirements and further development of performance information and indicators that support improvement and experiences of people who require care and support.

The expected outcomes for the programme are:

• Pro-active discharge planning from admission and monitor estimated date of discharge;
• Early referrals process established in social work practice across all acute and community hospitals;
• Mental health capacity assessments undertaken in a timely manner within community and acute settings;
• Awareness of system capacity or capability issues shared for wider learning in relation to the whole system of care and work in partnership to support the development of escalation plans;
• Resource implications associated with the unscheduled care or pro-active discharge process identified and used to inform redesign, development and commissioning opportunities;
• Introduction of pathways that meet local needs;
• Ensure unscheduled care processes support patient safety and person centred care;
• Partnership working with Primary Care, NHS24, Scottish Ambulance Service, ADOC, Third Sector, Independent Sector and out of hours services to develop robust responses; and
• Identification of information and technology requirements that will support the reduction of unscheduled care.

Older People and People with Complex Care Needs
This programme aims to support Older People and those with complex care needs to proactively access and direct the high quality care and services they require to live a long, safe, active and healthy life at home or in a homely setting, drawing on support from informal networks and services available in their local community and developing self-management skills.

There are a number of key objectives for the programme:

• Place the older person and those with complex care needs at the heart of decision-making about their assessment, treatment, care and support, with a focus on maximising independence;
• Create a fully integrated, community-based physical health, mental health and social care team within each Partnership;
• Focus on preventative care and early intervention to support the effective management of long-term conditions;
• Establish home or homely setting as the norm for the delivery of specialist health and social care service delivery;
• Offer consistency and continuity of care for individuals at home, in a homely setting and in hospital;
• Make use of technological advances to support the older person and those with complex care needs in managing their long-term condition(s) with rapid support when required from the integrated team;
• Support the individual receiving care and their family in planning, securing and delivering the highest quality of person-centred end of life care; and
• Connect people to a local community based support network.

The planned outcomes are to reduce hospital admission; reduce length of stay; increase number of people supported in home/homely environment; reduce hospital re-admission rates; reduce numbers of delayed discharge; and reduce social isolation.

Acute Services - IHO (Institute of Healthcare Optimization) Whole System Patient Flow Programme
The objectives of this programme are to implement Admission, Discharge and Transfer (ADT) Criteria for discrete levels of care across all medical inpatient wards on the Ayr and Crosshouse acute sites. This will provide a framework to assist discharge planning (including criteria led discharges) and will increase objectivity in the day to day planning of hospital
capacity. It will also establish the means to gather a comprehensive data set to indicate demand for specialty care by objective clinical need, as opposed to the proxy measures currently used (e.g. consultant, ward, discharge diagnosis). This data set will be used to conduct discrete event simulation which will indicate the specialist medical capacity required to best match the clinical needs of our patients.

This work is intended to provide earlier access for patients to senior specialist review; reduction in length of stay; reduction in median time of discharge (i.e. earlier in the day); reduction in acute Occupied Bed Days (OBDs); reduction in patients ‘boarded’ out with specialty; and, reconfigured medical ward footprint to better match capacity to demand based on clinical need.

**Primary Care – Ambitious for Ayrshire**

The vision for primary care services across Ayrshire and Arran is to achieve:

* A strong local primary care service, supporting people in their day-to-day lives to get the best from their health, with the right care available in the right place when they need it. The overall theme is of partnership between individuals, communities, the health and social care and with partners

This vision is congruent with that set out in the national strategies of *National Clinical Strategy, 2015, Realistic Medicine, 2015* and *Pulling Together – transforming urgent care for the people of Scotland, 2015* as well as the *Health and Social Care Delivery Plan, 2016* and the Scottish Government’s Outcomes for Primary Care of:

- We are more informed and empowered when using primary care;
- Our primary care services better contribute to improving population health;
- Our experience as patients in primary care is enhanced;
- Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care; and
- Primary care better addresses health inequalities.

To respond to these pressures, a service model is being developed with GPs at the core of a hub or network of health, social and third sector provision, with the GP focusing on the care of individuals with more complex and undifferentiated conditions. Within this model each health and social care professional will need to work collaboratively and to the top of his or her competency level. This sits alongside the implementation of the new PMS contract.

This work is being progressed through eight key workstreams to set out how the vision for Primary Care in Ayrshire and Arran will be achieved, these are:

1. Development of services around GP clusters / localities;
2. Enabling effective service user pathways, support for self-care and shared care;
3. Investigating and addressing health inequalities (communities, priority groups, stages of life);
4. Enabling leadership for safety and continuous quality improvement for multi-disciplinary teams in practices, clusters and localities;
5. Increasing the capacity of services in the community, maximising expertise provided by contractors, achieving collaborative provision and shared care;
6. Ensuring workforce sustainability and development of new skills and roles;
7. Improving primary care infrastructure — premises and information technology and shared access to records; and
8. Integrating and enabling sustainable Out of Hours Services supporting unscheduled care.

The key outcomes are to ensure that primary care services are sustainable; practices are improving the quality of care by working in clusters of practices and undertaking peer review and continuous quality improvement; pathways are informed and supported to provide for safe, effective, efficient and patient centred care; collaborative leadership across clinical contractors is supporting primary care contribution to cluster and locality working; there is a shared understanding of the primary care response to deprivation and need; an integrated Out of Hours service, which is providing safe, effective and person-centred care which supports service providers to deliver; and, enhanced opportunities for GP recruitment and retention in Ayrshire and Arran.

NHS 24

NHS Ayrshire and Arran is the sole NHS Board working with NHS24 to develop strong partnership working and establish a NHS Model Office as a test and learn environment for NHS24’s new system and processes to achieve joint benefits, and improved care and outcomes for the population of Ayrshire and Arran. This work will also inform the wider roll out across Scotland of NHS24’s new system and processes.

This work will also support the transformation of Ayrshire and Arran’s urgent out of hours care through joint working with NHS24. This is in response to the fragility of primary care out of hours services which requires immediate and innovative changes and the opportunities offered by integration. It will also test new ways of working for NHS24 and Ayrshire and Arran in line with national review of urgent out of hours services, Pulling together: transforming urgent care for the people of Scotland, 2015.

NHS24 will create a Model Office environment populated by a 'Test & Learn Team' which will test the new NHS24 software with Ayrshire and Arran. This Team will operate in a protected environment which will allow them to work with us and test out new processes, functions and systems as well as learning from and adapting the model during the phased implementation of the NHS24 new technology platform.

This test will also look to enable NHS24 and Ayrshire and Arran to provide the right our of hours support to the public at the right time, by testing new ways of triaging calls in order to support integrated, out of hours services to achieve safe, efficient and effective care (right care at the right time by the right professional), thereby enhancing the patient experience.

Being a partner with NHS24 will provide Ayrshire and Arran with opportunities for future tests of change such as the joint development of Advanced Nurse Practitioners, as both
within the Board’s urgent care services and NHS24, the role of Advance Nurse Practitioners (ANPs) is being expanded.

**Planned Care: Improving Access – The Modern Out Patient (including DCAQ)**
The Modern Out Patient, formerly known as Delivering Outpatient Integration Together, or DOIT, is a national programme which supports NHS Boards and Health and Social Care Partnerships to deliver more integrated and accessible outpatient services and better outcomes for people who need to use these services.

The programme aims to ensure that all patients are seen at the right time, by the right person, and that the right information is available.

The objective is to use outpatient resources appropriately and improve patient experience. This will be done by reviewing and streamlining administrative procedures so that they support the patient pathway and make effective use of resources; establishing a patient reminder service; implementing advice only referrals; developing and implementing e-Internal referrals; reviewing outpatient clinic template configuration to maximise new patient capacity; undertaking Demand, Activity, Capacity and Queue analysis; and, in lieu of paper casenotes, implement Clinical Portal technology coupled with paperlite working. The clinical portal and paperlite will provide ease of access to clinical information to manage out-patient consultations and clinical administration across the continuum of care. The major benefit to using clinical portal will be that it can be accessed by any clinician who has appropriate role based access from any premises across the Board and also by clinicians from regional services in other Boards. This model will therefore help to progress the Health & Social Care agenda.

Work will also be undertaken on Pathway Management. This will involve considering use of alternatives to face to face consultations, e.g. advice only referrals, telephone consultations and letters to patients; examining alternatives to a follow up appointment with a consultant; the direction of patients to the most appropriate healthcare professional at point of referral and throughout their pathway; and, the discharge procedures including patient initiated review.

**Children’s Services**
Building on the pan Ayrshire work in support of the implementation of the Children and Young People (Scotland) Act 2014, named person arrangements, and the integrated Children’s Service Planning in East, North and South Ayrshire, a further proposal is being developed to identify areas for further examination in support of transformational change. This is at an early stage with ongoing discussion across the partners.

**Technology Enabled Care (TEC)**
The aim of the TEC Programme is to promote independence, choice and quality of life for people and to support a higher number of people to live independently in their own homes by developing a framework or whole systems approach with which to deliver integrated, mainstream equitable services across NHS Ayrshire and Arran and its three Health and Social Care Partnerships.
The TEC Strategy underpins this aim and its objective over the next three years is further utilise TEC across North, South and East Health and Social Care Partnership and Acute Services. TEC is an enabler of transformational change and offers alternative approaches to deliver health and social care services. Alongside pathways which are designed around the person and providing services by the right person, at the right time in the right place, TEC will contribute to maximising efficiencies across a system while achieving person centred outcomes. A national Outcomes Model has been developed which underpins the scalability and mainstreaming of TEC. Locally these are identified as:

- Increased number of people using HMHM (PODS and Florence) to monitor Long Term Conditions.
- Increased use of Technology to support Diabetes Services.
- Improved Compliance/Medicine usage.
- Reduction in admissions for Acute Diabetic complications.
- Reduction in inappropriate referrals.
- Reduce length of stay through Tele- Rehabilitation.
- Improved access to equipment.
- Increase access to KIS within Acute.
- Improved quality of information contained within ACP.
- Less spend on Overnight Services.
- Ability to increase Day Services.
- Increase access to Telecare universally.
- Increased use of appropriate Telecare according to risk.
- Increase in number of people using Telecare.
- Numbers of new people using Telecare.
- Reduction in avoidable Hospital admission by 10% over the next 5 years.
- Reduction in readmission rates of 10% each year.
- Provide early intervention and appropriate support for patients with Diabetes and Respiratory Conditions.
- Reduction in A&E attendances.

**Acute Services - FastForward**

>>Fast Forward is an approach, based on the Institute for Healthcare Improvement 90 day concept approach, which has been devised in-house to support rapid cycle development of service level action plans. Successful organisations set clear long-term goals, and regularly review their transition towards those long term goals. The process seeks to:

- Establish an improved understanding of the service;
- Challenge the existing model of service delivery and its ongoing sustainability;
- Agree priorities for changes to future service delivery in the short, medium and longer term; and
- Develop a clear approach and timeline for priority development to produce an Annual Service Plan.

Building on the work undertaken during 2016/17 supporting reviews for the specialties of Trauma & Orthopaedics; Cardiology; General Surgery; and Respiratory, the outcomes and impact of this work are now being seen in some areas, and will influence spend in 2017/18
onwards. A further draft schedule of reviews due to be undertaken within 2017/18 is in the course of development.

**Acute Services - Performance Intelligence Support to Acute Service Planning**

The provision of performance intelligence and benchmarking data is intended to provide insights for service planning to enable a fact-based understanding of problems, informed decision making based on a best value approach, and to track areas for performance improvement and service development. This approach is increasingly being used across services, with the current focus on supporting speciality level site based planning and the >>FastForward service review processes.

**Acute Services – Modelling Unscheduled Care**

Capita has been engaged to undertake Unscheduled Care modelling using the HORIZON Modelling tool. The objectives of this work are to be further refined following discussion with Capita. At this time they are aimed at achieving maximum impact from the CAU; modelling the alternatives to acute bed stays for those who no longer require acute care; considering the impact of the core modelling work undertaken for the Older People and those with Complex Care Needs Model of Care; and, assessing the benefits from the Institute of Healthcare Optimization work.

7.2. **Best Value Programmes**

**Directorate Restructuring - Corporate and Clinical Support Services**

The purpose of undertaking the Corporate and Support Services directorate review was to demonstrate best value in everything that we do; to make the most efficient use of existing resources in order to meet the increasing demand these services; and ensure that customers’ requirements are met in the most cost effective manner. The review is now complete and implementation has commenced.

**Directorate Restructuring - Human Resources**

This programme will review all services provided by the HR/OD Directorate, looking to the future to identify the optimal way to deliver the Directorate’s range of people related services to meet customer needs and deliver on the Board’s purpose and objectives, within available resources, whilst meeting our efficiency requirements. Processes will be streamlined to remove duplication; non value added activity stopped; and ways of working reviewed and modernised to make the most effective use of technology. The aim is to transform the functioning of the Directorate to the benefit of the Board; patients; internal customers; those who use HR/OD services; and, staff within the Directorate.

This will also place the Directorate in a position to participate in, and deliver on, the national work being undertaken on the full implementation of the eEmployee Support System (eESS) and the recently re-launched and reinvigorated national Shared Services programme. This requires HR communities to be agents of change and spread good practice/excellence, working together more effectively with a once for Scotland approach. To achieve this, standard systems are needed for transactional processes to allow more time to be focussed on supporting or leading transformational change.

Locally, the four key drivers are to:
1. Contribute to the Board’s Cash Releasing Efficiency Savings (CRES) requirements in a planned, long term and sustainable way;
2. Deliver a quality, streamlined, and modern operation by working through a programme of review and redesign;
3. Respond to staff feedback from the staff survey and iMatter on the growing demand being placed on the HR/OD service to ensure that by reviewing and refocusing the work of the Directorate, a quality, sustainable service is delivered by staff who feel valued and fulfilled; and
4. Contribute to and support the implementation of the national HR shared services work to develop strategic options for the delivery of HR/OD services to support NHSScotland into the future, underpinned by the full implementation of eESS.

**Shared Services - NHS Scotland Procurement Review**

Preparation of an Outline Business Case has ceased and been replaced with a strategy document which was submitted to the Chief Executives’ meeting mid February 2017 and agreed. Any actions arising will be incorporated into our local plans.

**National Shared Services Initiatives**

There are number of programmes within the National Shared Services initiatives in which we are fully engaged; Logistics and Fleet; Capital Planning, PFI contracts; Estates, Professional Fees. Actions arising from national work will be implemented locally, as appropriate.

We are scoping opportunities with Lanarkshire, Dumfries and Galloway and Greater Glasgow and Clyde across all activity areas covered by the national shared service initiative to determine whether regional collaborative working could release additional efficiencies and at an earlier time. In addition we are working with the three HSCPs and Local Authorities on Joint IT and Information Governance.

**Realistic Medicine - Effective Prescribing**

This programme is linked to the national programme for Effective Prescribing and aims to improve the cost effective use of medicines in NHS Ayrshire and Arran through a programme of established and transformational change initiatives.

The objectives are to:

- Develop and deliver the effective prescribing plan for medicines in primary and secondary care using the established approach;
- Undertake 1300 polypharmacy reviews across primary and secondary care;
- Develop further secondary care whole system transformational change plans including:
  - Accelerated whole system approach to biologics and biosimilars and achievement of the national biosimilars uptake target
  - Increase engagement of secondary care clinicians in review of utilisation of high cost medicines linked to patient outcomes
  - Undertake review of OP prescribing in key specialties
  - Review medicines supply arrangements in secondary care
• Develop and test a whole system transformational approach to respiratory, analgesics and antidepressant prescribing.

NHS Ayrshire and Arran has a well established and effective approach to improving the effective prescribing of medicines in primary care. This work has resulted in the cost per prescribed item in primary being below the national average. This is underpinned by a proactive approach to formulary management with good compliance with the current range of medicines within the formulary. However further work on narrowing formulary choice will be included in the whole system transformational prescribing plans.

Significant assessment work has been undertaken through the Medicines Resource Group (MRG) with effective prescribing plans and savings agreed for 17/18. These plans include an increased focus on polypharmacy reviews to improve the quality of prescribing for patients on multiple medicines and to review the higher volume of items prescribed for patients across a range of medicine categories.

Due to the increasing costs of medicines in secondary and specialist services, an increased focus on the effective use of medicines in secondary care is required. This will require increased clinical leadership and engagement from medical, pharmacy and nursing staff. A number of areas of work have been identified to progress and project plans will be developed by the end of March 2017. The transformational change impact will be identified as part of the project planning with any financial savings prioritised where appropriate within the project plans.

NHS Ayrshire and Arran has a high volume of items prescribed per patient and this has a significant impact on the overall cost per patient for prescribed medicines in primary care. A transformational approach to effective prescribing is required to tackle the volume of medicines prescribed. This approach will be initially tested in the area of respiratory, analgesics and antidepressant prescribing. These programmes will be developed through engagement with key clinical leaders and stakeholders and will aim to develop and implement new services to improve outcomes for patients by re-investing savings from prescribing. A proportion of savings will be required to support the organisational CRES target.

**Realistic Medicine – Better Quality Better Value**

The Better Quality Better Value (BQBV) programme which is part of National Services Scotland NSS shared with us some data, outlining potential savings if NHS Ayrshire and Arran reduced the volume of certain procedures of “low clinical value” to the Scottish mean. It is noted that 81% of potential savings are concentrated in three procedure groups:

- Cataract Surgery
- Knee Replacements
- Minor Skin Lesions

These procedures are more accurately referred to as procedures providing “better quality better value” as they may have a significant positive impact on clinical symptoms and
quality of life for the patient. We will be looking at access criteria to ensure that only patients likely to benefit from these procedures may access them.

**Workforce including Medical Workforce, Nursing Workforce**
The collective aim for this programme is for the Board to have the right workforce, with the right skills and competencies, at the right time to provide high quality, sustainable and affordable services, and for this workforce to be utilised in the most efficient and cost effective way, where all staff work to the maximum of their capability.

The important role that workforce has in successfully implementing change programmes, both in terms of workforce planning and human factors, is recognised, together with an understanding of current and future workforce challenges in terms of demography, supply, changing skills and roles. This is required to predict future need and develop robust action planning. The NHS Board’s 2016/17 Workforce Plan identifies key workforce actions.

Workforce planning and evaluation is a key element of all of the programmes of transformational change and service redesign. It is appropriate to pull these together into an overarching Workforce Change Programme overseen by a Workforce Planning Programme Board, which identifies the key current and anticipated future workforce challenges for the Board, and the actions being taken to address these.

The three main objectives sitting within this programme are to:

- Improve attendance; skill mix; management costs; vacancy management; and time to recruit;
- Ensure the workforce implications and improvements arising from the work of the programmes within the Portfolio for Transformational Change are captured and the overarching impact and interconnections identified; and
- Address Staff group specific actions or improvements relating to the Medical and Nursing workforce.

**Estates Master Plan**
A key component of our plan for future delivery of services is focussed on the necessary infrastructure at all points of service delivery, whether in the community or secondary care setting. The Estates Master Plan will review our existing infrastructure in conjunction with future model of service delivery, seeking to optimise and rationalise existing infrastructure alongside a plan for new capital developments. It will identify surplus property and obsolete buildings for disposal across the estate. This will ensure the most effective and efficient use of existing property. In addition, projects which may include new buildings, refurbishment or extensions of existing buildings will improve the sustainability and performance of the estate, supporting clinical services for the foreseeable future.

**Enhanced Performance Framework**
The Health Foundation (2015)\(^1\) highlights seven key success factors for transformational change in the NHS. In respect of performance management these include:

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\(^{1}\) Transformational change in NHS Providers, Health Foundation, 2015
clear accountability for performance and effective management structures to implement change;

- insights from data analysis that enable a fact-based understanding of problems, inform decision making and track performance; and

- Capabilities to identify the root causes of problems, plan and prioritise how to solve them and manage implementation in a structured way.

The enhanced approach to Performance Scrutiny within NHS Ayrshire and Arran has therefore been designed to support transformation change in these ways. Over the next three to five years this approach will develop to support performance scrutiny and improvement discussion for core areas of business and to support transformational change programmes. This continuing approach to monitoring, challenge and review underpins our approach across the system.

**Best Value Initiatives**

In respect of efficiency and productivity, we are progressing a number of areas where there is opportunity for increased best value, although not all of these will result in financial savings. Initiatives are being undertaken in respect of elective Theatre productivity/activity and Catering, Cleaning, Estates and Laundry services with feedback from involvement in national work being incorporated locally. Other activities are reported within their respective programmes.

### 7.3. Collaborative Working

**National Services Scotland (NSS)**

A range of support is being provided from NSS. This includes an aligned single point of contact with NSS, data analyses to support informed decision making; and project support across a range of topic areas.

**Healthcare Improvement Scotland - Effective Care Programme (ECaP)**

This programme utilises a similar approach to that of FastForward. There are ongoing discussions to scope the application of the process to complement existing local work. Actions arising from this will be incorporated into the Delivery Plan as appropriate.

**Healthcare Improvement Scotland - Health Improvement Alliance Europe**

Scottish Government Health and Social Care Directorate has selected a small number of NHS Boards (NHS Ayrshire & Arran, Scottish Ambulance Service, NHS Lothian, Healthcare Improvement Scotland (HIS), NHS Highland) to participate in developing the above Alliance in partnership with Institute for Healthcare Improvement (IHI).

IHI has previously established a successful Alliance of 40 healthcare providers in the USA with the aim of collaborating to maximise opportunity for improvement.

Previously the alliance members had agreed to three key workstreams and these were the focus for a recent event:

- Population health;
- Joy at work; and
- Quality Improvement (QI) in a financially constrained environment.
Population health is focused on what is meant by this term and what it should encompass. There is recognition that there are similarities and differences across the countries involved and that ‘Europe’ is not actually represented by those present. Whilst as yet there has been no discussion on what we might do to improve population health or learn from others who are making inroads, it is anticipated that this will be addressed.

Joy at work is acknowledged as being crucial but that the terminology might need some translation. It was also agreed that it should consider the whole person not just ‘at work’. Learning from each other will be shared and iMatter, a staff engagement process, puts NHSScotland Boards in good place already with this work.

Focusing on QI in a financially constrained environment is recognised as being important but the difficulties of maintaining this as finances tighten are acknowledged.

In addition, the opportunity is being taken to revise and rationalise nursing documentation which is an integral part of delivering the Excellence in Care Programme. This will include exploring opportunities for multidisciplinary unified approaches and electronic solution to release nursing capacity and improve efficiency.

Locally, we are exploring taking forward possible opportunities further with colleagues; taking forward actions together with HIS, including staying virtually connected for any potential resources; agreeing to test ‘Joy at Work’ activity; and establishing a documentation review group under the leadership of an Associate Nurse Director.

**Acute Services: Patient Flow - Scottish Ambulance Service**

The aim is to work collaboratively with the Scottish Ambulance Service in delivering an improved and sustained service for the patients of Ayrshire and Arran. We will do this by reviewing and streamlining current processes to support the patient pathway and make effective use of resources. The areas to be targeted are:

- Improved ambulance turnaround times within the Emergency Department/Clinical Assessment Unit (ED/CAU) by improving handover processes within those areas;
- Reduced reliance upon ambulances to discharge patients by improving the discharge planning process;
- Improved scheduling of ambulances required to facilitate patient discharge; and
- Reduction in cancelled Outpatient Appointments as a result of ambulance cancellations.

There is a close association between the work of this programme and that for Transport.

**NHS Dumfries and Galloway**

Discussions have commenced with NHS Dumfries and Galloway to develop structures and timelines to progress a collaborative approach. The range of issues being focussed on initially include Vascular, Urology, Head and Neck, Laboratories and the clinical model for the South West population (Girvan to Stranraer). Other areas include, medical workforce and an agreement that where opportunity arises to consider other functional services.
Transport
The West of Scotland Integrated Transport Hub is a collaborative partnership with key stakeholders, including Strathclyde Passenger Transport (SPT), Councils, NHS Boards, Scottish Ambulance Service and Community Transport. The Hub will look to co-ordinate relevant partners’ resources (vehicles and drivers) in conjunction with the Scottish Ambulance Service resources to develop improved transport solutions, avoid unnecessary or duplicate journeys and achieve economies of scale. The development of the Hub will be based on some core principles to improve quality, efficiency and co-ordination.

The overall aim of the Hub is to: “Develop an integrated single booking and scheduling point of contact for Health and Social Care transport services in the West of Scotland through SPT’s Contact Centre”.

This will improve the transport experience for the users of these services; improve the coordination and efficiency of health and social care transport provision in the West of Scotland; provide transport based upon need; reduce inappropriate journeys; assist with meeting the increasing demand; and, achieve budget efficiencies.
8. Delivery Plan

This Transformational Change Improvement Plan describes our programmes of transformational change and sets out our intention for this period of transformation from 2017 to 2020. Our plan is intentionally aspirational, seeking to make deliberate, sustainable improvement in the way that we deliver health and care services in Ayrshire that will achieve better outcomes for the people who use these services.

Accompanying this document is the annual Delivery Plan which describes in more detail how we intend to meet both the requirements of the Local Delivery Plan and the identified actions from each programme of transformational change necessary in that year to achieve the improvement required. This Transformational Change Improvement Plan should be read in conjunction with the relevant year’s Delivery Plan.