

Moving Forward Together.



# Moving Forward Together Programme Overview

# Welcome

## Today:

- Describe the Programme to transform **health and social care** services across **Greater Glasgow and Clyde: Moving Forward Together**
- Hear about local **Health and Social Care Partnership** plans and where they align with Moving Forward Together
- We will explain why we think we need to make changes to services
  - Describe what this might look like through our Vision to deliver Tiered Models of Care
  - Describe what work is already underway or planned locally that fits with the Vision
- Hear what people think about the Programme and start conversations about **what matters most to people**
- Let you know where you can get more information and stay involved

# Introduction to Moving Forward Together



## What is Moving Forward Together

- Moving Forward Together is a **Vision** to transform **healthcare** and **social care** services across **Greater Glasgow and Clyde**
  - It was developed by a **cross-system team** with clinicians, frontline staff and the six Health and Social Care Partnerships
  - It describes **new ways of working** that provide safe, effective, person centred care to:
- Aims to deliver improvements in care and outcomes for all patients service users and carers by:
  - **Maximising available resources**
  - **Making best use of innovation and technology**
- It has been approved by NHSGGC Health Board and noted by the six Integration Joint Boards
  - Sets a **strategic direction** of travel for the next **3 to 5 years** and beyond to meet future needs of the **whole population**
  - It is aligned with **Scottish Government** strategy and plans



# Why we need to transform services

There is increasing demand across the whole system



Advances in medicine and effective public health interventions are helping us all to live longer



As more of us live longer the demands on health and social care services are also increasing



Nature of illness has changed, people are now living with diseases and conditions that previously would have been fatal



Health and social care system is struggling to keep pace with extra demands



# What this means

Our **current models** of care are facing a number of challenges



The current **'fix and treat' approach** to healthcare doesn't focus on prevention, self-management and reablement



**Increasing reliance on hospital care** is simply not in the best interests of people



The **increasing demand** will simply **not be met** unless we change how services are accessed and used



There is a **limited** budget to spend on health and social care, and we need to use our resources to provide services that are **realistic, affordable and sustainable**

# What we want to do

To meet the challenges we face we aim to deliver an integrated and seamless **tiered system** of person centred care across the whole system that:

1. Maximises Primary, Community and Virtual Care Opportunities
2. Aligns with West of Scotland Regional Plans
3. Optimises our Hospital Based Services



Local tiers are provided across the whole of GGC at / close to people's homes to promote independence and self management



As treatment or care becomes increasingly more complex with severity of illness, it is provided in fewer and more specialist centres that serve an area or even a region

# Innovation and Technology

Central to developing **new ways of working** is better use of **eHealth, information and technology**

- **Integrated systems, records and care plans** that **improve communication, decision making and safety**
- Give the right '**people**' access to information to enable them to make confident **informed decisions**
- **Technology enabled care** to provide real-time information that supports people and services





## It's not just services that need to change...

- To help reduce pressure on the system people need to access the **right care**, in the **right place** at **right time**?
- We all need to **think, work** and **act differently** to:
  - Promote greater self care and health improvement with the community networks to support this
  - Support people to access and use services differently with knowledge of and trust in new models and alternatives
  - Work more collaboratively with the Third Sector, community planning partners



## Importantly...

We will need to work alongside **people** on concepts to **hear what matters most to them** to develop more detailed plans



# HSCP Plan & Objectives

## **Our Vision**

“Inverclyde is a caring and compassionate community working together to address inequalities and assist everyone to live active, healthy and fulfilling lives”

*“Improving Lives”*

# HSCP Plan & Objectives

## Six Big Actions

### Big Action 1:

Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health

### Big Action 2:

A Nurturing Inverclyde will give our Children & Young People the Best Start in Life

### Big Action 3:

Together we will Protect Our Population

### Big Action 4:

We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living

### Big Action 5:

Together we will reduce the use of, and harm from alcohol, tobacco and drugs

### Big Action 6:

We will build on the strengths of our people and our community

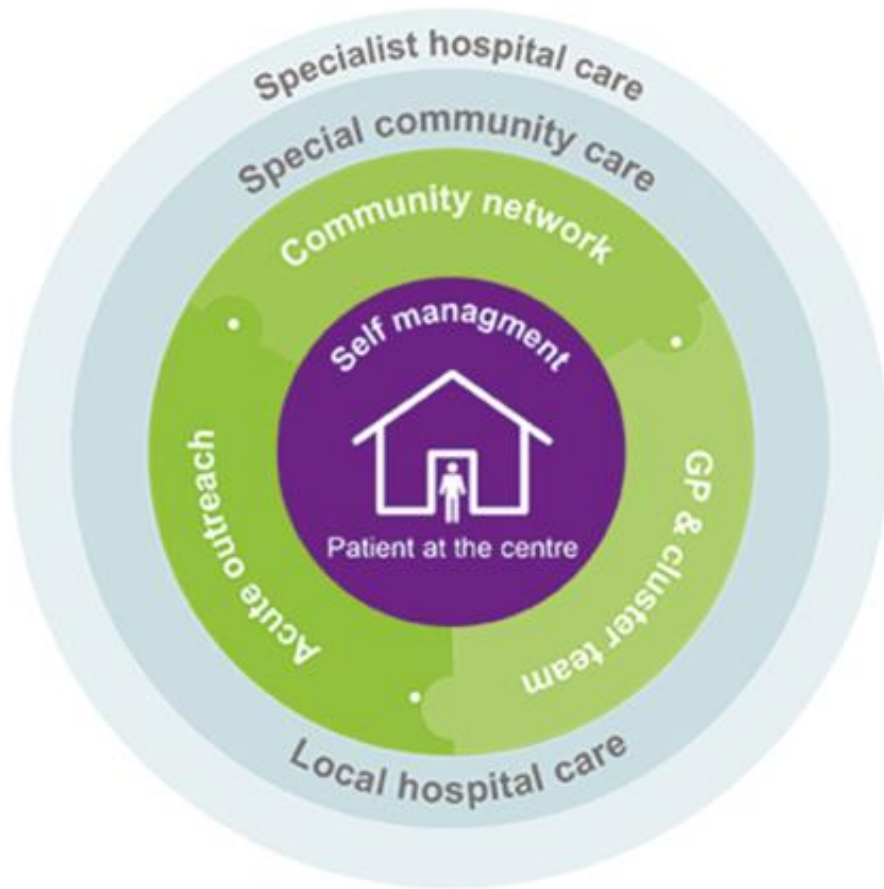
# Feedback and Questions

## What are your thoughts so far?

- Do you recognise the challenges we face and the need to change?
- Do agree with our direction of travel
- Other thoughts or questions?



# The Tiered Model of Care



- Puts the Person at the Centre
- Supports people to live longer healthier lives at home or in a homely setting
- Provides more care in or close to people's homes in their community
- Provides more specialist care in a community setting
- Provides world-class specialist hospital care for our whole population



# Person Centred

Moving Forward Together recognises The absolute need to put the person at the centre of all care

We need a system that:

- Is fair and built upon values of dignity, equality, freedom, autonomy and respect,
- Also recognises the needs of carers and ensures everyone is treated as an individual
- Empowers people to be more involved in and make better informed decisions their care
- Improves experience and outcomes



# Level 1: At home

## **Moving Forward Together aims to:**

Help people to live independently at home or in a homely setting within their community by:

- Promoting healthier lifestyles and supporting people to maximise their own health and wellbeing
- Supporting self management of long-term conditions and improving anticipatory care planning
- Using technology to monitor health, provide real-time information to improve decision making and prevent hospital admission
- Providing end of life care and supporting people to live how they want until death



## What this might look like

**In the future** technology and information will play be central to how we will be able to better support people to live independently at home.

**Mr Smith** live alones and has a number of long-term conditions.

The teams that support him are able to see the information from technology he uses around his home to monitor how he is coping day-to-day and to anticipate him needing more support if his health worsen.

Sometimes he is visited at home by the specialists, but often he speaks to someone for advice via a video call.





## What this might look like

**In the future** technology and information will play be central to how we will be able to better support people to live independently at home.

If **Mr Smith** does need to go to for more complex tests he can use Patient Portal to book, track and change appointments and see any results.

If he does need to go into hospital his anticipatory care plan is on an App and he has given the people involved in his care, including family members, access to this so that people understand what is 'normal' for him and importantly what matters most to him.



# What's happening locally

- **Telehealth**
  - Increasing the type and range of digital technology that is available to diagnose and monitor long term conditions which allows the individual to take control and manage their own health
- **STEP UP at Home**
  - Avoid unnecessary hospital admission by providing a short period of rehabilitation within the service users home
- **Home 1ST Reablement**
  - All older adults referred for a support service will undergo a 6 week reablement assessment this covers hospital discharge allowing development of discharge to assess model. Reablement aims to get people back to the level of independence
- **Access 1<sup>st</sup>**
  - Health and community Care are developing a single point of contact which will in future screen all referrals for Assessment and Care Management, Home Care Inverclyde Centre for Independent Living District Nursing
- **Locality Groups**
  - Brief weekly meetings between Team leads from across Health and Community Care to collaborate on support adult with complex care needs in the community

# Feedback and Questions

## What are your thoughts so far?

- Do you recognise the challenges we face and the need to change?
- Do agree with our direction of travel
- Other thoughts or questions?



## Level 2: In communities

**Moving Forward Together aims to:**

**Provide a network of community based services that can:**

- Offer advice, support or treatment to improve, maintain or support a return to health
- Rapidly escalate through the other levels care when required to meet individual needs

**The GP practice is at the core of the network coordinating care:**

- The practice team will be tied into a wider network providing easy access to a range of services that share information and care planning
  - These might be organised in clusters to share resources more effectively or aligned to a community hub
- In the wider community network there will be other teams and community assets delivering an extensive range health, social care and wellbeing services



## What this might look like

**In the future** a network of services will be available in the community in Hubs or via virtual networks

**Mrs Andrews** is visiting her local health and social care Hub to see her GP. Whilst there she mentions feeling a bit anxious lately as she has some money worries. The GP suggests she speaks to the Community Connector based in the Hub.

The Community Connector is able to make an appointment with a money advice worker and Mrs Andrews is able to logon to Patient Portal and sees that she can have this on the same day she is due to come back to undergo some tests needed to monitor her long-term condition.



## What this might look like

**In the future** a network of services will be available in the community in Hubs or via virtual networks

**Mrs Andrews** goes back to the Hub to see an Advanced Nurse Practitioner for tests in one of the multipurpose treatment rooms used by a range of visiting specialist hospital services.

Afterwards she speaks to the money advice worker who is able to review her circumstances, help her apply for some benefits to maximise her income and provide advice on some debt she has.

On the way home she receives a message to say her test results are in. She is able to login to Patient Portal and see that after being reviewed by her consultant everything is okay and a letter has been sent to her GP.



# What's happening locally

- New Health and Care Centre – Multi purpose hub – 2020
- Learning Disability Review – New Centre
- Addictions Review
- Support and improve young people's mental health
- Reduce inequalities
- Public health priorities
- Expanded multi-disciplinary team in primary care – Pharmacists, Physiotherapists, Advanced Nurse Practitioners, Community Links Workers
- Choose the Right Service – our information campaign to support the public to make the right choice

**Choose the right service!**



# Feedback and Questions





## Level 3

# Local hospital & special community care

### **Moving Forward Together aims to:**

Provide access to hospital and other specialist care as an extension to the care delivered in a person's home and community

- Wherever possible hospital care should be anticipated as part of a process of care and a system that:
  - Access to a wide range of day case and short stay treatments available within their local geographical sector
  - Provides highly specialist community care for some conditions with some services only having one team for the whole population
  - Enables and supports a person to return to independent living as soon as practicable and safe to do so
  - Meets the needs of people living with a single condition or those with a complex array or multiple needs



## What this might look like

**In the future** some hospital-based teams will provide outreach to and support other teams to deliver highly specialist care in the community

**Mr Smith** has respiratory disease and receives treatment and care from a hospital-based, consultant-led, multi-disciplinary team. Members of the team visit him at home to provide care that used to be delivered in the hospital.

The team has taught him techniques and strategies to cope with breathlessness and arranged home modifications to make his daily activities easier. Technology has enabled Mr Smith and the team to remotely monitor his condition and if it worsens they can get in touch with each other to make a decision about his care needs.

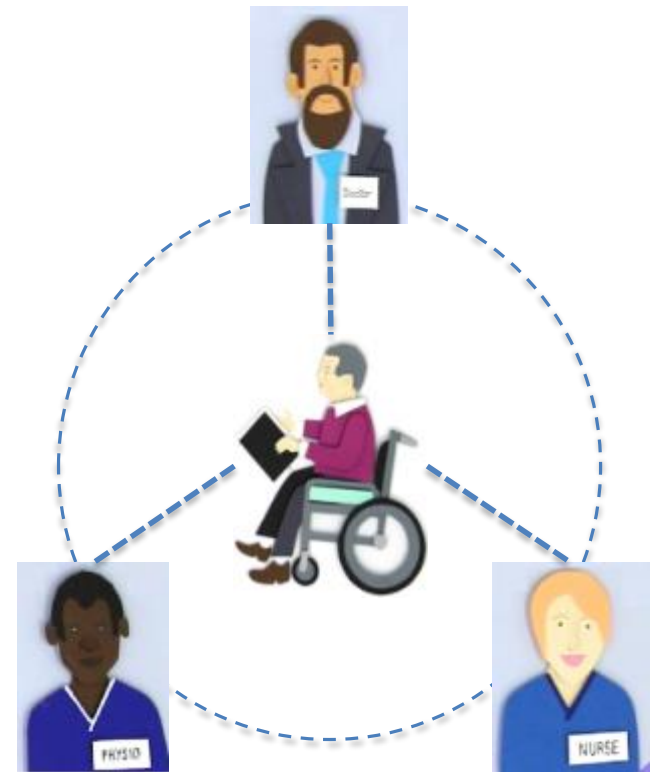


## What this might look like

**In the future** some hospital-based teams will provide outreach to and support other teams to deliver highly specialist care in the community

If Mr Smith does need an advanced assessments this is often done in his home and his care reviewed by his consultant and the team using a virtual clinic. They discuss changing his medication and think he might need some nutritional supplements so the pharmacist and the dietician will contact him to make an appointment to see him at home.

Before this Mr Smith had to arrange transport to go to the hospital to have assessments and tests done and sometimes when he was really breathless and worried he would call 999 and was often admitted to hospital where he could be monitored.



# What's happening locally

- New Health and Care Centre
- Home 1<sup>st</sup>
- Access 1<sup>st</sup>
- LD Review – New Centre
- Addictions Review
- Development of digital strategy, to take advantage of new technology and support better information sharing
- Review of Transport
- Scoping 7 day working

# Feedback and Questions



# Level 4: Specialist Hospital Care

## Moving Forward Together aims to:

Provide world class specialist hospital care to the whole population of Greater Glasgow and Clyde and beyond

- Some care will require access to specialist equipment or highly trained specialist staff
  - These services might have to be delivered by a single team or from a single location
  - By working this way we are able to deliver better outcomes whilst effectively using our resources
- Provide more day case and short stay procedures to minimise the time people are in hospital
- Where safe to do so we will use 'hub and spoke' models and hospital outreach to deliver some elements of care as locally as possible



## What this might look like: Specialist Hospital Care

Our current model of care for people who need chemotherapy to treat cancer



70% of all patient treatments are given at the Beatson West of Scotland Cancer Centre



25% at the New Victoria Infirmary



5 % at Inverclyde Royal and the Vale of Leven hospitals

The Beatson opened in 2007 with a capacity to provide a **maximum of 30,000 treatments per year**. It currently delivers almost **38,000** with this projected to reach **53,000 by 2025**

# What this might look like: Specialist Hospital Care

How we want to deliver chemotherapy to treat cancer in the future



50% of all patient treatments are given at the Beatson West of Scotland Cancer Centre



50% in 3\* cancer treatment units and in 5 cancer outreach centres



Some treatments eventually given in community setting including pharmacies

A **tiered model** with **Beatson outreach** to other settings will ensure we meet capacity and deliver more services closer to where people live





# How we currently provide services

For people who need chemotherapy to treat cancer

Mr Smith lives in Greenock and he has been diagnosed with prostate cancer. For this, he is prescribed a medication called Abiraterone, which is available in oral tablet form.

In the current clinical model, he attends the Beatson West of Scotland Cancer Centre every 4-8 weeks for an outpatient appointment with a consultant oncologist.

His oncologist gives him a prescription to take to the hospital pharmacy. All his appointments are at the West of Scotland Cancer Centre.



# How we want to deliver services

For people who need chemotherapy to treat cancer

In the proposed new model, Mr Smith will attend the Royal Alexandra Hospital for his initial assessment and the start of his treatment.

If his first treatment goes well, he will then go to Inverclyde Royal Hospital every 4-8 weeks for an outpatient appointment with either a specialist nurse or a pharmacist from the Beatson

He will be given the choice of getting his prescription from the hospital pharmacy or his local high street pharmacy.



# Feedback and Questions



# Tabletop discussion

We would like to know:

- What **matters most** to people
  - Help us develop new models of care that are person centred
- How can we **work together** to meet challenges
  - What can you do as an individual
  - What can others do
- How can we keep the conversations going and involve you going forward



## Find out more and stay involved



The screenshot shows the homepage of the 'Moving Forward Together' website. At the top, the title 'Moving Forward Together.' is displayed in a teal and purple font. Below the title is a navigation menu with seven items: Home, Moving Forward Together, Resources And Documents, Transformation In Practice, How To Get Involved, Groups And Engagement, and Latest Updates. The main content area features a large photograph of a diverse group of people, including two women knitting, a young girl in a bicycle helmet, and several men in a workshop setting. Below the photo, the heading 'Moving Forward Together' is followed by three paragraphs of text explaining the website's purpose and providing contact information.

**Moving Forward Together**

The way health and social care services in Greater Glasgow and Clyde are provided is changing for the better.

If you live in East Dunbartonshire, East Renfrewshire, Glasgow, Inverclyde, Renfrewshire or West Dunbartonshire or if you work within health and social care services in these areas, then you may be affected by this.

This website will provide information as the plans develop, explain what these changes are, what this means for you as a patient, a service user or a member of staff and how you can help us shape these plans.

Please use these webpages to keep up to date with the Moving Forward Together Programme and to find out more.

### For further information

Visit: [www.movingforwardtogetherggc.org](http://www.movingforwardtogetherggc.org)

Call: **0300 123 9987 (free phone)**