Moving Forward Together

Moving Forward Together

GCVS Thinkspace Event 25 Nov 2019

Programme Overview

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 was reviewed by a group of **patients, service users, carers** and their representatives
  - It describes **new ways of working** that **provide safe, effective, person centred care**
- Aims to deliver **improvements in care and outcomes** for all patients service users and carers by:
  - Maximising our **available resources**
  - Making best use of **innovation and technology**

A blueprint for future delivery models

- It has been **approved** by NHSGGC Health Board and **noted** by the six Integration Joint Boards
  - Sets our **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 **West of Scotland** and **Scottish Government** strategy and plans

We have and will continue to work with people on the concepts to hear **what matters most** to them to develop more detailed plans to transform services

The underlying principles

Moving Forward Together is based on a set of Principles to guide how we will transform health and social care

- A whole system approach to health and social care
- Using the knowledge and experience of our wide network of expert service delivery and management teams
- Engaging with and listening to our staff and working in partnership
- Involving our service users, patients and carers as early as possible
- Reduce our dependency on hospital based care and inpatient beds
- Support people to self-manage and deliver more care in communities closer to people's homes
- Embracing technology and the opportunities of digital and eHealth
- Looking beyond today's constraints for tomorrow's solutions

Integration Joint Boards Strategic Priorities

Moving Forward Together aligns with the strategic priorities to deliver integrated health and social care services

- Early intervention and reduction in emergency admissions
- Shifting the balance of care from hospitals and institutions to the community
- Avoid unnecessary delays in discharge from hospital
- Promoting individual independence and choice
- Supporting unpaid carers
- People have positive experiences of health and social care services (including at end of life)
- Tackling inequality
- Improving life chances for vulnerable children

Why do we need to transform services?

There is increasing demand across the whole system

More of us are living longer

- Advances in medicine and effective public health interventions
- People living with disease and conditions that were previously fatal
- Demand on health and social care service are increasing
- System in struggling to keep pace with demand

Current models of care are facing a number of challenges

Increasing reliance on hospital care

- Current ‘fix and treat’ model doesn't focus on prevention self-management and reablement
- Hospital treatment and care is not always the best thing for people
- Demand will not be met through traditional ways of working
- Resources, skills and expertise need to be used to provide services that are affordable and sustainable

Developing new models of care

To meet challenges we will have to find new ways of working

- Looked at population data, available evidence, existing strategies, advancements in medicine and technology
- Presented to clinical and frontline staff across the whole system to ask what already works well or what can we do differently
- Based on their knowledge, expertise and experience we need to shift the balance of care to the community, focus on prevention, self-management and avoid hospital admission
- Sense checked and reviewed ideas with a group of people - patients, service users, carers and their representatives

What we want to do

We want to deliver an integrated and seamless **tiered system of care** that**:**

- Places the Person at the Centre
- Supports people to live longer healthier lives at home or in a homely setting
- Recognises the needs of carers
- 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

What will it look like?

Tiered models of care working across the **whole system** to:

1. Maximise Primary, Community and Virtual Care Opportunities
2. Align with West of Scotland Regional Plans
3. Optimise 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

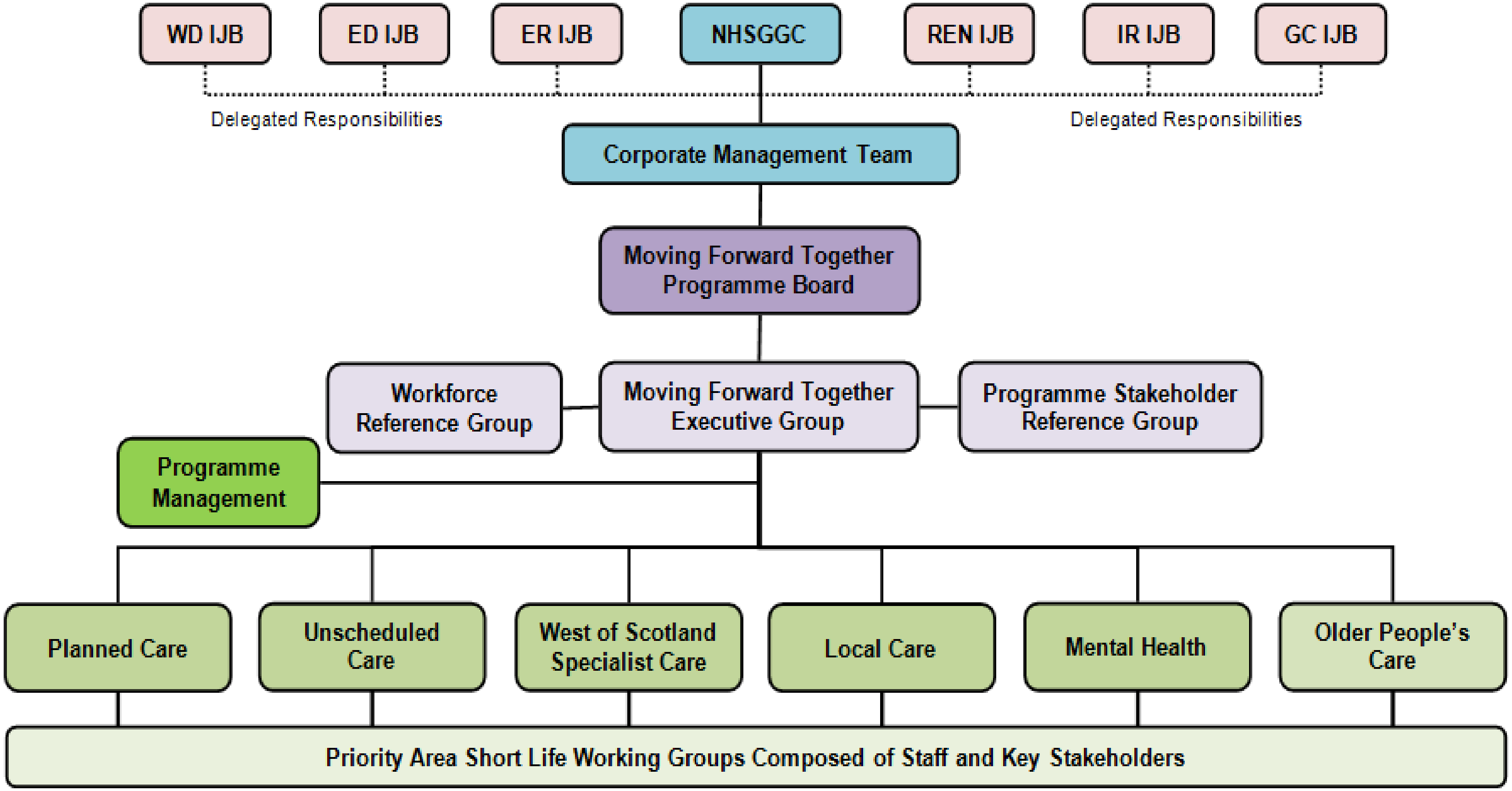
As treatment or care becomes increasingly more complex with severity of illness, it is provided in fewer and more specialist centres that serve an area or even a region

Moving Forward Together

Implementing the Vision

Six **'Workstreams'** have been setup with cross-system expertise

- Looking at the concepts and principles set out in the vision to develop new ways of working and models of care across health and social care



Planned Care

Planned Care is described under Moving Forward Together as:

> ***Services which are offered by prearranged appointment in community and hospital settings to diagnose, intervene, treat, monitor and maximise people's health and wellbeing.***

The Planned Care Workstream will look at new ways of working to link hospital and community services and to deliver more care closer to people's homes. It will use digital solutions and technology to create a seamless coordinated system and transform outpatient appointments. Where people do need to visit hospitals, the aim will be to do more in fewer appointments and wherever possible day-case treatment will become the norm.

Planned Care Priorities

The Planned Care Workstream is going to initially focus on these areas to transform health and social are services:

1. **Outpatient Transformation** to deliver more follow-up appointments in the community through use of technology to provide virtual clinics from a service called NHS Near Me
2. **Maximisation of Community Health Venues** and using flexible spaces in Hubs and Health Centres to shift some services, interventions and specialist staff from the hospital to the community setting
3. **Diagnostic One Stop Shop Model** providing co-located multiple specialist services and teams that can diagnose people faster and start them on treatment sooner

Unscheduled care

Unscheduled Care is described under Moving Forward Together as:

> **Services that are unplanned requiring out of hours urgent appointments, attending a minor injury unit or emergency department or needing an ambulance via 999**

It will develop a range of services, new ways of working and work alongside people to ensure they access the right service in the right place at the right time. This will be to improve self-care and anticipate needs to prevent hospital admission and ensure that people only use emergency services when there is a need to do so.

Unscheduled Care Priorities

The Unscheduled Care Workstream is going to initially focus on these areas to transform health and social are services:

1. A range of **Community Alternatives to Emergency Departments** and improving knowledge of and supporting people to use these appropriately and to self-care better

2. **Working with care homes** to improve the anticipatory care needs of the elderly and interventions to prevent admissions to hospital

3. **Comprehensive out of hours hubs** with resources to support an enhanced community network in-line with the Out of Hours service review

4. **Developing processes to support people** appropriately in the community or at home to prevent avoidable attendance at Emergency Departments

GGC Regional Care

The GGC Regional Care Workstream is described under Moving Forward Together as:

> **The specialist services that are delivered within Greater Glasgow and Clyde as part of the regional network that covers the whole of the west of Scotland and some nationally delivered services**

It will optimise the very specialist treatment and care that people get for complex conditions that require specially trained staff with access to specific equipment or other specialist teams. Where possible we will develop hub-and-spoke service models to deliver as much care as locally as possible making best use of innovation and technology.

Moving **Forward** Together.

What are our priorities

The Greater Glasgow and Clyde Regional Care Workstream is going to initially focus on these areas to transform health and social are services:

1. **Develop a West of Scotland Cancer Strategy** that will see changes to how we provide chemotherapy services and complex cancer surgery aligned with best use of the Beatson West of Scotland Cancer Centre

2. **A comprehensive review of Neurosciences** to develop a long term plan for services including the development of a tiered model of care for Neurology to where possible deliver more care locally

3. **Deliver on the implementation** of the National ‘Best Start’ strategy which will change how we provide Maternity and Neonatal services putting the mother and child, and family, at the centre of care.

Local Care

Local Care is described under Moving Forward Together as:

> ***The complete range of services that can be provided within people’s communities and homes to support self-management and maximise individual health and wellbeing, or to support people to live how they want until death***

It will optimise General Practice, Primary Care Teams and develop networks of community based services. Wherever possible there will be a focus on innovation, using technology and digital solutions to develop new models of care and ways of working.

Local Care Priorites

The Local Care Workstream is going to initially focus on these areas to transform health and social are services:

1. **Long-term condition management** and testing the principles of self-care, supported self-care and remote self-management
2. **Palliative and end of life care** system that supports people to make choices at the end of life the same way it has during their life
3. **Self-management health literacy and technology** to support and educate people to manage their own conditions
4. **Anticipatory Care Planning** via a joined-up, co-produced and shared plan that works seamlessly across the whole system

Mental Health

Mental health is described under Moving Forward Together as:

> ***The range of services that combined cover the life-course of people with mental health issues, learning disability and alcohol and drugs services to provide prevention and early intervention to promote and support good mental health and recovery to support people to live independently***

The Mental Health Workstream will work to deliver the 5 year strategy for adult mental health services that was developed in parallel and is consistent with the principles set out in moving forward together to provide more anticipatory care and shift the balance of care from hospital based services to the community.

Mental Health Priorities

The Mental Health Workstream is going to initially focus on these areas to transform mental health across health and social care:

1 **Implementation of the unscheduled** care review develop as part of the Mental Health Strategy working in partnership with Emergency Departments, Primary Care Out of Hours and community alternatives to meet people's needs and support the wider system

2 Align and **redesign services in Primary Care Mental Health** with a particular focus on responding to stress and distress as well as clinical conditions.

Older People's Care

Older People's Care is described under Moving Forward Together as:

> ***The range of services that combined provide treatment and care for the older population – often those with multiple conditions, complex needs such as dementia, or the frail elderly – delivered in people's homes, communities and in hospital settings***

The Older People's Workstream will look at new ways of working to link hospital and community services and deliver more care in or closer to people's homes. We will focus on early intervention and identifying opportunities support people to live well at home or in a homely setting independently and connected to their community.

Older People's Care Priorities

The Older People's Care Workstream is going to initially focus on these areas to transform health and social are services:

1. **Maximising intensive community support** and testing new models of care such as consultant geriatricians outreach into communities and the use of frailty practitioners to provide more care in peoples homes or care homes

2. **Early identification and Prevention of Frailty** by developing a set of tools to identify risk much earlier to support independence, prevent avoidable hospital admissions and promote community based care

3. **Develop a dementia framework** that examines new approaches to care as alternatives to inpatient hospital care with community based facilities and arrangements so that care can be delivered more locally

Partners and community assets

"How do you tackle the issues that health and social care can't? We work with people in the community to tackle things like deprivation"

Moving Forward Together recognises that transformation will only be realised by working alongside communities, partners and the Third Sector

- Health and Social Care Partnerships have been setup to:
  - Work with community members on the planning and delivery of services
  - Create positive conditions for communities to be meaningfully involved and influential
  - Identify and engage in and across communities to support them in the improvement of health outcomes
- The Programme will work to hear **what matters most** to people to enable whole system transformation for the population that also aims to meet local needs